URBAN SAFETY BRIEF

No. 2/2016

High time for policy rehabilitation

Local government and substance use problems

This second in a series of Urban Safety Briefs considers the evidence on appropriate local government roles and responsibilities around substance use problems. It refers extensively to the SA National Drug Master Plan for 2013 to 2017, which is available at https://www.gov.za/documents/national-drug-master-plan-2013-2017.

The SA Cities Urban Safety Reference Group's Briefs Series is designed to distil the state of current knowledge on urban safety-related topics for a policy and planning audience. It is presented quarterly to the City Budget Forum and other key stakeholders.

urban safety reference group

BACKGROUND

The misuse of mind-altering substances can have a range of negative consequences for communities. In South Africa, there have since 1994 been major changes in the profile of substances misused. Whereas once alcohol, cannabis and methaqualone (a sedative also known by brand names Mandrax or Quaalude) dominated, the political, economic and social changes since have seen the influx and spread of a number of others.[1] Alcohol remains the most misused substance, with binge drinking consumption patterns proven to be responsible for immense harms, including direct health effects, foetal alcohol spectrum disorders, increased sexual risk taking, and physical trauma and death due to interpersonal violence and accidents.[2] Alcohol use disorders account for more than twice the deaths nationally as other drug use disorders, so alcohol should be at the centre of policy thinking on substance use.[3] Data on the precise extent and impact of the problematic use of illicit substances are comparatively less available, but costs are also known to include damage to physical and mental health, to workplace productivity and educational outcomes, safety, public property, social stability and development, and so on.[4]

Substance misuse is widely believed to have risen considerably in South Africa in the last 20 years. The World Health Organisation (WHO) estimates that 15% of the population has a substance use problem. The following statistics taken from a survey carried out between June 2010 and March 2011 by the Central Drug Authority (CDA) of South Africa put SA as one of the drug capitals of the world:

Levels of marijuana, cocaine and amphetamine use in South Africa are **twice as high** as in some other countries worldwide.

The CDA estimates that around **7000 people die** each year due to driving under the influence of alcohol.

Substance use problems are associated with **heightened levels** of crime and sexual violence victimisation.

The total social cost of illicit drug use is estimated at **± 6.4% of GDP**.

Some youths develop substance use problems as early as the **age of 12**.

The social and economic costs of alcohol abuse are estimated at **R130 billion** per annum.

1 Sonja Pasche and Bronwyn Myers, 'Substance Misuse Trends in South Africa', *Human Psychopharmacology*, 27 (2012), 338–41 (p. 338).

2 Pasche and Myers, pp. 338–339.

3 World Health Organization Global Health Observatory data repository, Age-standardised death rates, alcohol and drug disorders, available at http://apps.who.int/gho/data/view.main.58100.

4 Peter Streker, 'Under the Influence: What Local Governments Can Do to Reduce Drug and Alcohol Related Harms in Their Communities', *Prevention Research Quartery*, 2012, 1–16 (p. 4).

The country is now considered to host the largest and most diversified African market for illegal substances,[5] both for transhipment purposes and domestic use.[6] Getting reliable estimates of use prevalence is very difficult and different studies have had widely different results, but the main psychoactive drugs consumed are known to include:[7]

TABLE: Common SA drugs

PSYCHOACTIVE EFFECT	DRUG TYPE	SOME COMMON NAMES
UPPERS – have a stimulant effect on the central nervous system	Cocaine Crack (derivative of cocaine) Methamphetamines Ecstasy Nicotine Caffeine ADHD medication	Coke, blow, Charlie Rocks, freebase Meth, crystal, glass, ice, tik MDMA, e, Adam, Molly Tobacco, cigarettes Coffee, java, joe Ritalin, Adderall
DOWNERS – have a depressive or tranquilising effect on the central nervous system	Alcohol Heroin Methaqualone Tranquilisers Inhalants	Booze, dop Smack, gear, junk, unga, H Mandrax, buttons Benzos, Valium, Xanor Glue
HALLUCINOGENS OR 'ALL AROUNDERS' – have a distorting effect on perceptions	Cannabis LSD Mushrooms	Marijuana, dagga, ganja, zol Acid, tabs, smarties Shrooms

These can also be mixed with each other and other components, for example in the heroin and cannabis mix known as **whoonga** or **nyaope,** and a new ecstasy-based pill called **Mercedes.**

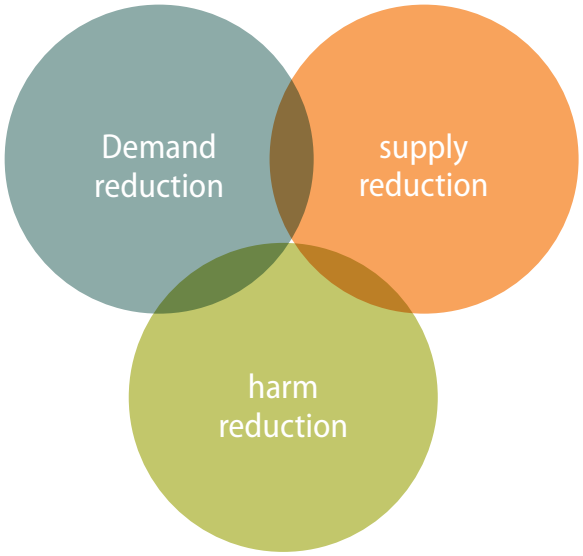
Substance use policy is often conceptualised as falling under three broad categories: 1) attempts to reduce the **demand** for the relevant substances, 2) attempts to reduce its **supply**, and 3) attempts to reduce the impact or **harm** of its use.

These concepts can be described as:

"Demand reduction, or reducing the need for substances through prevention that includes educating potential users, making the use of substances culturally undesirable (such as was done with tobacco) and imposing restrictions on the use of substances (for example by increasing the age at which alcohol may be used legally);

Supply reduction, or reducing the quantity of the substance available on the market by, for example, destroying cannabis (dagga) crops in the field [or controlling the trade conditions of legal substances]; and

Harm reduction, or limiting or ameliorating the damage caused to individuals or communities who have already succumbed to the temptation of substance abuse. This can be achieved, for example, by treatment, aftercare and re-integration of substance abusers/ dependents with society."[8]



The three broad categories of approach to substance use policy. A balance between them is usually considered the most desirable and likely to be effective.

5 Karl Peltzer and others, 'Illicit Drug Use and Treatment in South Africa: A Review', *Substance Use and Misuse*, 45 (2010), 2221–43 (p. 3).
6 United Nations Office on Drugs and Crime, *World Drug Report 2014* (United Nations publication, 2014), p. 31.
7 Burnhams Dada, Siphokazi and others, *Monitoring Alcohol, Tobacco and Other Drug Use Treatment Admissions in South Africa*, 2015.
8 South African National Department of Social Development, 'National Drug Master Plan 2013-2017', 2013, 1–168 (p. 29).

DISCUSSION

01 Global policy context

Globally, the question of how best to regulate access to drugs is currently more hotly contested than ever before. There is a common perception that existing approaches that stress criminal justice methods have not only failed to reduce access to these substances, but have had a range of other negative consequences – for example, in hindering efforts reduce HIV transmission among very high risk populations. The 'drug' issue has a tendency to be highly emotive and polarised, especially as there is as yet very little evidence of what the outcomes of different approaches will be.

However, an increasing number of national and sub-national governments are experimenting with a range of alternative regulatory mechanisms, even including full legalisation of certain substances. This is accompanied by a growing sense that a one-size-fits-all model is unlikely ever to be successful, but instead that different places will likely need to adopt very different approaches depending on their different contexts of substance use and abuse, the nature of their existing markets, the local character of organised crime, and their regulatory and enforcement capacities.

02 The National Drug Master Plan

South African substance policy and practice are guided by the National Drug Master Plan 2013-2017 (NDMP), as formulated by the Central Drug Authority (CDA) in terms of the Prevention and Treatment of Drug Dependency Act (20 of 1992) and the Prevention of and Treatment of Drug Dependency Act (70 of 2008).[9] It is a broad and extensive policy that acknowledges that substance use problems cut across the different spheres of government and different considerations (including social, economic, health, legal, political, and ethical) and require interdisciplinary, interdepartmental, multi-level policy approaches.

The targeted OUTCOMES of the NDMP are envisioned as:

1. Reduction of the bio-psycho-social and economic impact of substance abuse and related illnesses on the South African population,
2. Ability of all people in South Africa to deal with problems related to substance abuse within communities,
3. Recreational facilities and diversion programmes that prevent vulnerable populations from becoming substance abusers/dependents,
4. Reduced availability of dependence forming substances/drugs, including alcoholic beverages,
5. Development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment,
6. Harmonisation and enforcement of laws and policies to facilitate effective governance of the supply chain with regard to alcohol and other drugs, and
7. Creation of job opportunities in the field of combating substance abuse.

03 Local government responsibility

The NDMP aims to set out the role of national, provincial and local authorities towards achieving these outcomes. Local government is expected to take the lead in the establishment and functioning of Local Drug Action Committees (LDACs) to combat substance abuse on a local level, in keeping with Provincial Drug Master Plans, liaising with Provincial Substance Abuse forums.[10] There are a number of specific resolutions towards the goals above that LDACs are expected to contribute, such as through imposing restrictions on legal alcohol sale hours, regulating and controlling alcoholic home brews, and ensuring equal access to resources that can help prevent vulnerable populations from becoming substance dependent. Many of these resolutions are likely to be excellent methods of reducing some of the harms around drug and alcohol misuse.

However, a major shortcoming of the NDMP is that it is silent or vague on a number of questions of funding – that is, where exactly the budget is to be sourced and monitored for each project.[11] A second is that local policies and decision-making are overshadowed by the national level, a common problem in drug policy internationally.[12]

9 South African National Department of Social Development, p. 4.
10 South African National Department of Social Development, p. 113.
11 Simon Howell and Katherine Couzyn, 'The South African National Drug Master Plan 2013-2017: A Critical Review', *South African Journal of Criminal Justice*, 28 (2015), 1–23 (p. 22).
12 European Monitoring Centre for Drugs and Drug Addiction, *Drugs Policy and the City in Europe*, EMCDDA Papers (Luxembourg: Publications Office of the European Union, 2015), p. 2.

04 Challenges in municipalities

It appears that a few of the larger municipalities have substance abuse plans and committees in place, but many others have made lit-tle or no progress toward this end. According to the CDA, the functioning of the mechanisms envisioned in the NDMP on the municipal level is heavily compromised. Reasons include that many municipalities have no dedicated people to deal with substance abuse matters, and/or have no dedicated budget, and/or are not co-ordinating their different programmes – and overall are not implementing the NDMP at all.[13] On a broader level, the CDA has struggled to make the NDMP a reality, partly because it has simply not been able to meet the costs of such an expansive and expensive national endeavour.[14]

05 Local government costs

Local governments have generally played a fairly limited strategic policy role, especially around illegal drugs, with most key decision-making happening at the national or international level. It is constrained in that it seldom has the legal, financial or practical capacity to influence such factors as legal drinking ages, regulation of alcohol marketing, or overall law enforcement approaches. Yet drug problems often emerge in urban spaces before spreading to other areas and certain urban environments play host to some of the most acute problems around harmful forms of drug and alcohol use.[15] The relative concentrations of disposable income as well as poverty, plus other infrastructure and social conditions in urban centres make them highly susceptible to the development of substance use markets and problems.

Many of the negative outcomes of drug or alcohol intoxication and dependence are borne at least partly on a local level. Just a few examples are:

- Damage to **workforce productivity** and the local economy,
- Damage to **perceptions of safety and reputation** of the local area,
- Damage to **public property**,
- **Sexual risk behaviour:** link between HIV and injection drug use (IDU) in South Africa, unintended pregnancy and sexually transmitted infections (STIs),
- **Crime & violence:** homicide, intimate partner violence, rape and abuse of children
- **Physical and mental health problems:** injury and death rates, lung and other cancers, heart disease, stroke, chronic respiratory disease and other conditions and mental illnesses such as depression,
- **Educational behaviours:** binge drinking, school dropout and low academic ambitions,
- **Economic and social costs:** national and local government budgets depleted
  - Security costs related to anti-social behaviour
  - Cleaning up related litter and body fluids,
  - Subsidising enforcement through metropolitan policing,
  - Managing the alcohol licensing system,
  - Providing mitigating infrastructure such as extra pedestrian barriers, and
  - Providing treatment services.[16]

Properly understanding and estimating these costs should help local governments motivate for budgetary support for substance use policy measures.

06 SA policy position in global context

More and more countries are moving towards non-criminal justice approaches to drug policy, and South Africa has so far played an ambiguous role. During the recent United Nations General Assembly Special Session on Drugs, some South African representatives aligned the country with the highly punitive Russian position, while the Department of Social Development took a sharply different position, instead speaking in support of "comprehensive, accessible, evidence-informed, ethical and human rights based drug use

13 Central Drug Authority briefing to the parliamentary committee on social development, 19 November 2014, at https://pmg.org.za/committee-meeting/17907/ [Accessed 2 June 2016].
14 Howell and Couzyn, p. 22.
15 European Monitoring Centre for Drugs and Drug Addiction, p. 4.
16 Peter Streker, 'Under the Influence: What Local Governments Can Do to Reduce Drug and Alcohol Related Harms in Their Communities', *Prevention Research Quarterly*, 2012, 1–16 (p. 4).

prevention, dependence treatment and after care services".[17] In the first week of June 2016, the Central Drug Authority also announced a major change in its policy approach.[18] It acknowledged the global and national debate around cannabis regulation, noted that there was little evidence that supply reduction through criminalisation was effective at reducing cannabis abuse, and recommended the decriminalisation of cannabis.

This is a dramatic shift and although the editorial of the prestigious South African Medical Journal lauded it, it stressed that it was not enough and that there was ample evidence supporting legal regulation of *all* psychoactive substances.[19] It seems likely that the South African position will in the long term move away from law enforcement responses and place ever greater emphasis on the 'softer' methods of reducing the harms around substance use, such as focusing on health, social development and education.

07 Movement towards city leadership

Drug policy that is focused on the criminality of drugs will necessarily be a largely national level responsibility. The further drug policy moves in the direction of legal regulation or measures that are based on health, social development and education approaches, the closer city governments will have to come to taking central responsibility. City leadership will become increasingly important in setting the tone and direction. This will need to be accompanied by shifts in budgetary allocations.

08 City-driven harm reduction

Even in countries where the use of certain substances remains criminal, cities have been laboratories of an ever expanding range of demand reduction and especially harm reduction approaches. Harm reduction policies aim primarily to reduce the negative consequences of some of the use of psychoactive substances, *without necessarily attempting to reduce the level or extent of their consumption.* They are based on a respect for human rights, human dignity and health for all.

09 Examples from other cities

A number of cities especially in Europe have already tended to stress a range of 'softer' substance abuse policy approaches and have had considerable success at improving the lives and prospects of their communities.[20] The starting point is often the provision of needle and syringe exchange systems and opioid substitution treatment for people who inject drugs. Providing these high-risk users with shelter and clothing also helps with getting health and social services to these hard to reach communities. These are often provided by mobile units. Interventions in recreational nightlife settings include 'safe party' initiatives, which for example give partygoers information about safer alcohol and other drug use and offer chemical testing services. Each city has its own unique substance use situation and must be given the policy room to explore such creative solutions.

10 Treatment centres

A key investment in reducing harm from alcohol and other drug use is the provision of quality treatment or rehabilitation centres in a range of different forms, to suit community members' different needs. Local studies have shown that the available treatment services are perceived to be of poor quality and limited effectiveness, and there is an urgent need for an improved monitoring and evaluation system for these services.[21]

17 Statement by Hon. Hendrietta Bogopane-Zulu, Deputy Minister of Social Development, South Africa, and Chairperson of the first AU specialized technical committee on health, population and drug control to the Commission on Narcotic Drugs (CND). See more at http://www.criminology.uct.ac.za/news/deputy-minister-social-development-indicates-commitment-harm-reduction-efforts-substance-use#sthash.0SOKDOhr.dpuf, [accessed 6 June 2016].

18 Central Drug Authority, 'Position Statement on Cannabis', *South African Medical Journal*, 106 (2016), 569–70.

19 Keith Scott, 'Editorial: Comment on the Central Drug Authority's Position Statement on Cannabis', *South African Medical Journal*, 106 (2016), 545–46.

20 European Monitoring Centre for Drugs and Drug Addiction..

21 Bronwyn Myers and others, 'Identifying Perceived Barriers to Monitoring Service Quality among Substance Abuse Treatment Providers in South Africa', *BMC Psychiatry*, 14 (2014), 31

11 City-level data

In order for cities to understand and best respond to their substance use issues, they need to understand those problems. Cities can see dividends in research into for example, the current prices of different drugs, where they are purchased and why, what the range of substance usage patterns are, and how and where the substance use related costs are borne.

CONCLUSIONS

The South African situation in terms of alcohol and other drug use is serious and has worsened and diversified over the last 20 years, although alcohol remains the primary driver of substance-related harm. Problems with substance use impose a range of costs to communities and to city governments.

The South African National Drug Master Plan has had limited impact nationally and especially on a municipal level. A number of its recommendations are yet to be taken up by cities. Cities are required to take the lead in developing and funding comprehensive substance use policy frameworks.

It has become clear on the global scale that one-size-fits-all approaches will not work, but that each place needs to develop a unique set of programmes to deal with substance use issues. There is growing scope for local experimentation beyond or entirely in place of criminal justice methods.

South Africa's Central Drug Authority has recently seemed to come to a similar conclusion and has recommended the decriminalisation of cannabis. Based on an accumulating body of research evidence and international practice, it is likely that policy around other drugs will also move further away from criminal justice methods.

Cities can increasingly be leaders in shaping their policies around illegal drugs. They should be creative and do so around harm reduction principles, which place a respect for human rights, dignity and health above ideals of drug-free cities. Access to quality treatment centres and good city-level understandings of substance use issues will be essential.

> A focus on harm reduction principles is necessary, which place a respect for human rights, dignity and health above ideals of drug-free cities

RECOMMENDATIONS

The NDMP mandates Mayors to establish Local Drug Action Committees (LDACs).

- **Each municipal council must determine the status of its LDAC:** It must be determined whether such a body is in place, who participates in it, how often it meets, what its policy principles are, and what its budgetary allocation is.
- **Each municipal council must ensure that its LDAC meets NDMP recommendations:** LDACs must be composed of the municipal departments concerned, NGOs, CBOs, FBOs and any other local structure concerned. It is further recommended that young people be explicitly invited and integrated into LDACs.
- **Once/if in place and appropriately constituted, LDACs must:**
  - Commit to **evidence-based** policy measures.
  - Encourage **co-operation** between city leaders to understand and work towards global and national good practice in substance use policy. A good first step would be convening a national meeting or conference of LDAC representatives. National and international experts and civil society groups must be invited to contribute to this process.
  - Ensure that they have good and up-to-date **knowledge** about their unique local substance use situations. **Research** must be conducted into for example the ease of availability, purity and price of drugs, youth pathways to substance use and criminal drug market involvement, and the conditions of substance abuse treatment centres. Institutions such as universities should be invited to be knowledge partners.
  - Ensure that they use a **balanced policy** approach, including all three categories of drug policy options, namely *demand reduction, supply reduction,* and *harm reduction.*

LDACs should consider policy approaches including:

DEMAND REDUCTION: Reducing the need or desire for the substances

1. Creating alternative recreation spaces, diversion programmes, job creation opportunities and positive leisure activities for citizens, especially the youth.
   - **Specific example:** Support programmes that provide recreational and skills development resources to the youth, especially in vulnerable populations.
2. Promoting substance abuse awareness and responsible consumption of alcohol, information distribution, education, access and assistance for the public at various city information and service points.
   - **Specific example:** Develop accessible information resources (e.g. pamphlets and posters) on substance use problems and ensure that they are available in all city facilities.

SUPPLY REDUCTION: Reducing the availability of the substances

3. Focusing much of their supply reduction effort on reducing alcohol-related problems, by ensuring that existing regulations are enforced.
   - **Specific examples:** Immediately implement and enforce current laws and regulations that seek to reduce the availability of alcoholic beverages and ensure that health and safety regulations are enforced at premises where alcohol is purchased.
   - Reduce accessibility of alcohol through bylaws, for example imposing restrictions on the times and days of the week that alcohol can be sold legally.
4. Ensuring that law enforcement operations around illicit drugs receive full co-operation from local agencies.
   - **Specific example:** Establish specific forums where the police can engage with metro police, businesses, and communities to work together to help reduce drug availability.

HARM REDUCTION: Reducing the negative impact of the substances already being used

5. Assessing the quality and needs of treatment centres within their areas and assist wherever possible.
   - **Specific example:** Complete an audit of local treatment centres to identify their most pressing needs in order to provide better services.
6. Promoting measures that allow for safer, less harmful use of alcohol and other drugs.
   - **Specific example:** Require venues and events with liquor licenses and/or that are known to host illegal substance use to provide customers with harm reduction measures such as free water, convenient public transport options, and medicines that help reverse drug overdoses.

This brief was compiled by the SA Cities Urban Safety Reference Group with support from the UCT Centre of Criminology.
The Urban Safety Reference Group is a platform for peer-to-peer learning and knowledge sharing amongst practitioners from the SACN member cities as well as other key government role-players on urban safety and violence prevention. It is convened by the South African Cities Network (SACN) with the support of the GIZ-Inclusive Violence and Crime Prevention (VCP) Programme.

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