

MINI DRUG MASTER PLAN

(2011/12-2013/14)

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GLOSSARY

Abuse: Sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances. (As defined in The Prevention of and Treatment for Substance Abuse Act, 2008)

Aftercare: Ongoing professional support to a service user after a formal treatment episode has ended in order to enable him or her to maintain sobriety of abstinence, personal growth and to enhance self reliance and proper social functioning.

Brief Motivational Interventions: Interactions with clients between 5 and 60 minutes in duration using cognitive behavioural and motivational interviewing techniques where clear advice is given.

Detoxification: A medically supervised process by which physical withdrawal from a substance is managed through administration of individually prescribed medicines by a medical practitioner in a health establishment, including a treatment centre authorized to provide such a service under the National Health , 2003 (Act no. 61 Of 2003).

Dual Diagnosis/co-morbidities: A patient has both a substance use disorder and another health disorder. These are often co-occurring psychiatric disorders but can also refer to co-morbid health conditions including HIV/AIDS, TB.

Early Intervention: A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided prior to patients presenting of their own volition and, in many cases, before they become aware that their substance use may cause problems. It is directed particularly at individuals who have not developed a physical dependency or major psychosocial complications. (As defined in the National Drug Master Plan 2006-2011).

Fetal Alcohol Spectrum Disorders: Include the range of permanent conditions that result from fetal exposure to alcohol, with Fetal Alcohol Syndrome being the most severe condition.

Fetal Alcohol Syndrome: A characteristic pattern of physical and mental impairments related to neurocognitive damage as a result of an alcohol-exposed pregnancy, resulting in low intelligence, behavioural disorders, poor social judgement, and general difficulty in performing everyday tasks.

Harm Reduction: The holistic treatment of service users and their families, and mitigating the social, psychological and health impact of substance abuse. (As defined in the Prevention of and Treatment for Substance Abuse Act, 2008)

Morbidity: Refers to a diseased state, disability or poor health due to any cause.

Mortality: Refers to the fatal outcome of morbidity (i.e. death).

Prevention: A proactive process that empowers individuals and systems to meet the challenges of life's events and transitions by creating and reinforcing conditions that promote healthy behaviour and lifestyles. (as defined in The National Drug Master Plan 2006-2011). It generally required three levels of action: primary, secondary and tertiary prevention.

Substances: Chemical, psychoactive substances that are prone to be abused including tobacco, alcohol, over the counter drugs, prescription drugs, and substances defined in the Drugs and Drug Trafficking Act 1992 (Act No. 140 of 1992), or prescribed by the Minister after consultation with the Medicines Control Council established by section 2 of the Medicines and related substance Control Act, 1965 (Act no. 101 of 1965).

Substance Use Disorders (SUDs): Substance use disorders are mental and behavioural disorders resulting from psychoactive substance use.

Treatment: The provision of specialised social, psychological and medical services to service users and to persons affected by substance abuse with a view to addressing the social and health consequences associated therewith. (as defined in the Prevention of and Treatment for Substance Abuse Act, 2008)

ACRONYMS

AA: Alcoholics Anonymous
AIDS: Acquired Immuno-Deficiency Syndrome
AlAnon: AlAnon Family Support Groups
ATOD: Alcohol, tobacco and other drugs
AUDIT: Alcohol Use Disorder Identification Test
BI: Brief Interventions
BMI: Brief Motivational Interventions
CBT: Cognitive Behavioural Therapy
DoH: Department of Health
DOTS: Daily observed therapy
DoSD: Department of Social Development
EAP: Employee Assistance Programmes
FASD: Fetal Alcohol Spectrum Disorders
FAS: Fetal Alcohol Syndrome
HCV: Hepatitis C Virus
HIV: Human Immunodeficiency Virus
HVB: Hepatitis Virus B
IDU: Injecting drug users
MCC: Medicines Control Council
MDMP: Mini Drug Master Plan
MI: Motivational Interviewing
MMT: Methadone maintenance therapy
NA: Narcotics Anonymous
NarAnon: NarAnon Family Support Groups
NDMP: National Drug Master Plan
NMSS: Non-natural Mortality Surveillance System
PHC: Primary Health Care
PPC: Patient placement criteria
SADHS: South African Demographic and Health Survey
SAPS: South African Police Service
SUD: Substance Use Disorder
SACENDU: South African Community Epidemiology Network on Drug Use
STIs: Sexually Transmitted Infections
TB: Tuberculosis
WHO: World Health Organisation
WHO ASSIST: WHO: Alcohol, Smoking and Substance Involvement Screening Test



FOREWORD BY MINISTER

Local studies show that over the past decade, there has been a rapid rise in the abuse of alcohol and other drugs in our communities. Substance abuse reaches across social, gender, age, cultural and religious barriers and has a major impact on crime, health, the economy and a range of social problems.

In the health sphere substance abuse significantly contributes to all the major categories of disease burden. This includes deaths and injuries due to traffic accidents and violence; contracting and treatment of HIV/AIDS and Tuberculosis; chronic diseases such as cardiovascular diseases and cancer and contributes to maternal and child mortality through high prevalence of fetal alcohol syndrome and other conditions. This scourge is a major threat to the achievement of the 12 key priority outcomes in the National Government Programme of Action and in health in particular to the achievement of a "long and healthy life for all South Africans".

In his opening address to the Second Biennial Summit on Substance Abuse that took place between 15 – 17 May 2011 at the International Conference Centre, Durban, State President Jacob Zuma emphasized that the fight against substance abuse requires renewed and more energetic attention from government. Furthermore, the honourable President stated that given the magnitude of the problem government

was not going to succeed working alone and greater collaboration was required between government, non-governmental organizations, youth formations, academia, political parties, faith based organizations and other.

Delegates to this Summit emphasized the threat that alcohol and drugs pose to this country and urged government to develop an action plan and to put in place programs towards curbing demand and supply of alcohol and drugs and reducing the harm associated with this abuse. This mandate is in line with the provisions of the Prevention and Treatment of Drug Dependency Act No. 20 of 1992 (as amended) and the Prevention of and Treatment of Substance Abuse Act No. 70 of 2008 (which will soon replace the former) which charge all key departments that have a role in curbing substance abuse to draw up Mini Drug Master Plans in line with their core functions.

This document outlines the activities that the National Health Sector will undertake as a response to substance abuse, in line with the 10 Point Plan of the Department of Health and the National Service Delivery Agreement (NSDA). It includes regulating precursor chemicals and medicines and substances with the potential for abuse, conducting screening (especially for at risk groups), providing health services to substance abusers, managing co-morbid substance abuse and other mental health disorders, infectious diseases and chronic conditions and providing information and education around substance abuse.

I am confident that this plan will guide the health sector and thereby contribute towards the realization of the key priority outcomes in the National Government Programme of Action and the achievement of "long and healthy life for all South Africans". This National Health Mini Drug Master Plan will assist provinces in developing and implementing the necessary interventions required to achieve the goals set in the broad inter-sectoral National Drug Master Plan.

Dr AP Motsoaledi (MP)
Minister of Health
DATE: 01 JULY 2011

PREFACE

Alcohol and drug abuse is a phenomenon as old as humankind but it continues to present a significant public health problem. Research has shown that substance abuse is expanding rapidly, destroying individuals, families and entire communities and undermining national economies. The negative impact of substance abuse cannot be underestimated.

Today, our nation faces great challenges in terms of direct and indirect health and social consequences of substance abuse. Human and financial resources are lost in the workplace, road and domestic accidents are drastically increased due to substance abuse, drug and alcohol misuse impacts on diseases such as HIV and AIDS, non-communicable diseases, mental disorders and other diseases.

The Mini Drug Master Plan translates the resolutions relating to the health sector taken at the Second Biennial Summit that took place on 15-17 May 2011 in Durban. It is in line with the principles of drug demand reduction which emphasize that programmes should be implemented at primary, secondary and tertiary levels to be able to reduce the negative health and social consequences of substance abuse.

Through this plan, the Department of Health will comply with the requirements set out by the National Drug Master Plan which requires that the key departments that were identified to have a key role in supply, demand and harm reduction should develop a plan that implements activities on substance abuse within their mandate.

The goal of the Mini Drug Master Plan is to galvanize the health sector to scale up health education, health promotion, screening and treatment for those who are at risk for substance abuse.

The implementation of this Mini Drug Master Plan will no doubt contribute to a more improved and responsive health services in relation to substance abuse, raised public awareness concerning harm caused by abuse of substances and promote a long and healthy life for all South Africans.



A handwritten signature in black ink, appearing to read 'Ms MP Matsoso'.

**MS MP MATSOSO
DIRECTOR GENERAL**

ACKNOWLEDEMENTS

The National Department of Health-Directorate: Mental Health and Substance Abuse would like to express its sincere gratitude to our partners, organizations and all those persons who in one way or another contributed to the development of the Mini Drug Master Plan.

1 BACKGROUND

Substance abuse in South Africa places an immense health and socio-economic burden on society. As in the rest of the world it reaches across social, racial, cultural, language, religious and gender barriers. Research has highlighted the link between substance abuse and various health and social problems, in particular:

- intentional and non-intentional injuries and premature death;
- dysfunctional family life;
- risky sexual behaviour and infectious diseases, such as tuberculosis, hepatitis C (HCV) and sexually transmitted infections including HIV/AIDS;
- cancers;
- mental health problems such as increased risk of anxiety, depression and some psychoses;
- antenatal and neonatal complications such as fetal alcohol spectrum disorders (FASD);
- child abuse and neglect;
- crime (particularly crimes of violence, especially family violence; property crimes and crimes associated with the supply of or trafficking in substances);
- absenteeism and school failure; and
- loss of productivity, unemployment and other negative economic effects.

Reducing substance abuse related harm is therefore key to a number of government priority outcomes including 1)Improved quality of basic education 2)A long and healthy life for all South Africans and 3)All people in South Africa are and feel safe.

Substance abuse has significant negative impacts on public health in terms of increased morbidity and mortality. Reducing substance related harm will increase life expectancy through for example less violence and traffic accidents and will also positively impact on prevention as well as care and treatment of HIV and AIDS and Tuberculosis. As maternal and child health are also negatively affected by substance abuse (for example through Fetal Alcohol Syndrome and chronic diseases such as cardiovascular disease), redressing substance abuse will contribute to promoting more healthy women and children.

The Prevention and Treatment of Drug Dependency Act (No. 20 of 1992) as amended (to be replaced by the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008) is the primary legislation governing substance abuse in South Africa and is administered by the Department of Social Development. The Act provides for the establishment of the Central Drug Authority (CDA) which is constituted by the selected government departments and sectors, substance abuse experts and non governmental organizations that have a role in supply, demand and harm reduction of and from substance abuse. The CDA coordinates all efforts from the selected sectors towards curbing substance abuse supply, demand and harm reduction

In terms of the Prevention and Treatment of Drug Dependency Act, as amended, and in accordance with the National Drug Master Plan (NDMP), the key/specific departments as listed in the Act and NDMP are charged with drawing operational plans in line with their core functions. These plans are referred to as Mini-drug Master Plans (MDMP). The specific Units within the Department of Health that were identified by the Act to have a critical role in curbing substance related problems are the Medicines Control Council and the Mental Health and Substance Abuse Units.

The Department of Health (DoH) is tasked with the provision of specific services with regard to responding to substance abuse related problems. These include regulating precursor chemicals, regulating medicines and substances with the potential for abuse, managing medical emergencies, medical complications, detoxification as indicated by available protocols, and co-morbidities including other mental disorders and infectious diseases as prescribed by the National Health Act 63 of 2003 and the Mental Health Care Act 17 of 2002.

This MDMP outlines the activities/strategic interventions that the Health Sector will implement in responding

to substance abuse, in accordance with the National Department's 10 point Strategic Plan 2010-2013. It also outlines areas in which the Health Sector will work with key partners to improve both preventive and curative services and ensure better health access.

This MDMP directs interventions through action steps and timeframes and ensures that these correspond with and contribute to the National Drug Master Plan. Priority areas and interventions that need to be implemented have been selected based on short, medium and long term objectives. .

2 GOAL OF THE MINI DRUG MASTER PLAN

The goal of this Mini Drug Master Plan (MDMP) is to reduce the health, economic and social burden caused by substance abuse in South Africa, through the provision of targeted demand and harm reduction interventions provided by the National Department of Health, thereby supporting the implementation of the National Drug Master Plan.

3 GUIDING PRINCIPLES

- Systematic, multifaceted responses are required. Singular stand-alone responses do not generally solve complex substance abuse issues. The DoH will work with a range of stakeholders throughout the country, including other departments and spheres of government, service providers and substance abusers and those affected by their use to develop such responses.
- Integrated responses are required that complement national and provincial programmes and established health, social welfare, and other regulatory structures and improve reporting to the citizens, target communities, service providers and various government spheres.
- An emphasis will be placed on evidence-based interventions.
- The principle of social inclusiveness is reflected through a commitment to reducing the impact of use on our most vulnerable populations – previously disadvantaged communities, young people, people affected by HIV/AIDS, people who are homeless, women (especially pregnant women), elderly people, commercial sex workers, people who are mentally ill and physically disabled.
- Demand reduction and Harm reduction are key principles
Demand reduction refers to activities that aim to reduce the demand for drugs through prevention of substance abuse, treatment and relapse prevention of existing problems. Harm reduction refers to practical strategies that meet substance users "where they're at," in order to reduce the negative consequences of their use when they are unable to stop their use via abstinence-oriented treatment services. These can include medications that can be used as substitution treatments, though never offered in isolation

4 DEFINING LEVELS OF SUBSTANCE USE AND APPROPRIATE INTERVENTION

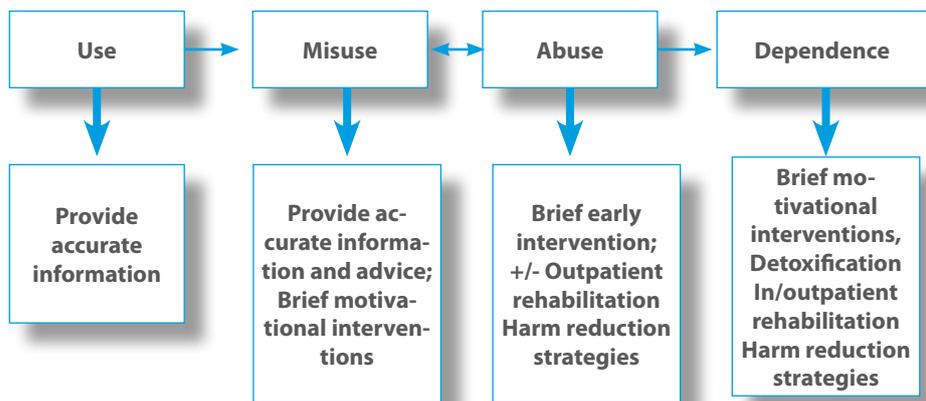
Most people who use drugs and alcohol do so occasionally and experience few or no negative consequences. However, some people do experience negative and/or harmful consequences. The level of these consequences varies according to the type of drug, the quantity used, and the frequency of that use. The different levels of use are as follows:

- **Use:** recreational or occasional use with no adverse health or social consequences.
- **Misuse:** excessive or problematic use of a substance with some adverse consequences.
- **Abuse:** a pattern of substance use that damages the individual's physical or mental health or causes social harm. It is important to note that although a person can experience harmful drug use, it does not mean they are drug dependent. There are specific criteria that determine if a person is drug dependent, discussed below.
- **Dependence:** Substance Dependence is defined by DSM-IV as a maladaptive pattern of substance use that leads to impairment or distress and manifests itself by the following: failure to fulfil important obligations at work, school or home, uses substances in a manner that is physically hazardous, legal problems due to substance use, social or interpersonal problems due to or exacerbated by substance use. Dependence causes changes in the way the brain's neurotransmitter systems work and causes physical adaptation of the body to the substance, tolerance (namely the need to consume

increasing amounts of a drug to obtain the desired effect; and withdrawal (namely physical and psychological symptoms that the person experiences when they reduce or stop using a drug or are relieved by resuming use of the drug). Dependence is also defined by loss of control over taking of the substance (namely a strong desire or sense of compulsion to take the drug or unsuccessful efforts to cut down or control use) salience, so that the substance takes over the person's life and a great deal of time is spent obtaining or using the drug or recovering from its effects and the user progressively neglects alternative pleasures and interests or important activities; and continued use despite clear evidence that it is harmful.

It is unrealistic to expect all drug dependent patients to immediately stop using all drugs. Some patients will relapse to regular drug use, while others will be abstinent most of the time, but occasionally use drugs. For many of these individuals, interventions that focus on reducing the health consequences and other harms associated with drug use may be indicated. For instance, many may benefit from substitution medications that enable users to reduce or stop their intake of illicitly obtained drugs; so these substitution treatments and other harm reduction services need to be readily available and accessible.

Prevention and treatment of substance use disorders (SUD), much like HIV/AIDS or diabetes, require medication and clinical interventions, as well as social approaches. As the patient progresses along this disease spectrum, intervention strategies should be appropriate for the level of problem severity as described in the diagram below:



5 PRIORITY AREAS, STRATEGIES AND INTERVENTIONS

The Department's 10 point plan which outlines priorities for strategic intervention provides the framework for this document. For this MDMP, seven of these priorities have specific relevance, ie. provision of strategic leadership and creation of a social compact for better health outcomes, improving quality of services, improving human resource management, accelerated implementation of HIV and AIDS plan and reduction of mortality due to TB and associated diseases, mass mobilisation for better health for the population, review of the drug policy, and strengthening research and development.

For each of the relevant priority areas, health sector-related interventions will be implemented. These strategies and interventions are based on current scientific knowledge, available evidence on effectiveness and cost-effectiveness, and knowledge of best practices. They are the most viable options for South Africa to pursue, given their feasibility to implement and likelihood of positive impact on substance abuse. A summary of these key priority areas is given in Table 1, together with proposed strategies, action steps and time frames.

5.1 Provision of strategic leadership and creation of social compact for better health outcomes

Increasing Leadership and accountability

The National DoH has a key role to play in overseeing the implementation of the MDMP and ensuring that provincial health departments actively participate and implement provincial drug master plans and report on the implementation of their MDMP. The national DoH will also raise the profile of substance abuse as a health and social issue and work with other departments in preventing substance abuse through legislative and policy initiatives.

5.2 Improve quality of services

For this priority area, the focus is on improving the quality of substance abuse treatment and aftercare services.

5.2.1 Improving the quality of treatment and aftercare

Treatment focuses on halting, reducing, or reversing the negative health and social consequences associated with substance use disorders. Treatment also focuses on preventing further health and social harms related to continued substance abuse (i.e. harm reduction interventions to reduce HIV-risk among injection drug users).

Box 1: *Principles of effective treatment*

- *No single treatment is appropriate for all individuals*
- *Treatment needs to be readily available*
- *Effective treatment attends to multiple needs of the individual not just his/her substance use*
- *An individual's treatment plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs*
- *Remaining in treatment for an adequate period of time is critical for treatment effectiveness*
- *Counselling (individual and/or group) and other behavioural therapies are critical components of effective treatment*
- *Medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies*
- *Dependent or abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way*
- *Medical detoxification is only the first stage of treatment and by itself does little to change long-term substance use*
- *Treatment does not need to be voluntary to be effective*
- *Possible substance abuse during treatment must be monitored continuously*
- *Treatment programmes should include assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counselling to help patients modify or change behaviour that place themselves or others at risk of infection*
- *Recovery from substance dependence can be a long-term process and frequently requires multiple episodes of treatment*

The National Institute of Drug Abuse, NIH 00-4180

Internationally accepted principles of effective treatment

While recognizing that internationally-developed treatment models need to be adapted to suit the South African context, principles of effective treatment should always be adhered to.

5.2.1.1 Detoxification

Detoxification is the first phase of treatment for people with substance dependence; it is not the entire treatment; and should always be followed by the second and most important phase, an inpatient or outpatient relapse prevention/rehabilitation treatment programme. It should be timed so that the patient engages in their treatment programme as soon as possible after detoxification. In cases where the patient attends an outpatient programme, detoxification should be delayed until the patient has engaged in the programme.

Detoxification:

- Involves a graded and controlled reduction in drug tolerance, thereby minimizing unpleasant withdrawal symptoms
- It is a medical process and should use safe, recognised, evidence-based detoxification protocols
- It is indicated when withdrawal from a substance is dangerous (e.g. alcohol or benzodiazepine)
- It is indicated where withdrawal is highly uncomfortable, thus predisposing the individual to relapse (e.g. opioids).

Short to medium-term activities

- Current detoxification protocols for substance dependence must be up to date and appropriate essential medications must be available. The United Nations and Commission on Narcotics Drugs has passed a consensus statement on essential medications that all signatory countries should have available for detoxification and withdrawal and the WHO has developed key detoxification guidelines that should be adhered to.
- Medications approved by the MCC to assist with opioid substitution therapies (OST) must be available in all DoH tiers of service. Where possible, DoH should facilitate advocacy for the generic forms of these essential medicines to be made available and be registered at the MCC.
- As part of the introduction and implementation of opioid substitution therapies, the DoH should review and train medical practitioners, nurses and others working with people who use drugs in appropriate substitution protocols and guidelines. The WHO has published relevant guidelines to OST prescribing that should be adhered to.
- As the risk of overdose is greater for individuals who have undergone a period of treatment or abstinence from opioids, medication should be made available at all facilities to prevent and counter opioid-related overdoses.
- Detoxification services should be made available at all PHC, secondary and tertiary level facilities.

5.2.1.2 Prevention of Relapse

Detoxification is only the first part of treatment, and always needs to be followed by a more intensive treatment programme that focuses on changing substance abuse behaviour via teaching relapse prevention strategies or techniques, building skills and supports for longer-term recovery, and in some instances addressing immediate contributors to substance abuse. While the DoSD is responsible for the delivery of these psychosocial rehabilitation programmes, the effective delivery of these services can only occur with inputs from and partnership with DoH.

Apart from psychosocial rehabilitation, some people who use substances may require pharmacological interventions to enable them to reduce or stop their intake of substances. Individuals who require pharmacological interventions often have a history of several failed attempts at treatment and are unable to remain abstinent for long periods of time, may have more severe and chronic substance abuse problems and often have co-occurring mental disorders and low levels of appropriate social support for recovery and treatment.

As mentioned earlier, there are several medications available for this purpose, particularly for the management of alcohol and opioid dependence, with overwhelming evidence in support of their effectiveness in reducing the harms associated with ongoing alcohol problems and illicit opioid use. These pharmacological interventions can be administered in both inpatient and outpatient settings, depending on patient's needs, and availability of resources. These interventions should be protocol driven, and conform to evidence based practices.

Short-term activities

- Protocols on psychosocial rehabilitation must be up-to-date and available in all DoH facilities
- DoH to provide substitution medications where indicated and guided by evidence.

- Alongside the provision of medication, DoH will provide some behaviour change counselling and referral to more intensive services as needed.

5.2.1.3 Aftercare

Aftercare or continuing care services assists patients to reintegrate into the community and maintain positive treatment gains by providing planned, structured follow-up support to assist the patient to remain abstinent. Internationally, involvement in community-based self-help support groups for people with substance abuse problems is believed to be an important component of treatment and aftercare. The most common self-help/mutual help organisations are the 12-step support groups. These groups are based on the principles of Alcoholics Anonymous, and are found worldwide including South Africa. They provide support for the person with the substance abuse problem and derivatives of these groups provide support services for affected families. Several studies have demonstrated that patients involved in a 12-Step support group (NA/AA or AlAnon/NarAnon) either during or post-treatment, display better treatment outcomes than service users without this 12-Step involvement.

- DoH to develop protocols for a stepped down/tiered system of care where allocation of service and intensity of service provided will be influenced by problem severity for substance abuse patients
- DoH health practitioner to prescribe medication to prevent relapse if indicated.
- AA/NA pamphlets and other information such as Meeting Lists must be available in DoH facilities.

5.2.1.4 Harm Reduction

Harm reduction is a set of practical strategies focused on reducing the negative consequences of drug use, these range from strategies that promote safer drug use (such as needle and syringe exchange programmes focused on reducing the risks associated with injecting), to managed use (via the provision of substitution medications) to abstinence. Harm reduction strategies meet substance abusers “where they’re at,” addressing conditions of use along with the use itself. Harm reduction is a person-directed, strengths-based approach to working with people who abuse substances. It does not expect an individual to make unrealistic changes in their lives, but sets pragmatic goals so that the person can see immediate positive results. For people who find abstinence difficult, or cannot or will not stop using substances, harm reduction/minimization strategies and interventions are especially suitable as these strategies reduce the negative public health consequences of substance abuse. As such, harm reduction fits firmly alongside prevention and treatment.

The following box describes the central principles of harm reduction practice

Box 2: Key Principles of Harm Reduction

- *Accepts, for better and for worse that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.*
- *Understands drug use as a complex, multi-faceted condition that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.*
- *Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.*
- *Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.*
- *Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.*

Short term activities

- Prescribe medication for substitution therapies if indicated according to evidence-based guidelines and treatment protocols.

Medium to long term activities

- Introduce evidence-based strategies to prevent initiation to injection among opiate and stimulant users as a means of preventing injection-drug related public health risks
- Introduce evidence-based harm reduction programmes for injection drug users in areas where there are established injection drug using populations.

5.3 Improve human resource management

5.3.1 Capacity development

For the aforementioned key activities in priority areas to be realised, the DoH will build capacity among its workforce to address substance abuse related problems in an evidence-based manner. Key recommendations for capacity development in each priority area are outlined in Table 2.

5.3.2 Early intervention

The DoH will in the **short to medium term**:

- Provide training in Brief Interventions (Screening tools, Motivational Interviewing (MI), Cognitive Behavioural Therapy (CBT) and appropriate referral) for identified health professionals (Doctors, Nurses, Social Workers) in PHC, secondary and tertiary level hospitals.
- Increase capacity for prevention, identification and development of appropriate interventions for individuals and families affected by FASD.
- Train all health professionals working with pregnant women in recognising and managing peri-natal mental health problems
- Ensure that staff at trauma units receive training so that they can address medical complications from all persons who abuse substances (including overdoses), patients who inject drugs or who come in with other drug complications (e.g. from exposure to so-called date rape drugs or from mixing alcohol with substances like gamma-hydroxybutyrate (GHB)).
- Medical doctors and pharmacists will receive further training on what they can do to detect patients who are abusing (or likely to abuse) over-the-counter and prescription medications and what they can do to reduce the incidence of such abuse.

5.3.3 Detoxification

An important factor to ensure the success of detoxification services will be the adequate provision of resources for the training and support of health professionals so that they are adequately trained to provide safe detoxification and appropriately treat and refer those patients with substance abuse problems. Specifically:

- DoH will provide training in substance abuse detoxification protocols for identified health professionals in PHC for uncomplicated detoxifications;
- DoH will provide training in protocols for identified health professionals in secondary and tertiary level hospitals for complicated detoxifications and patients with co-morbid physical and mental health problems.
- DoH will provide information for staff in PHC, secondary and tertiary hospitals on appropriate referral resources and models of substance abuse treatment.

5.3.4 Relapse prevention

- DoH will build capacity among relevant staff on medications that assist to prevent relapse, and appropriate protocols for medication assisted relapse prevention.

5.3.5 Aftercare

- DoH will build capacity amongst relevant staff regarding viable aftercare and support programmes to

which patients can be referred following treatment.

5.3.6 Harm reduction

- DoH to build capacity among relevant staff regarding harm reduction principles and practices.
- DoH to build capacity among relevant staff on medications that assist to prevent relapse.

5.3.7 Dual diagnosis

- DoH to cross-train their health workforce in substance abuse issues. Cross-training should involve provision of screening tools for both co-occurring disorders, strategies for effectively intervening in both disorders, case management strategies, and information about where to make appropriate referrals to.

5.3.8 Substance use and infectious diseases

- DoH to facilitate cross-training whereby infectious disease health workers are exposed to substance abuse issues; and health workers working in the substance abuse area are exposed to issues related to prevention and management of infectious diseases.

5.4 Accelerated implementation of the HIV and AIDS and sexually transmitted infections national strategic plan and increased focus on TB and other communicable diseases

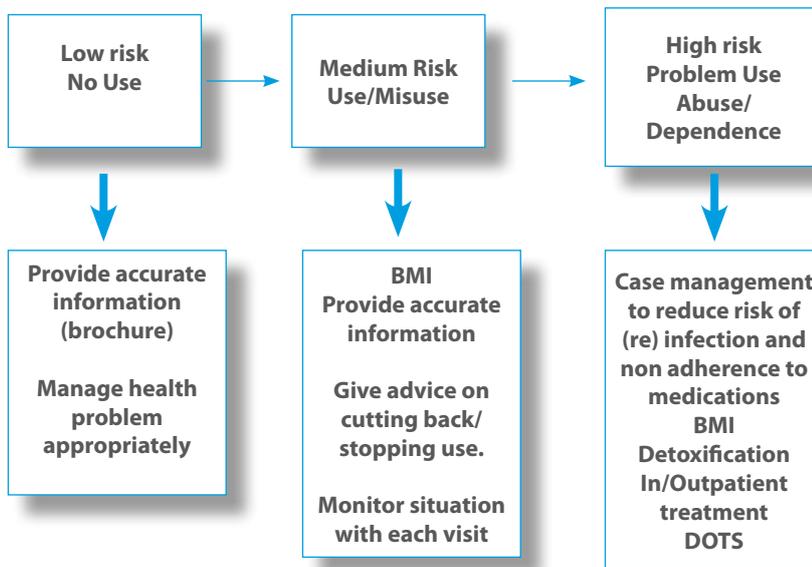
5.4.1 Improving the management of co-occurring infectious diseases among people with substance use disorders

Persons with substance use disorders very often have co-occurring health problems and infectious diseases. Substance use is strongly associated with sexual risk behaviours such as trading sex for money to buy alcohol or drugs, multiple sexual partners and inconsistent condom use due to the disinhibitory effects of drugs (especially alcohol and stimulants). These factors place people who use drugs at risk for contracting STIs such as HIV as well as other sexually transmitted infectious diseases including HCV. In addition smoking drugs and the unhealthy environments in which drug users often find themselves places them at increased risk for TB. In addition people who are infected with HIV or another STI and/or HCV have poorer health outcomes and are less responsive to medications if they continue to use substances. Preventing and treating these infectious diseases among people who use substances remains a key responsibility of the DoH.

Short to medium term activities (Table 1)

- DoH will screen all patients at HIV, TB, sexual health and, neo-, peri- and ante-natal clinics for AOD use.
- Substance abuse issues will be integrated into HIV/TB and other infectious disease prevention programmes. For example information on how substance use can affect the immune system and medication compliance and the role that substance abuse plays in increasing sexual and other risk behaviour (such as injecting drug use and sharing pipes) should be included in HIV awareness and prevention programmes.
- Patients receiving treatment for substance abuse whether, detoxification, as part of a mental health treatment programmes, or stand alone treatment for a SUD will be assessed for risk of HIV, TB, STIs, HVC, HBV and other infectious diseases, screened for the presence of these diseases, and provided with access to suitable medications (such as ARVs) where indicated. Ongoing substance use should not limit people access to lifesaving medications.

Suitable interventions to follow after screening the patient for substance use:



5.5 Mass mobilisation for better health for the population

For this priority area, there are three key focal points: a) Prevention of substance abuse-related problems and b) Early intervention activities for substance abuse and c) addressing co-occurring mental health problems (non communicable diseases). Each will be discussed in turn:

5.5.1 Focus I: Prevention of substance abuse related problems

Prevention encompasses all activities that (i) prevent initial substance use and (ii) delay the onset of problematic use. Prevention activities will include both universal messaging (i.e. blanket media campaigns) and messages that target high-risk groups (i.e. pregnant women, children/youth, and marginalised groups). Even though public information and education campaigns can raise awareness and impart knowledge about the health and social consequences of the harms caused by substance abuse, evidence of their effectiveness in reducing such harms is weak (Anderson *et al.*, 2009). However, together with media advocacy, information campaigns can be used to promote the availability of effective interventions and mobilise public opinion and action.

Reliable, consistent, accurate and relevant information about substance abuse will be disseminated as part of health promotion. The DoH will also support other departments and agencies, such as the South African Police Service and others who work in the supply reduction arena rather than demand and harm reduction, by assisting with the contents of their information and educational materials and ensuring consistency with DoH messaging. DoH will also work with the Department of Trade & Industry (and its provincial counterparts) to ensure that there is appropriate health messaging at points of sale of alcohol products. Allowance for such notices has been made within Chapter 7 (Para. 41) of the National Liquor Act 59 of 2003 and requires consultation with the Minister/ Department of Health.

Short term activities

- Develop reliable and relevant multi-media information material on substance abuse for distribution/viewing at all DoH services:
 - o Separate information for alcohol, tobacco and the different licit and illicit drugs will be developed.
 - o Substance abuse related prevention activities undertaken by DoH will include reference to the increased risk for contracting infectious diseases (such as HIV, STIs, TB, HBV, or HCV) associated with substance abuse.
 - o Targeted information and messaging will be developed for specific high risk groups that addresses their unique risk profiles (such as pregnant women, women in general, injection drug users, and young people).

Mid to long term activities

The DoH will regularly review information materials to ensure that material is up-to-date and presented using the best media for different audiences. The DoH will look into the need for/suitability of imposing a levy on public alcohol advertisements (e.g. on radio, TV, & billboards) that could be used by agencies other than the liquor industry to develop counter-advertisements promoting responsible drinking practices.

5.5.2 Focus II: Early intervention for substance abuse related problems

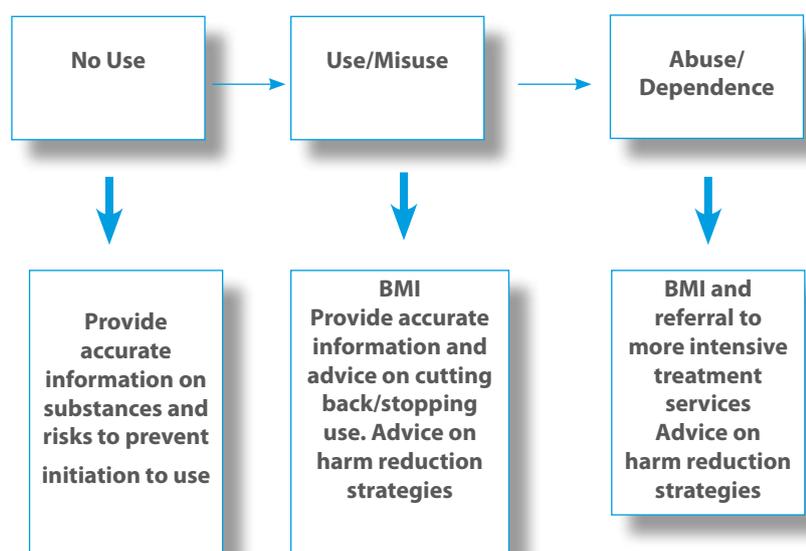
Early interventions consist of identifying and treating potentially harmful substance use prior to the onset of overt symptoms or problems. Early interventions are suitable for individuals who have not yet developed obvious signs of dependence but who are abusing substances and have experienced some adverse consequences of use

Early detection (screening) and brief interventions, especially brief motivational interventions (BMI) using cognitive behavioural and motivational interviewing techniques are effective methods for the prevention of substance abuse-related health problems. Where more severe problems are detected that are not responsive to brief interventions, referrals will be made to higher threshold intervention services. Related to this, some forms of early intervention (such as BMI) are effective ways of building readiness for treatment and for motivating individuals with substance dependence to enter more intensive intervention services. In the short term efforts will be focused on screening all people attending trauma units, medical obstetric units (MOUs), STI/TB/HIV clinics, and mental health services for substance use/abuse-related problems and providing those who screen positive with brief interventions and referral (where needed) to treatment. In the medium to long-term these screening, brief intervention and referral to treatment services (SBIRT) will be expanded to all services offered at primary health care.

Screening

Screening forms a part of Early Interventions and several internationally validated screening tools have been adapted for use in South Africa, including the Alcohol Use Disorders Identification Test (AUDIT); a screening tool for alcohol use disorders, and the WHO-ASSIST for smoking and involvement in substance use.

Suitable interventions to follow after screening the patient:



Short to medium term activities (Table 1)

- Screening
 - o The following patients at primary health (PHC), secondary and tertiary level hospitals to be screened for substance use, and where indicated receive brief interventions and/or appropriate referrals to treatment
 - Pregnant women;
 - Individuals with co-morbid conditions such as HIV, TB, STIs and other infectious diseases. If present, the patient needs to be informed about how substance use/abuse impacts on the management and progression of these infectious diseases during a BMI.
 - Individuals who present at trauma units with alcohol or drug-related injuries,
 - Individuals who present at health care settings with alcohol or drug-related health problems
 - Individuals who present at health care settings with mental disorders (depression and other mood disorders, psychosis, post traumatic stress disorder, anxiety disorders should be screened for substance use/abuse and if present informed of how substance use impacts on the course and severity of their other mental disorders.
 - o All patients presenting with alcohol use problems at PHC or other treatment settings managed by DoH (i.e. detoxification facilities) should be screened for co-morbid medical and mental health conditions.
- Brief Interventions
 - o All patients who screen positive for using illicit drugs and abusing over-the-counter and prescription medications, or who screen above a certain threshold for alcohol and tobacco use should (where indicated) receive brief interventions and/or appropriate referrals to more intensive treatment services.

5.5.3 Focus III: Improving the management of co-occurring substance use/abuse and other mental disorders

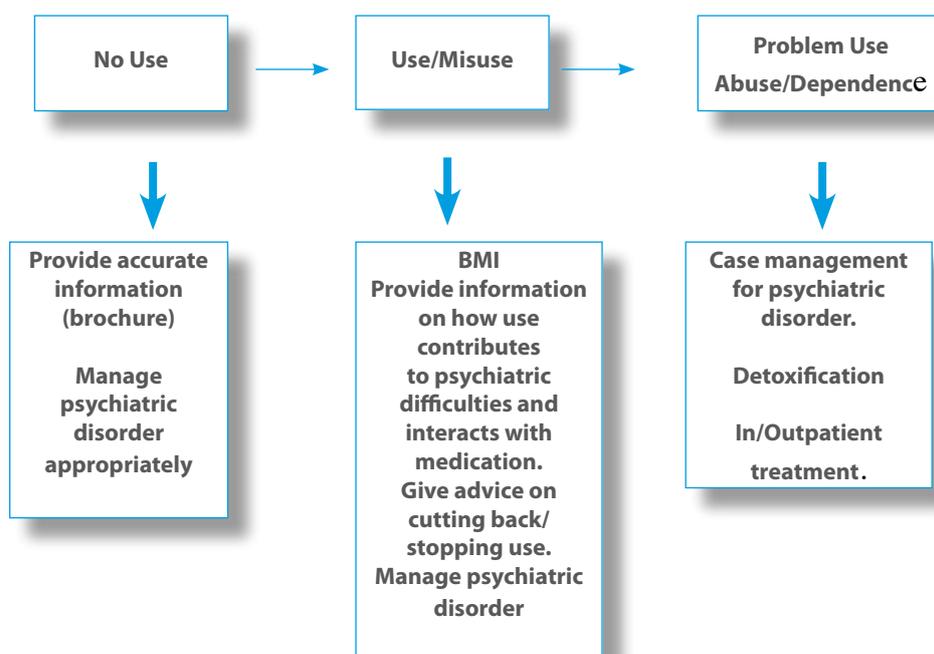
Persons with substance use disorders very often have other co-occurring mental disorders. When these other co-occurring mental disorders are not treated, patients will have poorer substance abuse treatment outcomes, more chronic health and social problems, and poorer long-term prognoses than individuals with substance use disorders alone. Conversely, untreated substance use/abuse problems often exacerbate the symptoms and course of other mental disorders and negatively affect patient responsiveness to mental health interventions and psychiatric medications. Patients with untreated dual diagnoses contribute to the large revolving door population in both mental health and substance abuse treatment settings and place a great burden on overstretched health services through their high lifetime use of health and mental health services. As such, it is important to identify co-occurring mental disorders among individuals with substance use/abuse problems (and equally identify substance use/abuse problems among individuals with mental disorders) and treat both disorders in an integrated fashion.

Short-term activities (see Table 1)

- All patients presenting with psychiatric emergencies or psychiatric problems (at PHC, secondary and tertiary level hospitals) should be screened for the use and problems related to the use/abuse of substances.
- Where substance use/abuse problems are present, patients with co-occurring mental disorders should be given information about how substance use impacts on the treatment of their other mental disorder and given advice to stop/reduce their substance use intake.
- Substance abuse issues also need to be integrated into mental health awareness, prevention and treatment programmes. For example
 - o Information on how substance use can affect mental health and exacerbate mental illness, medication compliance and interactions should be provided.

- All patients presenting with substance use/abuse problems at PHC or treatment settings managed by DOH (detoxification facilities etc) to be screened for other co-occurring mental disorders.
 - o If present, patient needs to be informed about how substance use/abuse exacerbates other symptoms, appropriate psychiatric medication/s need to be provided, and treatment for both disorders provided in an integrated manner.

Suitable interventions to follow after screening psychiatric patients for substance use/abuse:



5.6 Review drug policy

Improving the control of precursor chemicals & medicines

South Africa is a signatory to the International Narcotics Board’s (INCB) conventions on the control of precursor chemicals used for the manufacture of illicit drugs. The DoH will continue to implement strategies to control the manufacture, import and distribution of precursor chemicals such as ephedrine that can be used in the manufacture of illicit drugs. The DoH will also continue with current efforts to regulate the manufacture and sale of scheduled narcotics to limit diversion and non-prescription abuse of these drugs.

5.7 Strengthening research and development

5.7.1 Focus I: Commitment to monitoring and evaluation

To ensure accountability and transparency, annual reporting with regard to progress will be made to the Central Drug Authority.

- The Mini Master Plan will be reviewed on an annual basis. This review will focus on the extent to which progress has been made on addressing each priority area
- There is continual appraisal of provincial profiles of substance use/abuse to provide improved understanding of the nature and extent of the problem and mix of service required to respond effectively to the problem.
- DoH will support research to evaluate policy implementation as well as specific demonstration projects (e.g. to test the effectiveness and feasibility of interventions to reduce non-adherence of HIV and TB medications and/or to test the feasibility and effectiveness of harm reduction interventions to prevention initiation to injection drug use among opiate and stimulant users).

DoH will identify a core set of indicators to inform the monitoring and evaluation of the implementation of the MDMP.

5.7.2 Focus II: Strengthen support for strategic research

Current data collection systems will be strengthened and new data collection systems established to facilitate the monitoring of substance use/abuse and the impacts of substance use/abuse in the country. These systems are essential for evaluating the impact of interventions

With regard to broader research, DoH will embark on a process of identifying what research regarding substance use/abuse is needed to inform DoH policy and practice.

Given the emerging understanding of linkages between alcohol and other drug use and infectious diseases like TB and HIV, the links with interpersonal violence, FASD, and other mental health problems (and the associated burden on the health care sector), ^{1,2,3,4} priority will be given to funding demonstration projects that will guide health sector interventions in these areas.

Table 1: Summary of Priority Areas, Strategies & Interventions, Action steps, & Timeframe			
Priority Area linked to NDoH 10 point plan 2010/11-2012/13	Key focus	Strategies & Interventions	Action Steps
Provision of strategic leadership and creation of social compact	Strategic Leadership	Develop comprehensive national strategy to reduce substance use/abuse Ensure provincial buy-in to MDMP Engage with civil society	<ul style="list-style-type: none"> Encourage provinces to engage with MDMP and prepare provincial plans Ensure that the MDMP is on the agenda of regular meetings with principal substance abuse and mental health counterparts Where possible strengthen capacity of local health authorities to develop municipal substance use/abuse policies/programmes & community mobilisation efforts & initiatives.
Accelerated implementation of the HIV and AIDS and sexually transmitted infections national strategic plan and the increased focus on TB and other communicable diseases	Improve the management of co-occurring infectious diseases	Screening & brief interventions for hazardous & harmful drinking at PHC & other settings	<ul style="list-style-type: none"> Screen and brief interventions for alcohol in selected health centres (*trauma units, antenatal clinics, HIV & AIDS/TB/STI clinics, and psychiatric emergency and outpatient departments). Provide information via brochures for persons found to be at low risk for alcohol-related health problems, brief interventions for persons found to be at medium risk, & referral to treatment for those at high risk. Screening and Brief interventions for alcohol use disorders among Tuberculosis patients
Improve human resource management	Capacity development	Increasing capacity of health workers	<ul style="list-style-type: none"> Engage with the relevant Councils (HPCSA, Nursing Council) to introduce content and courses on substance abuse prevention and treatment. Explore the feasibility of creating a sub speciality in psychiatry for substance abuse with the HPCSA
			Timeframe
			Ongoing
			Short-medium term
			Short- to medium term

Mass mobilisation for the better health of the population	Prevention of substance abuse	Public information & awareness campaigns	<ul style="list-style-type: none"> Introduce targeted substance abuse prevention campaigns aimed at patients that use health services (such as pregnant women, adolescents) and who are not identified as already misusing alcohol or using other drugs Utilize radio, television, and print media to create public awareness. Introduce targeted prevention campaigns aimed at high risk groups that use PHC clinics Engage the Department of Trade & Industry and provincial Department of Economic Affairs to ensure that there are notices on responsible alcohol use and the dangers of misuse at points of sale of alcohol Engage with Department of Communications and DTI to consider (i) banning alcohol advertising (ii) banning alcohol advertising on radio & TV until after 21h00, (iii) ban advertising of alcohol anywhere youth would be exposed to such advertising (e.g. youth-oriented magazines, cinemas, on billboards near schools, libraries, playgrounds, at railway stations), and (iv) ban alcohol sponsorships where more than 15% of the audience is likely to be between 10 to 18 years Engage with DoT to ban any alcohol advertisements that is visible on or from a public road Work with DTI to ensure that there are appropriate health warnings at all points of liquor sale 	<p>Short term</p> <p>Medium term</p> <p>Short-medium term</p> <p>Short-term to Medium term</p>
	<p>Improve management of non-communicable diseases</p> <p>Improving the management of co-occurring mental disorders</p>	<p>Screening and brief interventions</p> <p>Ensure that co-morbidity addressed in general, substance abuse and mental health facilities run by DoH</p>	<ul style="list-style-type: none"> Screen patients seen at selected services (trauma units, medical obstetric units (MOUs), STI/TB/HIV clinics, mental health services) using AUDIT and/or ASSIST questionnaires Undertake screening of patients seen at all PHC clinics Where there is moderate misuse of alcohol/tobacco, abuse of over the counter or prescription medications or moderate use of other drugs, provide information and advice on cutting back/stopping use and advice on harm reduction strategies All patients presenting with substance use disorders at PHC or treatment settings managed by DOH (detoxification facilities etc) to be screened for other co-occurring mental disorders. 	<p>Short term</p> <p>Medium-long term</p> <p>Short-term</p> <p>Short-medium term</p>

<p>Review of the drug policy</p>	<p>Strengthen control of chemicals & medicines</p>	<p>Improve implementation of regulations relating to the manufacture and control of precursor chemicals used for the manufacture of illicit drugs</p> <p>Continue to control the manufacture and sale of scheduled narcotics</p>	<ul style="list-style-type: none"> • Ongoing implementation of regulations and International Narcotics Control Board (INCB) treaties relating to the regulation of precursor chemicals used in the manufacture of amphetamine type substances and other illicit drugs • Limit diversion of scheduled narcotic medicines to the street (abuse of prescription medicines) by continuing to enforce strict controls over the manufacture and sale of scheduled narcotic medicines 	<p>Ongoing</p>
<p>Improve access to relevant pharmacotherapy</p>	<p>Ensure that evidence based medications are provided in the Essential Drugs List. (EDL)</p>	<p>Integrate harm reduction strategies including opioid substitution therapies.</p>		
<p>Strengthening research and development</p>	<p>Monitoring and evaluation</p>	<p>Establish mechanisms to evaluate impact of roll out of activities carried out under MDMP</p>	<ul style="list-style-type: none"> • Agree on evaluation strategy (including outcome indicators to facilitate evaluation) • Establish mechanisms to collect data to facilitate evaluation of implementation of MDMP and if necessary appoint third party evaluators • Determine strategy for reporting on evaluation • Implement evaluation strategy 	<p>Short-term</p> <p>Short-term</p> <p>Short-term</p> <p>Short-term</p>
<p>Strategic research</p>	<p>Strategic research related to implementation of MDMP</p>	<ul style="list-style-type: none"> • Ongoing surveillance of substance abuse burden at community level and in health & social service system (via SADHS, SACENDU, NIMSS, etc) and improve systems of registration and monitoring of alcohol-attributable morbidity and mortality, with regular reporting mechanisms • Identify research needs for the short-term to medium-term. (e.g. demonstration projects). Motivate for additional funding if required. • Identify current and new partners to whom the research could be contracted by DoH or who could be persuaded to undertake needed research without DoH funding • Review findings on an ongoing basis and where needed commission new studies. 	<p>Short-term</p>	

Table 2: Summary of Capacity Development – all training to be accredited and provided by recognised service providers			
Interventions	Skills development & knowledge transfer	Participants	Timeframe
1. Prevention	<p>Knowledge of good practice with regard to public information & awareness campaigns, especially for vulnerable and marginalised groups such as women (especially pregnant women), youth etc.</p> <p>Information on how substance use can affect mental health and exacerbate mental illness, medication compliance and interactions.</p> <p>Information on how substance use can impact on HIV/TB and other infectious diseases</p>	<p>DoH staff</p> <ul style="list-style-type: none"> Doctors, nurses, social workers in PHC and secondary and tertiary level hospitals Community Health Workers (CHW) 	Short term and ongoing
2. Early Interventions	<p>Training in brief interventions:</p> <ul style="list-style-type: none"> Screening Tools: AUDIT and/or ASSIST Motivational Interviewing Cognitive Behavioural Therapy Appropriate referrals 	<p>DoH</p> <ul style="list-style-type: none"> Staff at trauma units, medical obstetric units (MOUs), STI/TB/HIV clinics and mental health services Medical doctors, nurses and social workers in PHC and secondary and tertiary level hospitals Community Health Workers (CHW) 	Short-medium term and ongoing
3. Detoxification	<p>Training in detoxification protocols & withdrawal management</p> <p>Appropriate referral</p>	<p>DoH</p> <ul style="list-style-type: none"> Uncomplicated detoxifications: Health professionals in PHC Complicated detoxification: Health professionals in secondary & tertiary health facilities 	Short-medium term and ongoing
4. Relapse Prevention	<p>Training in prescribing medication to prevent relapse if indicated.</p> <p>Capacity development with regard to evidence based treatment models and referral resources</p>	<p>DoH</p> <ul style="list-style-type: none"> Psychiatrists, medical doctors and mental health professionals in PHC and secondary and tertiary hospitals 	Short/medium-term and ongoing
5. Aftercare	<p>Training in viable aftercare interventions</p> <p>Information provision on self-help groups</p>	<p>DoH</p> <ul style="list-style-type: none"> Staff in PHC and secondary and tertiary hospitals 	Short-medium term and ongoing
6. Harm Reduction	<p>Information provision on harm reduction principles and practices</p> <p>Training in prescribing opioid substitution therapies (OST)/ Methadone maintenance therapy (MMT) and other pharmacotherapy</p> <p>Training in medical complications from injecting drug users (IDU), overdose, poly substance use, sexual and other risk behaviour such as sharing pipes and needles.</p>	<p>DoH</p> <ul style="list-style-type: none"> Staff at trauma units, PHC, secondary and tertiary hospitals and mental health services Medical doctors, nurses and social workers in PHC and secondary and tertiary level hospitals 	Short-medium term and ongoing

<p>7. Dual diagnosis</p>	<p>Training in brief interventions: Screening Tools: AUDIT and/or ASSIST Motivational Interviewing Cognitive Behavioural Therapy Appropriate referrals</p> <p>Training in screening for other co-occurring mental disorders</p> <p>Training in case management and appropriate interventions for both disorders</p>	<p>DoH</p> <ul style="list-style-type: none"> • Mental health staff at PHC, secondary and tertiary hospitals • Facilitation of cross-training whereby co-occurring mental health workers are exposed to substance abuse issues; and health workers working in the substance abuse area are exposed to issues related to mental health 	<p>Short-medium term and ongoing</p>
<p>8. Substance use & infectious diseases</p>	<p>Training in brief interventions: Screening Tools: AUDIT and/or ASSIST Motivational Interviewing Cognitive Behavioural Therapy Appropriate referrals</p> <p>Training in assessment for risk of HIV, TB, STIs, HVC, HBV and other infectious diseases.</p>	<p>DoH</p> <p>Staff at HIV, TB, sexual health and, neo-, peri- and ante-natal clinics.</p> <p>Facilitation of cross-training whereby infectious disease health workers are exposed to substance abuse issues; and health workers working in the substance abuse area are exposed to issues related to infectious diseases</p>	<p>Short- medium term and ongoing</p>

Table 3. Indicators to be used in monitoring and evaluating the implementation of the MDMP Alcohol:

Consumption	Harm	Treatment & Policy
Recorded adult (15+ years) per capita consumption in litres of pure alcohol	Age-standardized death rates for alcohol liver cirrhosis (per 100,000)	Number of in-patient/out-patient treatment admissions to health facilities for alcohol use disorders
Unrecorded adult (15+ years) per capita consumption in litres of pure alcohol	Age-standardized death rates for <i>alcohol-related</i> poisoning (per 100,000)	Number of out-patient treatment slots for alcohol use disorders in health facilities
Lifetime abstainers (%),	Alcohol dependence, 12-month prevalence	Number of beds for alcohol use disorders in health facilities
Past year abstainers (%)	Alcohol-use disorders, 12-month prevalence	Waiting period to receive in-patient treatment for alcohol use disorders in health facilities ("by type of treatment")
Heavy episodic drinkers (15+ years) during past 30 days (%)	Prevalence of fetal alcohol spectrum disorders (FASD) (%)	Waiting period to receive out-patient treatment for alcohol use disorders in health facilities ("by type of treatment")
Drinking among adolescents during past 12 months and 30 days (%)	Age-standardized death rates for <i>alcohol-related</i> poisoning (per 100,000)	Availability of counselling to pregnant women with alcohol use disorders or alcohol problems in health facilities ("by type of treatment")*
Heavy episodic drinking among adolescents during the past 30 days (%)	Age-standardized death rates for <i>alcohol-related</i> violence (per 100,000)	Brief interventions as a method of health promotion and disease prevention*
Age at first drinking among adolescents (%)		Training of health professionals at a regular basis in screening and brief interventions for alcohol problems*

Drugs (including abuse of over-the-counter and prescription drugs:

Consumption	Harm	Treatment & Policy
Drug use ("by type of drug") among adults (15+ years) during the past 12 months (%) (<i>Separate indicators for each type of drug</i>)	Drug dependence, 12-months prevalence (%)	In-patient/out-patient treatment admissions for drug detoxification
Drug use ("by type of drug") among adults (15+ years) during the past 30 days (%) (<i>Separate indicators for each type of drug</i>)	Infectious diseases among IDUs: HIV prevalence (%)	In-patient/outpatient treatment admissions for long-term drug rehabilitation (within health sector)
Drug use ("by type of drug") among adolescents during the past 12 months (%) (<i>Separate indicators for each type of drug</i>)	Infectious diseases among IDUs: Hep B prevalence (%)	Number of in-patient/out-patient treatment slots for drug use disorders (within health sector)
Injecting drug users IDUs (%)	Infectious diseases among IDUs: Hep C prevalence (%)	Number of beds for drug use disorders in health facilities
Cannabis use among adolescents during the past 30 days (%)	Infectious diseases among IDUs: TB prevalence (%)	Number of patients in treatment (in health facilities)
Age at first drug use among adolescents (%)	Age-standardized death rate for drug-related poisoning (per 100,000)	Number of patients in treatment in health facilities
	Drug use disorders, 12-months prevalence (%)	Waiting period to receive out-patient treatment for drug use disorders within health facilities ("by type of treatment")
	Non-fatal drug-related poisoning (%)	Waiting period to receive in-patient treatment for drug use disorders within health facilities ("by type of treatment")

*-indicators still need to be specified

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