

NATIONAL STRATEGY

FOR THE PREVENTION AND
MANAGEMENT OF ALCOHOL
AND DRUG USE AMONGST
LEARNERS IN SCHOOLS



basic education
Department
Basic Education
REPUBLIC OF SOUTH AFRICA



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The National Strategy for the Prevention and Management of Alcohol and Drug Use amongst Learners in Schools was based to a large extent on the KwaZulu-Natal Integrated Strategy for Teenage Drug Abuse (KZN Department of Community Safety and Liaison, & HSRC, 2006) and has been further developed in consultation with Directorates within the Department of Basic Education and with representatives from Provincial Education Departments.

While the Strategy offers the framework for the development of implementation plans at provincial, district and school levels, this is an ongoing process and as such, the Strategy is a working document that will be amended as required. Any comments and suggestions for improvement are welcomed. Please send any comments and suggestions to the Director-General: Basic Education; Health Promotion Directorate; Private Bag X895; Pretoria; 0001.

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Foreword



Alcohol and drug use has a detrimental effect on the health and well-being of South Africa, and is well recognised as a significant barrier to both teaching and learning.

It has been linked to academic difficulties, absenteeism, and drop-out from schooling, thus impacting negatively on the attainment of quality basic education. It is also associated with a host of high risk behaviours, including unprotected sex, crime and violence, traffic accidents, and mental and physical health problems.

It is for these reasons that in 2010, government established an Inter-Ministerial Committee (IMC) to combat alcohol and drug abuse in South Africa. The IMC aims to strengthen government's strategy to combat alcohol and drug abuse in the country and to mobilise individuals, groups and community structures to actively participate and support government in its efforts to do so.

The Department of Basic Education has developed this National Strategy for the Prevention and Management of Alcohol and Drug Use amongst Learners in Schools that focuses largely on prevention because most learners do not abuse alcohol and drugs. However, we aim to create an enabling environment for those learners who have become addicted to alcohol and drugs to access treatment, care and support services.

The approach of the Department towards alcohol and drug use is not a punitive one. The Strategy recognises that addiction is a disease and that alcohol and drug use is a social issue that is interwoven in the fabric of our society. Hence programmes in schools are based on restorative justice principles and must be complemented by programmes with families and in communities.

To fully achieve the goals and objectives of the Strategy, we depend on the ongoing support and cooperation of our provinces, districts and schools, together with our partners and education stakeholders. Working together, we can ensure that the schooling sector plays its role in combating alcohol and drug use.

A handwritten signature in black ink, appearing to read 'P. B. Soobrayan', with a long horizontal line extending to the right.

MR PB SOOBRAYAN
DIRECTOR-GENERAL
DATE:19 JULY 2013

Executive Summary

Alcohol and drug abuse is a global challenge, which has detrimental effects on the health, wealth and security of nations.

Its impact is being felt in schools in South Africa and is compromising the quality of teaching and learning and the safety of learning spaces. This strategy was developed to provide comprehensive guidance to the basic education sector in South Africa with regards to the prevention and management of alcohol and drugs in schools. It was developed in line with the Education Delivery Agreement aimed at improving the quality of basic education, as well as Schooling 2025 and Action Plan to 2014, whose major goals are improvement in learning outcomes and improved access to, and retention in, schooling. Alcohol and drug use, which is associated with poor scholastic outcomes and drop-out from schooling, is a barrier to achieving these goals.

This strategy is part of a national interdepartmental coordinated response which highlights the heightened focus on alcohol and drug abuse in the country and its impact on all sectors of society. The fight against alcohol and drug abuse in South Africa is being led by the Inter-Ministerial Committee and Technical Task Team on Combating Alcohol and Drug Abuse in which the Department plays an active role. The National Drug Master Plan that offers the blueprint for the country's approach to alcohol and drug use shares the vision of a Drug Free South Africa. The Department of Basic Education's approach to addressing alcohol and drug use is derived from these seminal initiatives and documents.

The National Strategy is located within a broad overarching framework called the Care and Support for Teaching and Learning (CSTL) Programme. This is a SADC initiative whose goal is to realize the education rights of all children, including the most vulnerable, through schools becoming inclusive centres of learning, care and support. Alcohol and drug use as a key barrier to learning is located within Health Promotion, one of the nine priority areas of the CSTL Programme in South Africa.

The document drew on a number of seminal papers and authors, including the KwaZulu-Natal Integrated Strategy for Teenage Drug Abuse, the South African Youth Risk Behaviour Survey 2008, South African Community Epidemiology Network on Drug Use (SACENDU) research briefs, and summaries of evidence-based prevention work by the United Nations Office on Drugs and Crime

(UNODC). Furthermore, key policies and programmes within education were also reviewed to influence the direction of the strategy. These include the Delivery Agreement, Schooling 2025, Action Plan to 2014, Safety Accord, Care and Support for Teaching and Learning Conceptual Framework and the Curriculum Assessment and Policy Statement for Life Orientation. Following the initial literature review, the document was further developed in consultation with directorates within the Department of Basic Education and with representatives from Provincial Education Departments.

Background

Illicit drug users in Africa make up roughly 17% to 21% of global illicit drug users and the majority of treatment demand in Africa is for cannabis abuse (63%) (UNODC, 2010).

Alcohol is the most abused legal substance in South Africa, while cannabis is the most common illicit substance used. It is estimated that around 28% of the population consumes alcohol, while cannabis use among adolescents range from 2% to 9%, and among adults is 2% (Peltzer et al., 2010; Peltzer and Ramlagan, 2007). It is noteworthy that per capita cigarette consumption in South Africa decreased by about half between the early 1990s and 2004. It is also important to note that poly-substance abuse remains high in South Africa with between 32% and 45% of patients in treatment reporting more than one substance of abuse (Plüddemann et al., 2010a). Overall, males tend to have higher rates of alcohol and other drug use than females, although females are more likely to abuse over-the-counter and prescription medicines.

Over time, there has been an increase in patients younger than 20 years who are reporting to treatment centres, with this age group comprising between 17% and 28% of patients in treatment (Plüddemann et al., 2010a). At present, about 21% of learners in grades 8-11 are current (monthly) tobacco smokers, while 35% have used alcohol during the past month (Reddy et al., 2010). Of concern is that 29% of learners binge drink on a monthly basis, defined as having 5 or more drinks in one sitting (Reddy et al., 2010). Research by Reddy et al., (2010) further reveals that about 10% of learners currently use cannabis, while 12% have ever taken at least one illegal drug such as heroin, mandrax, cocaine or methamphetamine ("tik"). Despite the ban on the use, possession, and distribution of alcohol, tobacco and drugs on school property in compliance with the South African Schools Act and the Department of Education Drug Abuse Policy Framework, research reveals that 13% of learners had used alcohol

South Africa has one of the highest rates of Foetal Alcohol Syndrome (FAS) in the world, leading to birth defects and developmental disabilities.

on school property, 8% had used cannabis, and 9% of learners had been offered, sold or given an illegal drug on school property (Reddy et al., 2010).

Determinants of Substance Use

In line with the CSTL Conceptual Framework, the Strategy uses the Ecological Systems Theory as the framework to identify the risk and protective factors related to substance use. Ecological Systems Theory recognises that individuals form part of many systems and contexts which affect development. These systems (the micro-, meso-, exo-, and macrosystems) start with the individual and extend outwards to family, peers, school and society. Any interventions implemented within the school for individual and systems changes must therefore be rooted in a more comprehensive approach that addresses risk factors outside of the mandate of education. This, in South Africa, is achieved through the National Drug Master Plan that is a multi-sectoral response to drug and substance use for the country.

Individual risk factors which have been linked to substance use include personality factors, such as novelty seeking, impulsiveness, aggression, rebelliousness, delinquency and unconventionality, as well as interpersonal distress such as depressive mood and a poor sense of well-being. In contrast, high self-esteem, good interpersonal relationships, and taking responsibility are protective against developing substance dependence.

Family factors which place adolescents at increased risk for alcohol and drug use include parental drug use and frequent family conflict, while a good attachment relationship, and parental monitoring and warmth are protective against substance use.

Deviant peer relationships indicated by behaviours such as skipping school, drinking alcohol, and experimenting with drugs, is one of the most consistent links to adolescent alcohol and drug use.

School factors which are related to alcohol and drug use include low academic aspirations, poor academic performance, and a lax attitude of schools towards alcohol and drug use by their learners.

Community factors such as exposure to public drunkenness and smoking, ease of access to alcohol and drugs, poor job opportunities, and an abundance of

free, unstructured time have all been linked to greater substance use.

Societal factors such as tobacco and alcohol taxation and the banning of tobacco advertising are some of the most effective tools for controlling tobacco and alcohol use amongst young people.

Consequences of Substance Use

Apart from being related to physical health problems, alcohol and drug abuse are also linked to a host of mental and social ills which affect the individual, families, schools and broader society. These include academic difficulties, mental illnesses such as depression, injuries, road accidents, crime, violence, and sexual risk behaviour which may result in HIV infection, unintended pregnancy and sexually transmitted infections (STIs).

Substance use, including binge drinking and tobacco use, has a negative impact on learners' academic performance, being linked to academic difficulties, absenteeism and school drop-out. In addition, alcohol and abuse has been linked with various physical and mental health problems, including heart disease, cancer, respiratory diseases, depression and schizophrenia. South Africa has one of the highest rates of Foetal Alcohol Syndrome (FAS) in the world, leading to birth defects and developmental disabilities. Injecting drug users also have an increased risk of contracting HIV and hepatitis through the sharing of needles.

Alcohol and drug use has also been linked to greater risk of injury and involvement in traffic accidents. In South Africa, about half of the drivers and pedestrians killed were found to be above the legal limit for alcohol use (Seedat et al., 2009; WHO, 2006). A large proportion of trauma patients, especially those below the age of 20, also test positive for substance (Parry et al., 2004c). Alcohol and drug use places adolescents at increased risks of experiencing violence. In addition, arrestees under the age of 20 are more likely to test positive for substance use (Parry et al., 2004c). Among a sample of arrestees in 2004, 45% tested positive for at least one substance (Parry et al., 2004c).

Alcohol and drug use also affects an individual's ability to make good judgements and increases engagement in risky sexual behaviour, which places individuals at increased risk of contracting HIV, STIs or experiencing early pregnancy.

It is because of the significant impact that alcohol and substance use has on the schooling system, that a host of decisive interventions have been instituted by the Department to prevent and manage its use.

Adolescents who use alcohol and other drugs are more likely to be sexually active than those who do not, and are more likely to engage in unprotected sex. In South Africa, 16% of learners reported using alcohol before sex, while 14% reported using drugs prior to sex (Reddy et al., 2010).

It is because of the significant impact that alcohol and substance use has on the schooling system, that a host of decisive interventions have been instituted by the Department to prevent and manage its use.

Policy Mandate

A number of international and national policies guide the development of strategy and substance prevention programmes. While the policy mandate is substantive, focus now needs to be shifted towards implementation. International policies, including the UN Convention on the Rights of the Child, and the African Youth Charter, mandate signatories to protect children from the use of substances, and their involvement in the production and trafficking of substances. Provision is also made for the inclusion of alcohol and drug use prevention in the school curriculum, rehabilitation of youth abusing alcohol and drugs and the strengthening of partnerships to eradicate drug trafficking.

The South African Constitution enshrines children's right to basic education, and to accessing basic health care and social services. National legislation also makes provision to redirect offenders between the ages of 10 and 18 into diversion programmes, including substance abuse treatment programmes. The Department of Basic Education adopts this restorative justice approach in dealing with alcohol and drug use among children as opposed to a punitive approach. The National Drug Master Plan 2006-2011 (currently being revised for 2012-2016) outlines the responsibilities of the Department of Basic Education in combating alcohol and drug use, which include the provision of effective alcohol and drug education programmes and the inclusion of alcohol and drug education into the Life Orientation curriculum. Education-specific policies declare all schools drug free zones, and require schools to adopt a code of conduct, including the management of learners who abuse substances. Policy within the schooling system ensures that alcohol and drug use is an integral component of the Life Orientation learning area, as defined by the Curriculum Assessment Policy Statements and is infused into other learning areas. This

is reinforced through co-curricular activities involving sport, safety-related activities and peer education programmes. Legislation within the education system also caters for testing of learners for alcohol and drug use with the goal of ensuring that those who test positive receive the necessary treatment, care and support.

Overarching Principles

A number of principles, informed by international and national interventions and guidelines, inform both strategy and programme development. The principles are grouped into those that apply to how programmes are set up and into what the content should be. A public health approach, which advocates different intervention approaches depending on the severity and nature of the substance use problem, is indicated. The focus in schools should be on prevention and education, as the majority of learners do not use alcohol and drugs, while strong referral links with public partners and civil society should enable learners to access treatment, care and support where necessary. The approach in DBE is on protecting teaching and learning spaces for all and ensuring quality education. Other factors to consider include the importance of collaborative partnerships because the mandate of preventing and managing alcohol and drug use extends beyond the schooling system; the use of prevention activities which are evidence-based, starting prevention education from an early age; delivering programmes over time rather than once-off, the inclusion of peer-led programmes, involvement of caregivers, and the importance of understanding youth perceptions.

Programme content should focus on protective factors as well as risk factors, emphasise both legal and illegal drugs, use interactive methods, avoid exclusively information-based programmes, avoid scare tactics and exaggerated information, and explore learners' goals for the future.

Strategy

The main goals of the strategy are to retain learners in school and to create a safe learning environment that contributes towards quality education. Objectives include ensuring that schools are alcohol and drug free zones, increasing knowledge, life skills and confidence amongst learners so that they are less likely to engage in problematic alcohol and drug use, and managing alcohol and drug use-related problems amongst learners in order to enhance learning outcomes and learner retention.

A number of principles, informed by international and national interventions and guidelines, inform both strategy and programme development.

The strategy is premised on four pillars, namely, to create an enabling environment for the prevention and management of alcohol and drug use; primary prevention that serves as the main thrust of the strategy as most learners do not use or abuse alcohol and drugs and education being the comparative advantage of the schooling system; early detection that focuses on identification of early signs of alcohol and drug use and dependence; and treatment, care and support that is focused on setting up referral links for learners to access the required services. Key focal areas of each of the pillars are outlined in the table below.

In order to implement the strategy, the support structures defined in the Care and Support for Teaching and Learning (CSTL) Programme at national, provincial, district and school levels will be used. These should as far as possible be merged with existing structures such as Safe School Committees, set up as part of the Implementation Protocol signed between the Department of Basic Education and the South African Police Service (DBE, 2011).

The Strategy is linked to the National Strategy on Screening, Identification, Assessment and Support (SIAS) which outlines the process of identifying, assessing and providing programmes for all learners requiring additional support so as to enhance participation and inclusion. The SIAS Strategy framework should be used to screen, identify, assess and support all learners who experience barriers to learning and development within the education system, including those who are currently enrolled in special schools. Alcohol and Drugs are barriers to learning and teaching: to this end, existing structures and support systems outlined in CSTL and in SIAS framework are key and need to be integrated at national, provincial, district and school levels.

The strategy outlines the role and responsibilities of the different levels of government as well as other important stakeholders. The Department of Basic Education's (DBE) responsibilities include the development of integrated policies on alcohol and drug use prevention and management, providing guidance and support for the implementation of policies, regular review of policies and legislation, coordinating multi-sectoral responses, monitoring and evaluating programmes and disseminating relevant research.

Provincial responsibilities include making available human and financial resources, aligning and managing provincial

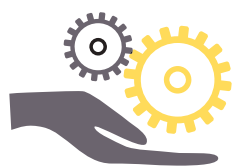
DBE interventions, development of implementation plans, coordinating multi-sectoral responses, implementing prevention programmes, training educators and other stakeholders, establishing reporting systems, gathering and responding to alcohol and drug use intelligence in partnership with Safe Schools partners, collating school records on alcohol and drug use and on treatment, care and support needs; and provision of the necessary support to affected learners and their families.

District officials and district based support teams should ensure the implementation of policies and programmes to combat alcohol and drug use in schools, ensure that Life Skills training forms an integral part of the curriculum, implement co-curricular activities including sport, peer education and safety interventions, assist with the training of educators, and establish links with lobby groups and stakeholders in the community.

Finally, school based support teams and principals should ensure that all learners receive lessons on alcohol and drug use through the life orientation learning area supported with co-curricular activities; link with NGOs and CBOs to implement prevention programmes, keep accurate records regarding referrals and incidents of alcohol and drug use, ensure recreational opportunities, strengthen referral systems, and implement drug testing in schools.

The strategy outlines the role and responsibilities of the different levels of government as well as other important stakeholders.

National Strategy for the Prevention and Management of Alcohol and Drug Use amongst Learners in Schools



Enabling Environment

Policy

- Develop integrated policies
- Allow for regular review of policy and legislation
- Implement policies in schools

Institutional

- Engender political support
- Establish support teams in schools
- Make available human & financial resources
- Advocate for more age-appropriate services and greater funding
- Keep accurate records of alcohol and drug use in schools
- Ensure that relevant research is disseminated
- Monitor and evaluate programmes

Partnerships

- Coordinate multi-sectoral and inter-institutional responses
- Participate in lobby groups in the community



Primary Prevention

Curricular

- Implement school-based alcohol and drug use prevention programmes including life skills training as part of life skills / orientation subject

Co-curricular

- Implement information & awareness campaigns
- Implement co-curricular activities and safety interventions such as peer education clubs
- Implement drug free sport programmes
- Involve families & communities



Early Detection

- Partake in early warning systems
- Train educators & parents to identify warning signs
- Train educators & district officials to conduct drug testing
- Implement drug testing in schools where there is reasonable suspicion that learners are using drugs



Treatment, Care and Support

- Establish strong referral systems to access treatment, care & support
- Create awareness of treatment and counselling services
- Address barriers that limit access to treatment amongst learners (e.g. transport, cost, stigma)
- Set up systems to ensure continuation of education during treatment

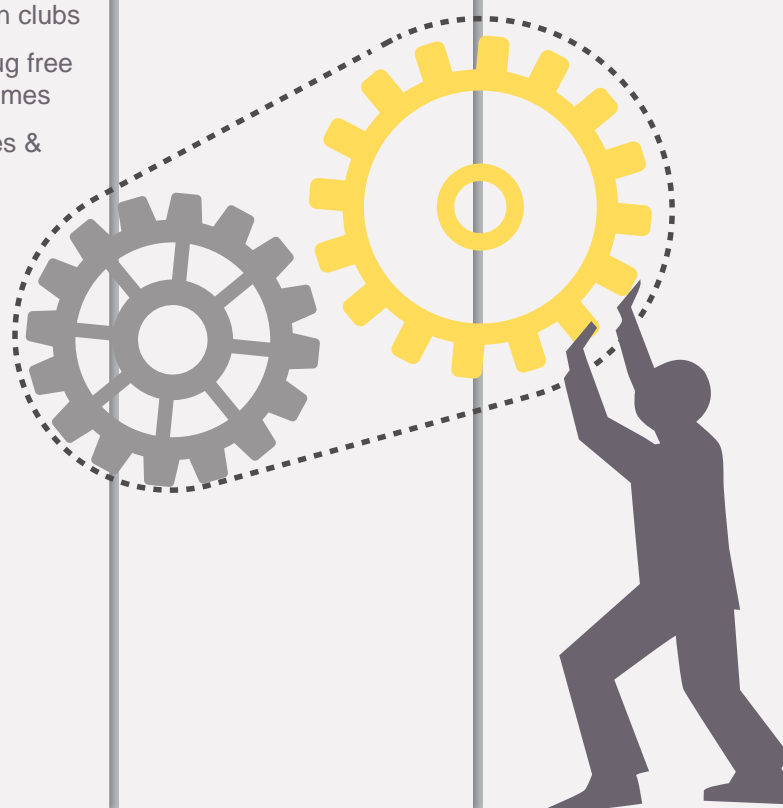


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Acronyms

AUDIT	Alcohol Use Disorder Identification Test
BEM	Boy Education Movement
CBOs	Community-based Organisations
CDA	Central Drug Authority
CSTL	Care and Support for Teaching and Learning Programme
DBE	Department of Basic Education
DBST	District Based Support Team
DOE	Department of Education
DOH	Department of Health
DSD	Department of Social Development
FAS	Foetal Alcohol Syndrome
GEM	Girl Education Movement
GYTS	Global Youth Tobacco Survey
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ISHP	Integrated School Health Programme
KYE	Know Your Epidemic
MDMP	Mini Drug Master Plan
MTSF	Medium Term Strategic Framework
MRC	Medical Research Council
NDMP	National Drug Master Plan
NGOs	Non-governmental organisations
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIMSS	National Injury Mortality Surveillance System
PES	Performance Enhancing Substance
SACENDU	South African Community Epidemiology Network on Drug Use
SADC	South African Development Community
SADHS	South African Demographic and Health Survey
SASA	South African Schools Act
SASSA	South African Social Security Agency
SAMHSA	Substance Abuse and Mental Health Services Administration
SBST	School-based Support Team
SIAS	Screening, Identification, Assessment and Support
STIs	Sexually Transmitted Infections
UN	United Nations
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation
YRBS	Youth Risk Behaviour Survey

Definitions

Adolescent A person aged 10 to 19 years, in accordance with the UN definition.

Alcohol Ethyl alcohol, or ethanol, is an intoxicating ingredient found in beer, wine, and liquor. Alcohol is produced by the fermentation of yeast, sugars, and starches. Alcohol affects every organ in the body. It is a central nervous system depressant that is rapidly absorbed from the stomach and small intestine into the bloodstream. Alcohol is metabolized in the liver by enzymes; however, the liver can only metabolize a small amount of alcohol at a time, leaving the excess alcohol to circulate throughout the body. The intensity of the effect of alcohol on the body is directly related to the amount consumed.

Amphetamines These are stimulants that speed up the body's system. Many are legally prescribed and used to treat attention-deficit hyperactivity disorder (ADHD).

- amphetamine (street names: Bennies, Dexies, Benzedrine);
- methamphetamine (street names: Ice, Meth, Crystal); and
- methcathinone (street name: CAT).

Drug A substance that produces a psychoactive effect. In this document, a drug refers to substances that are legal (e.g. alcohol, tobacco, over-the-counter medications and household goods, such as glue) and illegal (e.g. cannabis, methamphetamine, heroin and cocaine).

Drugs affect your central nervous system and can alter your mood, thinking and behaviour. Drugs may be divided into four categories:

Depressants Drugs that decrease alertness by slowing down the activity of the central nervous system (e.g. alcohol, analgesics and heroin).

Stimulants Drugs that increase the body's state of arousal by increasing the activity of the brain (e.g. caffeine, nicotine, amphetamines, ecstasy and cocaine).

Hallucinogens Drugs that alter perception and can cause hallucinations, such as seeing or hearing something that is not there (e.g. Lysergic Acid Diethylamide - LSD and 'magic mushrooms').

Other Some drugs fall into the 'other' category, as they may have properties of more than one of the above categories (e.g. cannabis (commonly known as dagga) which has depressive, hallucinogenic and some stimulant properties).

Polysubstance Use refers to using more than one drug at a time. This practice is very common in South Africa and leads to addiction. In addition, heavy use of tobacco and alcohol, known as 'gateway drugs', often lead to use of harder drugs such as cannabis, cocaine and heroin.

Substance This is equivalent to the definition for "drug". It includes both legal and illegal drugs, as well as other substances, such as glue or cleaning fluids, which may be abused.

Youth¹ Young people between the ages of 14 and 35. In the context of this strategy document, youth refers to young people who are still in school.

¹ South African Youth Policy 2009-2014

1. Chapter One: Introduction

Substance use is a global challenge, which has detrimental effects on the health, wealth and security of nations (UNODC, 2010). In South Africa, the end of apartheid resulted in the opening of borders, and greater access to a variety of drugs that were previously not available (Parry, et al., 2009). Abuse of alcohol and drugs has been linked with crime and violence (Parry, et al., 2004), risky sexual behaviour (Kalichman et al., 2006) and mental and physical health problems (Brook, et al., 2005; WHO, 2009). Collectively, this places a significant economic and social burden on the country.

Alcohol and drug use also has a devastating impact on South Africa's youth. It has been associated with academic difficulties, absenteeism and school drop-out (Flisher et al., 2003; Sutherland & Shepherd, 2001).

Ultimately this impacts negatively on the economic and social health of the country, as these individuals are likely to become unproductive members of society.

As a result of the impact of alcohol and drug abuse on the country as a whole, South Africa has prioritised it as an impediment to progress and development at the highest level of government. The Inter-Ministerial Committee on Combating Alcohol and Drug Abuse, together with the Interdepartmental Technical Task Team were set up in 2011 to ensure collective responsibility and concerted action on both alcohol and drug abuse through the development of an Anti-Substance Abuse Programme of Action.

1.1. Purpose of the Document

This document was developed in order to provide an integrated and comprehensive strategy that can guide the Department of Basic Education (DBE) and the provinces in a co-ordinated effort to address alcohol and drug use in schools. Currently, implementation is fragmented and programmes are not related to broader policies and strategies.

Key documents which influenced the development of the strategy include: The Education Delivery Agreement that focuses on improving the quality of education and Schooling 2025 and Action Plan to 2014, whose major goals are improvement in learning outcomes and improved access to schooling (DBE, 2010a). The work of the Department on alcohol and drug use is primarily articulated through **Goal 25 in Action Plan to 2014** – 'Use the school as a location to promote access amongst children to the full range of public health and poverty reduction interventions' (DBE, 2010). Interventions on alcohol and drug use also finds resonance with a number of other key goals and outputs of **Action Plan to 2014** and **Schooling 2025**. These include, among others:

- **Learner retention** - removing health and social barriers that prevent learners from remaining in schools, such as HIV and AIDS and alcohol and drug use (**Goal 10**);



- **Providing quality early childhood development** - addressing health barriers to learning through early intervention (**Goal 11**);
- **Effective in-service teacher development** - improving content knowledge and skills levels of educators to support implementation of the curriculum (**Goal 16**)
- **Support & accountability** - providing psychosocial support to educators through workplace programmes (**Goal 17**).

The National Strategy for the Prevention and Management of Alcohol and Drug Use amongst Learners in Schools is located within the broader conceptual framework of Care and Support for Teaching and Learning. The Care and Support for Teaching and Learning (CSTL) Programme is a SADC initiative that was adopted in 2008 by SADC Education Ministers to address the range of vulnerabilities faced by children in the region, such as poverty, HIV and substance abuse. These intrinsic, systemic and societal barriers are compromising the ability of children to realise their right to basic education. South Africa is one of six countries implementing Phase 1 of the programme.

The goal of the CSTL Programme is to realize the education rights of all children, including the most vulnerable, through schools becoming inclusive centres of learning, care and support. Importantly, CSTL is not a programme or policy, and is not intended to replace initiatives that already exist to support vulnerable learners. Rather it is an overarching framework for the initiation and expansion of care and support activities in and through schools. The National Strategy for the Prevention and Management of Alcohol and Drug Use amongst Learners in Schools cuts across several of the nine priority areas of the CSTL Programme (nutrition; health promotion; infrastructure, water and sanitation; social welfare services; safety and protection; psycho-social support; curriculum support; co-curricular support and material support) with the aim of creating a safe learning environment that contributes towards quality education.

The development of this document is further influenced by the National Drug Master Plan (NDMP) 2006-2011 that is currently under review for 2012-2016, which outlines the country's strategy to address the substance abuse problem. The NDMP was developed by the Central Drug Authority (CDA), whose secretariat is located in the DSD and is responsible for co-ordinating sector-based and departmental responses to substance abuse. The CDA requires the relevant national departments to develop Departmental and Provincial Drug Master Plans (D-and PDMP's), which are the operational plans of departments and provinces (DSD, n.d).

Alcohol and drug use affects everyone in the schooling system, including learners, educators and officials, either directly through the use of alcohol or drugs, or indirectly by its impact on the school environment and those in it. In order to provide a comprehensive approach, it is therefore important that the national strategy addresses all role

players. However, for the present strategy, the focus is on learners in the schooling system.

This strategy is intended for provincial and district co-ordinators who deal with alcohol and drug use-related problems in the schooling system, other government departments and non-governmental organisations intervening in and through schools, as well as senior management within the DBE. It should be used to guide provinces in developing implementation plans to address alcohol and drug use prevention and management.

This national strategy therefore aims to aid in the prevention and management of alcohol and drug use in schools, in order to ultimately improve learning outcomes and retention in schools.

1.2. Process of Development

The strategy is based on the KwaZulu-Natal Integrated Strategy for Teenage Drug Abuse developed by the Human Sciences Research Council (HSRC) on behalf of the KwaZulu-Natal Department of Community Safety and Liaison (2006). Other seminal documents which influenced the development of the strategy included the following:

- The Delivery Agreement, Schooling 2025, Action Plan to 2014, Safety Accord, Care and Support for Teaching and Learning Conceptual Framework, Curriculum Assessment and Policy Statement for Life Orientation, National Drug Master Plan 2006-2011 and its current revision for 2012-2016
- Umthente uhlaba usamila – The South African Youth Risk Behaviour Survey 2008 (Reddy et al., 2010)
- Substance abuse and the young: Taking action. Research brief, June 2009 (Morojele et al., 2009)
- SACENDU research briefs (www.sahealthinfo.org/admodule/sacendu)
- Conducting effective substance abuse prevention work among youth in South Africa (UNODC, 2004)

Initially, a literature review was conducted to outline the epidemiology of alcohol and drug use in South Africa, the impact of alcohol and drug use on young people, as well as the determinants and consequences of alcohol and drug use. Relevant national and international legislation and policies were also reviewed, as well as literature on effective interventions among adolescents. Key departmental interventions on alcohol and drug use were also considered and infused throughout the strategy document.

Inputs on the Strategy were also obtained from the Provincial Co-ordinators for School Safety and the HIV and AIDS Life Skills Education Programme Co-ordinators at an interprovincial meeting held on 4 June 2012.

2. Chapter Two: Background

This section provides an overview of substance use in South Africa and by its youth. Determinants and consequences of substance use are also outlined.

2.1. Substance Use in Developing Countries

It is estimated that globally between 3.5% and 5.7% of the population aged 15-64 years of age used illicit substances at least once during 2008 (UNODC, 2010). Similar rates of use were reported for this age group in 2000 and 2004 (4.2% and 4.7%, respectively) (UNODC, 2000; UNODC, 2004b). Of individuals who used drugs in 2008, between 16 and 38 million were problem drug users, who required treatment (UNODC, 2010).

There is a lack of data regarding substance use in many developing countries, particularly in Africa, which limits the understanding of drug use trends (UNODC, 2010). Illicit drug users in Africa make up roughly 17 to 21% of global illicit drug users (UNODC, 2010). In Africa, the majority of drug users seek treatment for cannabis (63%), although the demand for treatment related to opiate use (e.g. heroin) has increased from the late 1990s until 2008 (UNODC, 2010). Estimates of illicit drug users in Africa in 2008 are reflected in Table 1 below:

Table 1: Estimated number of illicit drug users in 2008 aged 15-64 years

	Cannabis		Opiate		Cocaine		Amphetamines		Ecstasy	
	Lower number	Upper number	Lower number	Upper number	Lower number	Upper number	Lower number	Upper number	Lower number	Upper number
North Africa	4 680 000	10 390 000	130 000	540 000	30 000	50 000	260 000	540 000	Cannot be calculated	
West & Central Africa	14 050 000	22 040 000	160 000	340 000	640 000	830 000	Cannot be calculated		Cannot be calculated	
Eastern Africa	4 490 000	9 190 000	150 000	1 730 000	Cannot be calculated		Cannot be calculated		Cannot be calculated	
Southern Africa	4 450 000	11 170 000	240 000	320 000	290 000	900 000	310 000	1 090 000	220 000	420 000
Africa	27 680 000	52 790 000	680 000	2 930 000	1 020 000	2 670 000	1 550 000	5 200 000	350 000	1 930 000

2.2. Substance Use in South Africa

A number of data sources show that an increasing range of substances are used in South Africa. These include tobacco, alcohol, cannabis and a host of illegal drugs.

South Africa's primary encounter with substance use, namely tobacco use, has shown positive trends over the past two decades. Overall, cigarette consumption in South Africa decreased between the early 1990s and 2004, with a per capita cigarette consumption reduction of about half. This can largely be attributed to tobacco control legislation and increasing taxes (DoH, 2007; Swart et al., 2004). According to the South African Demographic

and Health Survey (SADHS), smoking amongst men decreased from 42%, in 1998 to 35% in 2003 (DoH, 2007). Although the percentage of women who smoke decreased from 11% to 10% between 1998 and 2003, this may be an inaccurate reflection due to a larger proportion of Africans (the race¹ group with the lowest smoking prevalence) in the 2003 sample. In fact, the proportion of women that smoke daily, or occasionally, has remained constant or increased across all race groups during this time. Overall, there is a higher prevalence of smoking in urban as compared to rural areas, with the Northern and Western Cape reporting the highest smoking rates (DoH, 2007).

Alcohol consumption in South Africa is estimated at 28%, of which 7% is classified as “high risk” as determined by the Alcohol Use Disorder Identification Test (AUDIT) (HSRC, 2005). According to the SADHS (2007), current drinking levels in 2003 were reported as 30% for men and 10% for women, although the authors acknowledged that this is likely to be a gross underestimate of true drinking levels. These figures are lower according to the SADHS (1998) survey in which 45% of men and 17% of women reported current drinking. Among both genders, the White population have the highest levels of alcohol consumption, and the African population the lowest. However, hazardous or harmful drinking is highest amongst Coloured males and females, and African males (DoH, 2007). Similar to smoking, the highest rates of current drinking (past 7 days) were recorded in urban, rather than rural areas.

The research by the Department of Health (2007) further reveals that twenty three percent (23%) of male and 25% of female drinkers exceed the recommended levels for responsible drinking (less than 4 drinks per day for men; less than 2 drinks per day for women) over weekends, while the weekday equivalent is 1% and 4%, respectively. About 21% of men and 7% of women are estimated to have experienced alcohol problems in their lifetime, as determined by the CAGE questionnaire (DoH, 2007). The SADHS identified the Northern Cape as the province with the highest levels of hazardous or harmful drinking (DoH, 2007), while another national survey identified the Western Cape, Northern Cape and North West provinces as having the highest percentage of high-risk drinkers (HSRC, 2005). For both genders, symptoms of alcohol problems are highest amongst those individuals with the lowest levels of education, the Coloured population and individuals from the Northern Cape (DoH, 2007).

Cannabis is the most common illicit substance used in South Africa (Peltzer & Ramlagan, 2007). It is estimated that around 2% of adults in the population are currently using cannabis, with higher figures reported amongst adolescents (Peltzer et al., 2007; HSRC, 2005). Cannabis

use tends to be higher amongst males than females, is more prevalent in urban areas and is more commonly used by the Coloured and White population groups than other groups (Peltzer et al., 2007).

It is estimated that overall around 0.3% of the South African population uses cocaine, 0.3% sedatives, 0.2% amphetamines, and 0.1% use inhalants, hallucinogens and opiates (HSRC, 2005).

Substance use trends vary according to geographical areas and population. However, polysubstance abuse remains high in South Africa with between 32% and 45% of patients reporting more than one substance of abuse (Plüddemann et al., 2010).

The South African Community Epidemiology Network on Drug Use (SACENDU) tracks substance use trends in the country, and provides descriptive information on the nature and pattern of alcohol and other drug use by collecting biannual data from treatment centres around the country. Research by SACENDU indicates that in South Africa, alcohol remains the most common primary substance of abuse amongst patients seen for treatment, while cannabis remains the most common illicit drug (Plüddemann et al., 2010a). Exceptions are the Western Cape and northern regions (Mpumalanga and Limpopo provinces) in which methamphetamine (36%), commonly known as ‘tik’, and cannabis (44%), commonly known as ‘dagga’, are the primary drugs of abuse, respectively (Plüddemann et al., 2010a).

Research by SACENDU also indicated that there was a large increase in the demand for treatment for heroin in the Gauteng and Mpumalanga provinces, as well as in the city of Cape Town, from the late 1990s to 2007 (Parry et al., 2009b). Furthermore, heroin use appears to be shifting to African patients in Mpumalanga and Gauteng, and to Coloured patients in Cape Town. For example, from 2002 to 2007, the percentage of African patients treated for heroin-related problems in Mpumalanga increased from 13% to 52% (Parry et al., 2009b). Heroin use showed an increase in the second half of 2009 in the northern region (Mpumalanga and Limpopo), with 22% of patients reporting it as either a primary or secondary substance of abuse (Plüddemann et al., 2010a).

The use of crystal methamphetamine (“tik”) increased significantly in Cape Town between 2003 and 2006. While 2% of patients reported methamphetamine as their primary drug in 2003, this peaked at 42% in the second half of 2006 (Parry et al., 2009b).

Overall, South African males tend to have a higher rate of alcohol and drug use than females (Plüddemann et al., 2010c; Reddy et al., 2010). However, females are more likely to abuse over-the-counter and prescription medicines (e.g. benzodiazepines, codeine products and sleeping pills), with between 73% and 83% of these users being female (Plüddemann et al., 2008).

1 The terms African, white, coloured and Indian refer to demographic markers and do not signify inherent characteristics. These terms originated in the apartheid era, and were chosen for their historical significance. Their continued use in South Africa is important for identifying vulnerable sections of the population, monitoring improvements in health and socio-economic disparities and for planning effective intervention programmes.

2.3. Substance Use Amongst South African Youth

Over time, the proportion of South African patients reporting to treatment centres, who are younger than 20 years, has increased significantly (Parry et al., 2004b; Parry et al., 2009b). This may be due to increasing drug use amongst the youth as well as increased accessibility to treatment services (Parry et al., 2009b). At present the proportion of patients younger than 20 years who are being treated for substance use ranges from 17% to 28% across provinces (Plüddemann et al., 2010a). An increase in treatment demand has been noted amongst young African and Coloured individuals (Parry et al., 2009b). In Gauteng, 78% of heroin patients younger than 20 years were African during the second half of 2009 (Plüddemann et al., 2010c).

Tobacco and alcohol, as two licit substances, are the first substances that young people experiment with, probably because of their easy access and social acceptability. In fact, several studies have reported that tobacco and alcohol use leads to the use of other substances (the “gateway effect”) and that if their use can be prevented, then the uptake of harder drugs is less likely (Chen et al., 2002; Flisher et al., 2002; Siquerira and Brook, 2003; Warren et al., 2000).

The second South African National Youth Risk Behaviour Survey (YRBS) conducted among 10 270 grade 8 to 11 learners indicated that almost a third of learners had smoked cigarettes in their lifetime, with 21% being current (monthly) smokers (Reddy et al., 2010.). In South Africa, almost 7% of learners had smoked their first cigarette before the age of 10 years (Reddy et al., 2010). It is unclear whether smoking rates are declining among adolescents in South Africa. The South African Global Youth Tobacco Survey (GYTS) showed a decline in cigarette smoking from 23% in 1999 to 18.5% in 2002 (Swart and Reddy, 2003). In comparison, smoking rates reflected in the YRBS remained unchanged at 21% between 2002 and 2008 (Reddy et al., 2003, 2010). The Western Cape province reported the highest prevalence of smoking amongst learners (37%), and Coloured (36%) and White learners (34%) have higher rates of current smoking than African learners (18%) (Reddy et al., 2010).

Of concern is the use of smokeless tobacco products (e.g. chewing tobacco, snuff) by about 12% of learners (Reddy et al., 2010). Its use tends to be more popular amongst African (13%) and Coloured (12%) learners than amongst White (4%) or Indian (6%) learners (Reddy et al., 2010).

Nationally, 50% of learners have never used alcohol in their lifetime, while 35% currently use alcohol (past month use) (Reddy et al., 2010). Of concern are the high levels of binge drinking amongst learners, defined as having five or more drinks in one sitting, with 29% doing so in the 30

days preceding the survey. The age of initiation of alcohol use also appears to be decreasing, as more learners in younger age groups had their first drink of alcohol before the age of 13 years, than learners in older age groups. In 2008, 12% of learners have used alcohol before the age of 13 (Reddy et al., 2010). Overall, male learners had higher rates of alcohol use than female learners, except amongst Coloured learners, where females report higher rates of use. Binge drinking was most prevalent in the Western Cape (41%), Gauteng (36%) and the Northern Cape (35%) provinces, and amongst White (41%) and Coloured (39%) learners (Reddy et al., 2010).

Cannabis is the primary illicit substance of abuse amongst youth below 20 years of age. Taking into account variations by province, between 46% and 66% of youth in treatment indicate cannabis as their primary drug of abuse (Plüddemann et al., 2010c). Nevertheless, young people do not perceive cannabis as a dangerous drug (Nkowane et al., 2004). On average, 13% of all learners have tried cannabis in their lifetime, while 10% currently use it. Current (past month) use is highest amongst male (13%) and Coloured learners (18%), and is predominant in the Western (16%) and Northern Cape (14%) (Reddy et al., 2010).

With regards to other illicit substances used by South African learners, 12% have ever taken at least one illegal drug such as heroin, mandrax, cocaine or methamphetamine. A similar percentage (12%) of learners has ever used inhalants or over-the-counter medication to get “high” (Reddy et al., 2010). Inhalants are inexpensive and easy to purchase and its use is prevalent among vulnerable young children across the world (UN, 2004).

Rates of lifetime use for Mandrax, “club drugs” (e.g. ecstasy), cocaine and methamphetamine (“tik”) are 7% each, while 6% of learners have tried heroin. Across all “hard” illicit substances, males report higher rates of usage than females (see table 2). Significantly more African (12%) and Coloured learners (13%) than White (4%) or Indian (7%) learners have taken at least one illicit drug before (Reddy et al., 2010). Coloured learners were most likely to have used methamphetamine (10%) and Mandrax (13%).

Adolescents in Cape Town have been particularly affected by crystal methamphetamine (“tik”), with over 70% of patients younger than 20 years reporting methamphetamine as a primary or secondary substance of abuse during 2006 and 2007 (Parry et al., 2009b; Plüddemann et al., 2010).

Another emerging phenomena in school sport is the use of performance enhancing drugs. According to the Centre for Exercise Science and Sports Medicine, the use of substances to enhance performance is present in sport and is a major concern facing youth sport and anti-doping authorities (Gradidge et al., 2011). In a study among male athletes, aged between 15 and 18 years, involved in 1st and 2nd team high school sport in Gauteng province, 30 out of 100 respondents indicated that they were using Performance Enhancing Substance (PES) regularly (Gradidge et al., 2011). Four percent indicated that they

Table 2: Rates of substance use amongst grade 8-11 South African learners

		Male learners	Female learners	Total
Alcohol				
	Ever used	54.4%	45.1%	49.6%
	Current (past month) use	40.5%	29.5%	34.9%
	Binge drinking ³	33.5%	23.7%	28.5%
Cigarettes				
	Ever used	36.8%	22.4%	29.5%
	Current (past month) use	26.4%	15.8%	21.0%
Cannabis				
	Ever used	17.9%	7.6%	12.7%
	Current (past month) use	13.1%	6.5%	9.7%
Inhalants¹				
	Ever used	15.2%	9.2%	12.2%
OTC²				
	Ever used	12.8%	11.3%	12.0%
Mandrax				
	Ever used	9.2%	5.7%	7.4%
“Club drugs” (e.g. ecstasy)				
	Ever used	9.0%	4.7%	6.8%
Cocaine				
	Ever used	8.7%	4.7%	6.7%
Methamphetamine (“tik”)				
	Ever used	8.7%	4.6%	6.6%
Heroin				
	Ever used	7.4%	5.0%	6.2%

1 Inhalants include glue, aerosols, paint thinners, and petrol

2 These include over-the-counter and prescription medications which are used to get “high”

3 Binge drinking is defined as 5 or more drinks in one sitting

(Reddy et al., 2010)

were using anabolic androgenic steroids; 5% indicated that they were using growth hormone, 2% indicated that they were using insulin as a performance enhancer, and 4% indicated that they were using adrenaline/ephedrine to enhance performance. The study recommends the implementation of educational and behaviour change programmes to reduce the use of banned substances in school sport.

The then Department of Education (DOE) implemented a policy in 2002 that bans the possession, use and distribution of alcohol, tobacco and illegal drugs on all

school property (DOE, 2002). Yet the use of substances on school property by learners remains a concern. According to the 2008 YRBS, 13% of learners had used alcohol at school in the month preceding the survey, 8% had used cannabis, 8% attended school after drinking alcohol and 8% attended school after smoking cannabis (Reddy et al., 2010). Nationally, 9% of learners had been offered, sold or given an illegal drug on school property (Reddy et al., 2010).








2.4. Determinants of Substance Use

The adoption of risk behaviours such as drug use can often be traced to the period of adolescence, even though the health-related outcomes are experienced much later in life. Curiosity and experimentation, which may include trying alcohol and drugs, are characteristic of the adolescent stage of development (UNODC, 2004a). While some adolescents may continue using substances and become addicted, the majority of youth do not abuse substances (Reddy et al., 2010). An understanding of the determinants of adolescent drug use will allow for timely intervention and perhaps circumvent premature mortality. Limited South African data is available on the determinants of drug use. Nevertheless, studies in South Africa have shown that international models on the determinants of substance use (Panday et al., 2003; Panday et al., 2005) are largely applicable to the South African context.

In accordance with the CSTL Conceptual Framework, the Ecological Systems Theory provides a framework for considering the risk and protective factors related to substance use. It recognises that individuals exist within various settings, starting with the individual and extending outwards to family, peers, school and society. The Ecological Systems Theory consists of four systems referred to as the micro-, meso-, exo-, and macrosystems. The microsystem refers to an individual's immediate context (e.g. family), the mesosystem to other contexts the individual frequents (e.g. school, neighbourhood), the exosystem to contexts that impact on the individual but that he or she is not directly part of (e.g. parents' relationship with teacher), while the macrosystem refers to the broader cultural system (e.g. socio-economic policies). Individual development is affected, either positively or negatively, by interactions within and across contexts (Bronfenbrenner, 1979 in Duerden and Witt, 2010). For example, a child's relationship with his or her caregivers may influence how he or she interacts with peers. A brief overview of the most important determinants impacting on substance use by learners is presented in Table 3.

Table 3: Risk and protective factors for substance abuse by adolescents

	Individual 	Family 	School 	Community 	Societal 
RISK FACTORS	Delinquency Peer Pressure Rebelliousness Rejecting parental authority Sensation seeking Impulsiveness Aggression Poor sense of well-being	Parental drug use Family conflict Poverty / Affluence Family Context/ Structure and Cohesion Low Expectation	Deviant peer affiliation Skipping school Availability of alcohol and other drugs in or around school premises Low academic aspirations Poor school performance	Exposure to public drunkenness Neighbourhood affirmation of substance use Few job opportunities Abundance of free, unstructured time Ease of access to alcohol and other drugs	Advertising that promotes drug use Moral and Social Degeneration
PROTECTIVE FACTORS	Self confidence High self esteem Good relationships	Good relationship between caregiver & child Good communication between caregiver & child Parental monitoring (e.g. setting rules)	School policy on substance use Code of Conduct Quality of Educational Experience	Community disapproval of substance use Access to positive leisure activities	Taxation Controlling availability and access to substances Increasing minimum legal age of alcohol consumption Effective policy implementation

2.4.1. Individual Factors

Individual factors refer to underlying individual characteristics such as personality, attitudes and physical and mental health (Morojele et al., 2009). Personality factors, such as psychosocial unconventionality (tolerance of deviant behaviours, rebelliousness and rejecting parental authority), sensation or novelty seeking, impulsiveness, aggression, low harm avoidance and other disinhibition traits, have been identified as risk factors for adolescent drug use (Brook et al., 2005; Brook et al., 2006; de Wit, 2008). In fact, a household study of adolescents in Cape Town and Durban demonstrated that personal attributes, such as delinquency, unconventionality and deviant attitudes, together with peer influence were the most important factors predictive of adolescent drug use (Brook et al., 2006).

Interpersonal distress, such as depressive mood and a poor sense of well-being, has also been linked to adolescent drug use (Brook et al., 2005; Brook et al., 2006). Greater social maturity and social competence, measured by indicators such as being self-confident, taking responsibility, participating in discussions, concentrating on work, having high self-esteem, and getting along well with others, have been found to be protective against developing substance dependence (Arteaga et al., 2010; UNODC, 2004a). Religious involvement has also been associated with less alcohol use (Parry et al., 2004a).

Research amongst South African adolescents has also indicated that individuals may use drugs to forget or solve problems, to relieve stress, to be accepted, for curiosity's sake, and for enjoyment and excitement (UNODC, 2004a). Identity formation is a crucial aspect of an adolescent's developmental stage, and some individuals may start using drugs as they perceive it as setting them apart, and as it provides an outlet for rebellion (UNODC, 2004a).

Reviews also demonstrate that adolescents who initiate substance use at a younger age are more likely to become regular users, experience difficulty in quitting and suffer health- and socially-related outcomes later in life (Agrawal et al., 2006; King and Chassin, 2007; SAMHSA, 2010). For example, in the United States, it was found that individuals who had first used alcohol at age 14 or younger were more than 6 times as likely to be classified with alcohol dependence or abuse than those who had their first drink at age 21 or older (SAMHSA, 2010).

It is also important to note that the reasons for drug use may change as individuals progress from experimentation through continued use to addiction (UNODC, 2004a).

2.4.2. Family Factors

Parental drug use places the adolescent at increased risk for alcohol and other drugs use (Arteaga et al., 2010; Brook et al., 2006). In South Africa, parental drinking and marijuana use has been found to be related to adolescents' use of illegal drugs (Brook et al., 2006). The second South African YRBS (Reddy et al., 2010) also indicated that the prevalence of smoking among learners whose parents or guardians smoked, was higher (43%) than amongst those learners whose parents or guardians did not smoke (23%) (Reddy et al., 2010).

Frequent family conflict and involvement in child protective services by age 9 also increased the probability of future substance dependency (Arteaga et al., 2010). On the other hand, positive parenting practices can offer protection against alcohol and other drug use (Fletcher et al., 2004). Specifically, parental warmth, communication, a good attachment relationship between parent and child, parental monitoring, disapproval for trying drugs, and parent's expectations of their child's progress act as protective factors (Arteaga et al., 2010; Brook et al., 2006; Fletcher et al., 2004; SAMHSA, 2010). Parental child rearing factors such as setting rules, child-centeredness and identification with the parent were also found to be protective (Brook et al., 2006). Parents also have the ability to buffer the negative influence of substance-using peers (Sargent & Dalton, 2001; Marshal & Chassin, 2000).

It is also important to note that the reasons for drug use may change as individuals progress from experimentation through continued use to addiction (UNODC, 2004a).



2.4.3. School Factors

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One of the most consistent findings in research studies on substance use is the relationship between peer and adolescent alcohol and other drug use. Deviant peer affiliation, indicated by behaviours such as skipping school, drinking alcohol, or experimenting with drugs, increases the likelihood that an adolescent will use alcohol and other drugs (Arteaga et al., 2010; Parry et al., 2004a). However, it is unclear whether peer influence results in drug use, or if adolescents who use drugs select other drug-using peers as friends.

Availability of substances in and around the school, as well as a lax attitude of schools towards alcohol and other drug use by their learners, is likely to result in greater use of substances (Morojele et al., 2009). It is of concern that 9% of South African learners have been offered, sold or given an illegal drug on school property (Reddy et al., 2010). Low academic aspirations and poor school performance have also been linked to adolescents' use of alcohol (Morojele et al., 2001 in Morojele et al., 2009).

2.4.4. Community Factors

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The attitude of the community and neighbourhood towards the use of alcohol and other drugs, impacts on adolescents' rates of use. For example, community affirmation of smoking is associated with greater rates of smoking among adolescents (King et al., 2003), while exposure to public drunkenness on a daily or weekly basis is also associated with the risk of being drunk (Parry et al., 2004b). In addition, environmental stressors such as low socio-economic status, victimization and discrimination are also somewhat predictive of adolescent drug use (Brook et al., 2006). Having few or no job opportunities, and an abundance of free unstructured time, are also associated with a higher risk of drug abuse (UNODC, 2004a).

Ease of access to alcohol and other drugs also increases the likelihood of use (Brook et al., 2005). The majority of youth who use illegal drugs, such as cannabis, will have first used so-called gateway substances, such as alcohol and tobacco (Flisher et al., 2002). Exposure to environmental tobacco smoke was also higher among learners who smoked (75%) than those who did not (44%) (Reddy et al., 2010).

2.4.5. Societal Factors

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Advertising has glamorised tobacco and alcohol use. Studies have shown that tobacco advertising and promotion makes adolescents vulnerable to begin smoking (Lovata et al., 2003) and progress onto regular smoking (Choi et al., 2002).

Tobacco and alcohol taxation together with restrictions on physical availability are some of the most powerful policy tools for controlling tobacco and alcohol use amongst young people. There is ample evidence that shows that when the price of alcohol and tobacco is increased, consumption decreases, especially among young people, because of their limited disposable income (NIAAA, 2005). Studies in the US have also shown that increasing the legal age of alcohol consumption to 21, had a significant impact on reducing drinking and alcohol-related crashes amongst young people (NIAAA, 2005). Parry (2005), in his review of alcohol-related policies in South Africa, also recommended increasing the minimum age of drinking, graduated licensing for novice drivers, increasing the taxation on all tobacco products and increased restrictions on alcohol marketing.

2.5. Consequences of Substance Use

Apart from being related to physical health problems, substance abuse is also linked to a host of mental and social ills which affect the individual, families, schools and broader society. These include academic difficulties, mental illnesses such as depression, injuries, road accidents, crime, violence, and sexual risk behaviour which may result in HIV infection, unintended pregnancy and sexually transmitted infections (STIs).

2.5.1. Scholastic Problems

Substance abuse amongst learners is of concern, as it has a negative impact on learners' academic performance, academic aspirations and retention in schooling. Research has demonstrated that alcohol and other drug use has been associated with academic difficulties, absenteeism and school drop-out (Sutherland & Shepherd, 2001). In South Africa, significant associations have been made between past month alcohol use and academic failure among adolescents (Flisher et al., 2003), while those learners with better academic performance are less likely to use drugs (Reddy et al., 2007). In Cape Town, past month cigarette use significantly predicted high school dropout (Flisher et al., 2010), while another study found strong associations between binge drinking, school dropout and low academic aspirations (Morojele et al., 2001 in Morojele et al., 2009).

2.5.2. Mental and Physical Health Problems

Substance abuse has been linked with a host of physical and mental health problems, and is associated with elevated morbidity and mortality rates. Smoking substantially increases the risk of death from lung and other cancers, heart disease, stroke, chronic respiratory disease and other conditions, while alcohol contributes to more than 60 types of disease and injury (WHO, 2009). In South Africa, about 5-9% of deaths of individuals over the age of 30 years, are caused by tobacco (WHO, 2009). The World Health Organisation (2009) further reports that besides the direct loss of health due to alcohol addiction, alcohol is globally responsible for approximately 20% of deaths due to motor vehicle accidents, 30% of deaths due to oesophageal cancer, liver cancer, epilepsy and homicide, and 50% of deaths due to liver cirrhosis.

Foetal Alcohol Syndrome (FAS) is regarded as one of the leading cause of preventable birth defects and developmental disabilities (Viljoen et al., 2003). FAS is a problem throughout South Africa, however, it is of particular concern in the Western Cape province. This province has the highest prevalence of FAS in the world, with a recent

study detecting a prevalence of 68.0 – 89.2 per 1000 grade 1 students (May et al., 2007) compared to 0.3 to 1.5 per 1000 live births in the US (Viljoen et al., 2003).

Abuse of alcohol and other drugs has also been found to be associated with a range of mental illnesses, including depression (Brook et al., 2005) and schizophrenia (Degenhardt & Hall, 2006). South African suicide victims have also been found to have high blood alcohol concentrations (Seedat et al., 2009). A study of high school students in Cape Town demonstrated that methamphetamine use in the preceding year was significantly associated with more aggressive behaviour, higher mental health risk and depression scores (Plüddemann et al., 2010b). It is important to note that the impact of substances on mental health may be through a number of routes. For example, methamphetamine use may directly cause aggression, or aggression may indirectly result from sleep deprivation or paranoia, which is induced by its use (Plüddemann et al., 2010b).

Injecting drug users have a high risk of acquiring and transmitting human immunodeficiency virus (HIV) and hepatitis B, C and G through the sharing of needles (Plüddemann et al., 2008). A steady increase in the use of heroin, a drug which is often used intravenously, has been reported in South Africa, particularly in the urban areas of Cape Town and Gauteng (Plüddemann et al., 2008; Plüddemann et al., 2010).

2.5.3. Accidents and Injury

The use of alcohol and other drugs has been linked to greater risk of injury, and involvement in traffic accidents. A study conducted between 1999 and 2001, found that up to two-thirds of patients admitted with injuries to trauma units in Cape Town, Port Elizabeth and Durban had a blood alcohol concentration above the legal limit (Plüddemann et al., 2004). Parry et al., (2004b) reports that of 139 patients who were younger than 20 years and were admitted to trauma units in hospitals, between 29% and 32% had positive breath alcohol levels, 27% to 44% tested positive for cannabis, while between 2% and 29% tested positive for other illegal drugs such as methaqualone, opiates and cocaine. The National Injury Mortality Surveillance System (NIMSS) of 2008 (Donson, 2010) corroborated these findings with 54% of those fatally injured, including transport-related injuries, having positive blood alcohol concentrations.

Injury, especially that resulting from motor vehicle accidents is a leading cause of death and disability in sub-Saharan Africa for those under 29 years of age (UN, 2007). In South Africa almost half of the drivers and pedestrians killed in road traffic accidents were found to be above the legal limit (Seedat et al., 2009; WHO, 2006). In 2008, 56% of South African individuals killed in transport-related accidents had a positive blood alcohol concentration (Donson, 2010). Among South African adolescents, the use of alcohol and other drugs has also been linked to an increased risk of injury and death resulting from fights and road traffic accidents (Morojele et al., 2009).

2.5.4. Crime and Violence

Research suggests a strong link between crime and substance use (Parry et al., 2004c; UN, 2000). Alcohol and drug misuse has been linked to homicide, intimate partner violence, rape and abuse of children (Seedat et al., 2009). The NIMSS study of 2008 found that of those individuals killed in a transport-related accident, 56% had a positive blood alcohol concentration (Donson, 2010). A South African study suggests that the use of alcohol and other drugs by adolescents, as well as by those in the adolescent's social environment, and the availability of drugs in their environment are associated with an increased risk of experiencing violence (Morojele & Brook, 2006). In addition to offences such as drug dealing or drunk driving, the pharmacological effects of alcohol and other drugs may also lead to violence by increasing aggression and decreasing inhibitions.

Crime may also be motivated by the user's need for money to support continued use of alcohol and other drugs (Parry et al., 2004c). Data gathered from 1080 arrestees in Cape Town, Durban and Johannesburg in 2004 indicated that 45% tested positive for at least one substance. Arrestees aged 20 years or younger were the most likely to test positive for substance use (Parry et al., 2004c). Adolescents who frequently use substances are also more likely than those who rarely or never use them, to be exposed to violent acts (Morojele and Brook, 2006). Alcohol use among high school students was found to be a significant predictor of sexual abuse victimization in Cape Town (King et al., 2004).

Due to the strong association between crime and violence and substance abuse and its increasing proliferation in schools, in 2008, the then Department of Education introduced Guidelines for Random Search and Seizure and Drug Testing in Schools (DoE, 2002).

2.5.5. Risky Sexual Behaviour

Alcohol and drug use affects a person's ability to make good judgments and increases engagement in impulsive behaviours, such as having multiple sexual partners, which places a person at increased risk of contracting HIV and STIs or falling pregnant (Kalichman et al., 2006; Rosengard, Anderson & Stein, 2004). Interviews conducted with both injecting and non-injecting drug users in South Africa indicated that sexually active interviewees had an increased number of sexual partners when on drugs, and reported inconsistent condom use (Parry et al., 2009a). The South African National HIV Prevalence Survey of 2008 indicates that those individuals who are high risk drinkers and who use drugs for recreational purposes report the highest percentages of multiple sexual partners (26% and 24%, respectively) (Shisana et al., 2009).

Adolescents who use alcohol and other drugs are also more likely to be sexually active than those who do not (Santelli et al., 2004), and are more likely to engage in unprotected sex (Taylor et al., 2003). The psychopharmacological effects of some drugs tend to increase sexual arousal, decrease inhibitions and disempower females to resist

sex (Morojele et al., 2006). In South Africa 16% of school going learners reported using alcohol before sex, while 14% reported having used drugs before sex (Reddy et al., 2010). A study by King et al. (2004) also demonstrated that females and students who consumed alcohol were more likely to become victims of sexual violence. Exposure to alcohol and drugs also contributes to increased HIV risk for children because such environments usually have diminished protection and increased exposure to negative consequences (Shisana et al., 2005).

It is for these reasons that alcohol and drug use has been identified as a key area of intervention within the National Strategic Plan on HIV, STIs and TB, 2012-2016 (NSP, 2011).

2.5.6. Economic Consequences

Alcohol and drug abuse has a detrimental impact on the South African economy. Soul City commissioned a study to measure the costs related to alcohol abuse for the 2009/2010 financial year (Budlender, 2009). Focusing only on the costs reflected in government budget allocations, it was estimated that provincial governments allocate a total of R7 billion, and national government a total of R10 billion, on account of alcohol abuse. This estimate presents only a fraction of the true costs of alcohol abuse on society, as it does not include social costs, such as those arising from lost productivity, absenteeism, hospitalisation and treatment specific for alcohol abuse, increased use of medical benefits, increased workers' compensation claims, high job turnover, interpersonal conflict, injuries and damage to property. Furthermore, these costs do not include the economic costs of tobacco and illegal drug use.

The National Drug Master Plan (2012-2016) reports that the social and economic cost of illicit drug use and alcohol approximates 6.4% of GDP or about R136 380 million per year. In addition, up to 17.2 million persons (or roughly 1/3 of the population) in the families of users are affected negatively, both emotionally and financially, by the presence of the user in their midst; in the same way 1.78 million are affected by problem users.

3. Chapter Three: Policy Mandate

This section outlines both the international and national legislative and policy mandates that guide the development and implementation of substance use interventions, both directly and indirectly. The international and national policy mandate is substantive and requires a shift towards implementation of policies and enforcement of laws. However, there is recognition in South Africa that alcohol legislation must be strengthened as it pertains to accessibility, availability, as well as advertising and sponsorship. This is having a negative impact on the uptake and abuse of alcohol by young people.

The national policy framework and more specifically, that within education is based on restorative justice principles. This approach recognises that alcohol and drug use are addictive behaviours and that, rather than criminalising behaviour, learners and others within the school community abusing alcohol and drugs, require access to the necessary treatment, care and support services.

While the policy mandate on alcohol and drug use within the schooling system is substantial significant strengthening with respect to implementation is required. Areas of concern are as follows:

- Clarity on the purpose, procedures and consequences of drug testing;
- Clarity on schools obtaining liquor licenses to enable fund-raising activities;
- Role of schools and educators in the administration of medication to learners; and
- Implementation of the policy on drug free sport in schools.

3.1. International Policies

3.1.1. United Nations Convention on the Rights of the Child

This convention, ratified by South Africa on the 16 June 1995, sets a global standard to ensure human rights for children aged 0 to 18 years. Article 33 mandates signatories to institute measures to protect children from the illicit use of substances and the use of children in the production and trafficking of substances (UN, 1989).

3.1.2. Framework Convention on Tobacco Control

This document provides a framework for tobacco control measures at national, regional and international levels in order to reduce the prevalence of tobacco use and the exposure to tobacco smoke. It includes measures affecting both the supply and demand of tobacco products (WHO, 2003). The framework was ratified by South Africa on the 19 April 2005.

3.1.3. Protocol on Combating Illicit Drugs

This protocol was signed by the Southern African Development Community (SADC), and was ratified by South Africa on the 29 July 1998. It aims at assisting in the reduction and eventual elimination of drug trafficking, money laundering, corruption and the illicit use and abuse of drugs through co-operation among enforcement agencies. Other objectives include the elimination of the production of illicit drugs and the protection of the region from being used as a conduit for drugs destined for international markets (SADC, 1996).

3.1.4. Single Convention on Narcotic Drugs, 1961

This Convention aims to combat substance abuse by coordinated international action to deter and discourage drug trafficking. It limits the use and distribution of drugs to medical and scientific purposes. It also lists scheduled substances, and urges Parties to the Convention to take practical measures to prevent the abuse of drugs, and to provide early identification, treatment and rehabilitation. With regard to the youth, it urges Parties to develop leisure and other activities conducive to the sound physical and

psychological health of young people. South Africa ratified the Convention on the 16 November 1971 (UN, 1961).

3.1.5. Convention on Psychotropic Substances, 1971

While the Single Convention on Narcotic Drugs of 1961 was mainly focused on controlling drugs obtained from plant material (e.g. cannabis, opium, cocoa leaves), this Convention aims to control the use and distribution of psychoactive substances (e.g. amphetamines, psychedelics, benzodiazepines). The Convention limits the use and distribution of psychoactive substances to medical and scientific purposes. Similarly to the Single Convention on Narcotic Drugs of 1961, it also lists scheduled substances, and urges Parties to the Convention to take practical measures to prevent the abuse of drugs, and to provide early identification, treatment and rehabilitation. Parties are also urged to assist with the prevention of substance abuse amongst the general public, where there is a risk that substance abuse will spread (UN, 1971). South Africa acceded to the Convention on the 27 January 1972.

3.1.6. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988

This Convention, acceded to by South Africa on the 14 December 1988, provides comprehensive measures against drug trafficking. These include mandating international cooperation in tracing and seizing drug-related assets, as well as providing a legal basis for extradition in drug-related cases amongst countries with no other extradition treaties. The Convention also includes provisions against money laundering and the diversion of precursor chemicals (UN, 1988).

3.1.7. African Charter on the Rights and Welfare of the Child

This charter, which was ratified by South Africa on the 07 January 2000, addresses various rights and responsibilities of children, including rights to education, non-discrimination and health services. It also states that countries that have ratified the charter should take all appropriate measures to protect children from the use of substances, and to prevent the use of children in the production and trafficking of substances (African Union, 1990).

3.1.8. African Youth Charter

This charter, ratified by South Africa on the 28 May 2009, makes explicit provision for the development of life skills to form part of the education curriculum. It states that substance abuse prevention, as well as topics such as HIV/AIDS and reproductive health should form part of

the curriculum. The charter also make provision for the following: rehabilitation of young people affected by drugs, legislative steps to address the consumption

3.1.9. UNESCO International Convention against Doping in Sport, 2007

The Convention provides a legal framework with which all governments can address the growing prevalence and increasingly insidious use of performance-enhancing substances and methods in sport. In the interest of education and sport, UNESCO, through the Convention, emphasises the need for action to curtail trafficking and to regulate dietary or nutritional supplements which all fall under the auspices of governments. The Convention also helps ensure coordination of testing and the development of education, training and research programmes.



3.2. National Policies

3.2.1. South African Constitution

The South African Constitution is the supreme law of the country, which cannot be superceded by any other law or government action. The Bill of Rights is a cornerstone of the Constitution and it affirms the democratic values of human dignity, equality and freedom. The Bill of Rights (chapter 2) enshrines the right to basic education, right to life, right to not be unfairly discriminated against, right to privacy, right to bodily and psychological integrity, and the right of children to access basic health care and social services (Constitution of the Republic of South Africa, 1996).

3.2.2. Child Justice Act (No. 75 of 2008)

This act aims to keep young offenders out of the formal prison system. Provision is made to redirect children between the ages of 10 and 18 into diversion programmes, including substance abuse treatment programmes that attempt to reintegrate young offenders into family care, and to limit the stigma attached to crime.

3.2.3. Children's Act (No. 38 of 2005)

The Children's Act gives effect to the rights of children to care and protection as contained in the Constitution. In relation to drugs and substance abuse, the Act demands protection of children from being exposed, or being subjected, to behaviour that may harm the child psychologically or emotionally. The Act further states that a child in need of care and protection as a result of being addicted to a dependence-producing substance and is without any support to obtain treatment for such dependency, should receive treatment. Section 150(1) (d) of the Act make provision for the school to remove a child if the child is addicted to a dependence-producing substance and is without any support to obtain treatment for such dependency. However, the school must take steps to ensure that the learner continues with education and is referred to the relevant professionals.

3.3. National Legislation on Substance Use

3.3.1. Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008)

This Act aims to provide a comprehensive response for the combating of substance abuse in South Africa by focusing on mechanisms aimed at demand and harm reduction through prevention, early intervention, treatment and re-integration programmes. It also outlines guidelines

for the treatment of children and youth in treatment centres, provides for the registration and establishment of treatment centres and halfway houses, and allows for the development of minimum norms and standards to regulate both in- and out-patient treatment (DSD, 2009).

In addition, the Act outlines the responsibilities and powers of the Central Drug Authority (CDA). The CDA consists of representatives from various departments and sectors, including the Department of Basic Education (DBE). The functions of the CDA include, but are not limited to, overseeing and monitoring the implementation of the National Drug Master Plan, facilitating the coordination of strategic projects, encouraging government departments and private institutions to compile plans, and ensuring the development of effective strategies on prevention, early intervention, reintegration and aftercare services, and the prevention of HIV infection and other medical consequences related to substance abuse.

The aims of the Prevention of and Treatment for Substance Abuse Act (2008) of providing a comprehensive response to combating substance abuse in South Africa is reflected through the functions of the Inter-Ministerial Committee and the Technical Task Team on Combating Alcohol and Drug Abuse.

3.3.2. National Drug Master Plan 2006-2011

The National Drug Master Plan (NDMP) (2006-2011), currently being revised for the next five year period (2012-2016), was drafted in accordance with the stipulations of the Prevention and Treatment of Drug Dependency Act (No 20 of 1992). The administrative unit of the Act is the Central Drug Authority (CDA), whose secretariat is located within the Department of Social Development (DSD). The NDMP enables co-operation between Government departments and stakeholders in the field of drug prevention, and outlines the role that each department should play in fighting the scourge of drug abuse. According to the NDMP, the Department of Basic Education is responsible for ensuring that schools offer effective drug education programmes, for incorporating alcohol and drug use education into the Life Orientation programmes, and for empowering youth to take charge of their destiny, for example, by training young people as peer educators (DSD, n.d.).

3.3.3. Drugs and Drug Trafficking Act (No. 140 of 1992)

This Act seeks as its primary aim to address the problem of drug use, abuse and trafficking in South African society. The legal framework which it provides, defines it as illegal to use or be in possession of, or to deal in, drugs and in certain cases to manufacture or supply substances related to the drug trade. It also defines the duty to report certain information to the police, and how the police may use its powers to handle drug offences.

3.3.4. Tobacco Products Control Amendment Act (No. 63 of 2008)

This Act prohibits the advertising and promotion of tobacco products, the free distribution of tobacco products, the sale of tobacco products to and by persons under the age of 18 years, and allows for an increase of fines for non-compliance. It also prohibits the sale of tobacco products in any place where a person under the age of 18 years receives education or training. Alongside sustained increases in excise taxes, the original Tobacco Products Control Amendment Act No. 12 of 1999 has been credited with declines in both adolescent and adult smoking rates (Swart et al., 2004).

3.3.5. Liquor Act, 2003 (No. 59 of 2003)

This Act regulates the manufacturing, distribution and advertising of liquor. It allows for the establishment of a National Liquor Policy Council, which consults on national norms, standards, and policy for the liquor industry. The Act also prohibits the sale of alcohol to individuals under the age of 18 years (minors), and forbids alcohol advertising which targets minors. A person under the age of 16 years is also not allowed to be involved in an activity relating to the manufacture or distribution of alcohol, unless the person is undergoing training or a learnership.

3.3.6. Policy Guidelines for Youth and Adolescent Health (2001)

These guidelines aim to prevent and respond to specific health problems amongst the youth, and to promote the healthy development of all youth. Substance abuse is included amongst the 8 health priority areas, and schools are identified as a facility for health promotion, by, for example, incorporating health education into the curriculum (DOH, 2001).

3.3.7. National School Health Policy and Implementation Guidelines (2003)

This policy aims to support educators and the school community in removing health-related barriers to learning, providing access to health services and assisting with the delivery of health education and health promotion. It states that health promotion should incorporate areas such as Life Skills training and substance abuse education (DOH, 2002). The National School Health Policy and Implementation Guidelines (2003) is currently under review and is being transitioned to a more comprehensive and integrated response to school health services for all learners in the schooling system.

Emanating from the revised policy is the Integrated School Health Programme (ISHP) that is being designed to offer an integrated and comprehensive package of health services to all learners through a phased implementation plan beginning with the most disadvantaged school communities, and those least likely to access health services. An age and developmentally appropriate health services package is being designed with three main components – health screening, on-site service, and health education that is aligned to the four school phases within primary and secondary education namely (foundation (GR-3), intermediate (G4-6), senior (G7-9) and FET phases (G10-12)). The health services package is derived from the current burden of disease profile of children and youth, key health barriers to learning as well as risk factors for further health concerns.

A significant component of the health services package focuses on age appropriate health education and health promotion that will supplement and consolidate the existing knowledge provided through the Life Skills Programme and the Life Orientation learning area. Drug and substance use has been identified as a key area for health education among all learners.

3.3.8. South African Institute for Drug-Free Sport Amendment Act, 2006 (No. 25 of 2006)

This Act makes provisions for the testing of athletes for doping by sports administration bodies, and for punitive measures to be taken against national sports federations not complying with the regulations. The original South African Institute for Drug-free Sport Act, 1997, promoted the participation in sport, which is free from the use of drugs and other substances, which are intended to artificially enhance performance. The Act also allowed for the establishment of the South African Institute for Drug-free Sport. Objectives of the Institute include the development of educational programmes for the general and sporting community with regards to the dangers of doping in sport.

3.3.9. National Strategic Plan on HIV, STIs and TB 2012-2016

The National Strategic Plan for HIV, STIs and TB, 2012-2016 (NSP), is the country's five year plan to address the twin epidemics of HIV and TB. The Plan recognises the impact of alcohol and substance abuse on HIV transmission and vulnerability to TB, based on the findings of the Know Your Epidemic (KYE) report and other epidemiological studies. The risk for HIV transmission is increased through both unprotected sex and injecting drug use. In concordance with the work of the Inter-Ministerial Committee on Combating Alcohol and Drug Abuse, the plan calls for the implementation of a suite of interventions including taxation, limiting alcohol sales and advertising, advertising health messages and strengthening alcohol and substance abuse legislation in schools and tertiary institutions.

3.4. Educational Policies

3.4.1. South African Schools Act, 1996 (No.84 of 1996)

The South African Schools Act of 1996 aims to redress past inequalities in educational provision and to provide an education of progressively high quality for all learners (DOE, 1996). It requires schools to adopt a code of conduct, which is dedicated to the improvement and maintenance of the quality of the learning process. Alcohol and drug use in schools will infringe on the aims of the Code of Conduct of the Schools Act, which calls for the establishment of a disciplined and purposeful school environment, dedicated to the improvement and maintenance of the quality of the learning process.

3.4.2. Vision 2014 - Towards Schooling 2025

Schooling 2025 provides a vision of what the Department of Basic Education (DBE) would like to achieve by 2025. The Action Plan to 2014 provides specific goals that the DBE aims to achieve by 2014.

The Action Plan to 2014 is born out of the national Delivery Agreement 1: Improved Quality of Basic Education, which is one of 12 negotiated charters signed by the Minister of Basic Education and those key partners with direct responsibility for the improvement of basic education (e.g. Department of Health, Department of Arts and Culture, Department of Science and Technology, Department of Public Works). This agreement stems from one of the 12 key targets set out in the 2009-2014 Medium Term Strategic Framework (MTSF), which sets out the strategic mandate of government. The MTSF identifies strategic priorities and targets that serve as the basis for determining the government's implementation plans for the period to 2014.

The major goals of Schooling 2025 and Action Plan to 2014 (DBE, 2010a) include improvement in learning outcomes and improved access to schooling. Goals that have particular relevance to the prevention and management of substance abuse in schools are as follows:

1. *Learner retention (goal 10)*: Ensure that learners remain in school by effectively preventing and managing alcohol and drug use amongst learners and educators.
2. *Healthy workforce (goal 17)*: Ensure that teachers are able to work effectively, by managing alcohol and drug abuse amongst teachers, and providing psychosocial support to them.
3. *Providing access to public health interventions (goal 25)*: Ensuring that referral networks have been set up, so that learners with alcohol and drug use problems can be referred to the appropriate resources.

3.4.3. Employment of Educators Act (No.76 of 1998)

This Act regulates the conditions of service, discipline, retirement and discharge of educators. It calls for the mandatory dismissal of an educator found in possession of any intoxicating, illegal or stupefying substance while at work. An educator found to be under the influence of alcohol or drugs whilst at work will be subject to a disciplinary hearing and appropriate sanctions. An educator suffering from ill health as a result of alcohol or drug abuse may be sent for counselling or rehabilitation. However, employment may be terminated if the behaviour is repetitive.

3.4.4. Regulations for Safety Measures at Public Schools

These regulations declare that all public schools are drug free zones. No person may possess illegal drugs on public school premises, or enter the premises while under the influence of an illegal drug or alcohol. The regulations also make provision for the searching of school premises, or persons present on the premises, by a police officer, principal or delegate, if there is reasonable suspicion for possession of substances (DOE, 2001).

3.4.5. Policy Framework for the Management of Drug Abuse by Learners in Schools and in Public Further Education and Training Institutions

This policy intends to support learners who abuse substances, as well as staff and learners who are affected by substance abuse, and contribute to the effective prevention, management and treatment of drug use. It states that all South African schools should become tobacco, alcohol and drug-free zones. It also states that random drug testing is prohibited, and that drug testing should only be used where there is reasonable suspicion that a child is using drugs. It makes provision for preventive education via the Life Orientation curriculum (DOE, 2002).

3.4.6. National Guidelines for the Management and Prevention of Drug Use and Abuse in all Public Schools and Further Education and Training Institutions

These guidelines provide a framework for the way in which to operationalise the policy framework mentioned in 3.4.5. It provides direction as to the systems that should be put in place to address substance abuse in the schooling system. These include, amongst others, developing a

policy with regard to the management of substance abuse by learners for each school, establishing Learner Support Teams (LST), creating links with community resources, and implementing procedures for incident management (DOE, n.d.). The guidelines further recognise the inclusion of drug education in the Learning Area of Life Orientation which is currently implemented in schools. A healthy, drug-free life is further encouraged through learner's participation in sport and cultural activities.

3.4.7. Devices to be Used for Drug Testing and the Procedure to be Followed (2008)

This gazette lists the drug testing devices which can be used when testing learners for substances. It also outlines the procedures to be followed when testing learners for drugs. It must be noted that the guidelines specify that learners may only be searched after fair and reasonable suspicion of substance use has been established; drug testing should only be conducted by a staff member of the same gender as the learner; the results of testing should be kept confidential; and learners should be referred to the appropriate resources for counselling or treatment if found to test positive for substance use (DOE, 2008). The intention of drug testing is therefore not punitive but to ensure that learners addicted to substances access the necessary treatment, care and support services. The list of approved devices for drug testing is as follows:

- (1) Drug Detective Wipe Detection System for Surfaces
- (2) One Step Home Cocaine Test Strip
- (3) Multi-Drug Test
- (4) Quicktox Drug Screen Dipcard Test

- (5) Monitect Drug Screen Cassette Test
- (6) Toxcup Drug Screen Cup Test
- (7) Multi Panel Drug Testing Device
- (8) Smart Check Drug Screen Test
- (9) Drug Smart Cup
- (10) A Vit Ar Oral Screen 4 or Drugometer

3.4.8. Implementation Protocol between the Department of Basic Education and the South African Police Services on Prevention of Crime and Violence in All Schools (2011)

In response to increasing levels of crime and violence in the schools, in 2011 the Department of Basic Education and the South African Police Services signed an Implementation Protocol that 'aims to promote safer schools and prevent the involvement of young people in crime'. Alcohol and drug use is recognised as a key contributor to crime and violence in schools. The signing of the implementation protocol has resulted in schools being linked to local police stations and in setting up local reporting systems on school-based crime and violence. In addition, Safe Schools Committees have been established that work in partnership with local NGO's, local police and district officials to implement crime prevention programmes in schools and community mobilisation interventions.



4. Chapter Four: Overarching Principles

A number of principles have been identified to inform strategy and programme development when focusing on the prevention and management of substance abuse. These were informed by international and national interventions and guidelines (Cupp et al., 2008; Foxcroft et al., 2003; UNODC, 2010), and were also guided by the NDMP and the roles identified for the DBE within it (DSD, n.d.).

The following principles, in particular, apply to **demand side strategies** targeting the prevention and management of substance abuse amongst learners in a school environment. Broader **supply side strategic**

measures, such as those targeting the supply of alcohol and drugs by reducing their affordability or banning alcohol advertising, are therefore not focused on in the strategy.

The principles are grouped into two major themes, those that impact on the process of setting up programmes, and those related to the content of the programme. Where possible, linkages have been made to existing interventions on drug and substance use in the schooling system.

4.1. Methods Used to Deliver Programmes

4.1.1. Public Health Approach

Different intervention approaches are needed when tackling substance abuse among young people, depending on the nature and severity of the problem (Morojele et al., 2009). The public health approach details three phases of intervention. These include primary prevention, early detection, and treatment, care and support (UN, 2004). Primary prevention is applicable to those learners, who have not yet initiated alcohol and drug use. Early detection targets those that are experimenting with alcohol and drug use, but have not developed dependence. Treatment, care and support applies to the minority of youth, who have developed dependence and require treatment for it. As the majority of learners do not regularly use alcohol and drugs, the focus should be on prevention in the school environment. The school's role in treatment is the establishment of strong referral links with public partners and civil society, to enable learners to access treatment, care and support where necessary.

4.1.2. Collaborative Partnerships

Due to the immense challenge of addressing the substance abuse problem in South Africa, multi-sectoral and inter-institutional collaboration is essential for the effective development and implementation of strategies (United Nations Office for Drug Control and Crime Prevention, 2002). No single government department or institution has the sole mandate, or sufficient human and financial resources, to address the problem in isolation. Due to

the complexity of economic and social factors leading to alcohol and drug use, partnership with other government departments and civil society is essential. In fact, the need for partnerships is recognised in the CSTL Framework and multi-sectoral structures have been proposed to support integration at national, provincial, district and school levels.

At a governmental level, the demanding nature of the challenge has resulted in an intergovernmental response which helps to give alcohol and drug abuse political leadership attention, an opportunity for interdepartmental resource mobilisation and a national coordinated intervention response through the Inter-ministerial Committee and Technical Task Team on Combating Alcohol and Drug Abuse.

4.1.3. Evidence-based Strategies

Over the past few decades, a substantive evidence base has been developed on the effectiveness of various prevention and treatment methods. The United States National Institute on Drug Abuse was established in 1974, with a focus on training, research, treatment and prevention (Chepesiuk, 1999), while the UNODC which assists member states in the struggle against illicit drugs was established in 1997 (www.unodc.org). In South Africa, data collection on substance abuse was initiated in 1996 with the establishment of SACENDU (Parry et al., 2009b).

Prevention activities should be scientifically accurate, objective and free of value judgements. Activities that are based on intuition often transmit the wrong messages, and are perceived by young people as biased and lacking credibility (UNODC, 2004a).

4.1.4. Multiple Approaches

Due to the complexity and range of risk factors related to substance abuse, as well as the diversity of learners, comprehensive approaches to address substance use amongst learners are more likely to be successful than single-focused activities. A wide array of programmes and strategies are required to address substance abuse amongst learners. Individual programmes should be seen as part of a broader approach, and should be designed to complement one another (UN, 2000). The Department of Basic Education applies multiple concurrent approaches to address drug and substance abuse in schools. While the primary thrust of the programme is achieved through the Life Orientation learning area, through directly addressing drug and substance abuse and developing more generic life skills such as assertiveness skills to cope with peer pressure, curriculum-based interventions are supported by co-curricular activities. These include peer education clubs such as Soul Buddyz and Girl Education Movement (GEM) and Boy Education Movement (BEM).

4.1.5. Comprehensive Programmes

Research demonstrates that high risk behaviours tend to cluster together. For example, adolescents who use alcohol and drugs are more likely to engage in risky sexual and other deviant behaviours (Reddy et al., 2010). Programmes, such as life skills training, which address resistance skills and the development of relationship and personal skills aid in the prevention of multiple high risk behaviours.

The Department of Basic Education currently implements the HIV and AIDS Life Skills Education Programme for all learners across all grades. The programme assists learners to acquire knowledge, develop skills and establish values to make informed choices, responsible decisions, and to live healthy and balanced lifestyles. The programme also focuses on school-based activities linked to the curriculum. These include a focus on, among others, peer pressure, non-discrimination, alcohol, drug and substance use. A cross-curricular approach has been adopted for the delivery of the programme. Although HIV and AIDS and life skills education are primarily located in the Life Orientation Learning Area, some aspects have also been integrated into other Learning Areas.

4.1.6. Prevention Education Early in Life

Prevention education should ideally be initiated early in life (during primary school) and continued throughout the school career (UNODC, 2004a). Age of initiation is decreasing, and it is easier to prevent the uptake of substance use at an early stage, rather than attempting to intervene at a later stage when learners are already using drugs. Children are also exposed to alcohol advertising and the use of alcohol and tobacco in the community from a young age, therefore prevention education early in life is appropriate. Prevention

education is more effective at an earlier age when it is easier to influence attitudes or behaviour (UN, 2000).

4.1.7. Deliver Programmes over Time

Programmes should be delivered over time rather than on one occasion (UNODC, 2004a). Furthermore, multiple sessions in the short-term followed by regular booster sessions over time have been proven to be effective (Morojele et al., 2009). The Curriculum Assessment Policy Statement for Life Orientation has allowed for the infusion of lessons on drugs and substance use from Grades 3 and 4, and then repeated in all grades until Grade 12.

4.1.8. Target Interventions to the Appropriate Audience

Due to the heterogeneity amongst young people, programmes should be tailored to the defined target group. Programmes should therefore take cognisance of age, gender, developmental level, and culture. However, programmes should not be exclusively implemented amongst high-risk youth, as this may result in reinforced substance use amongst this group (Toumborou et al., 2007).

Infusion of lessons on drug and substance use in terms of CAPS ensures that all learners within the school system are taught about drugs and substance abuse. These lessons are further infused into different subject lesson plans (e.g., Biology, Life Orientation or Mathematics) in order to improve understanding and equipping learners to make informed decisions when confronted with the situation.

4.1.9. Understand Youth Perceptions

Programmes that work for adults may not necessarily work for adolescents. It is important to place oneself in the mindset of an adolescent when developing prevention programmes. It also helps to involve youth in the planning and implementation of prevention programmes (UNODC, 2004a).

4.1.10. Peer-led Strategies

Research has shown that peer-led strategies are effective in preventing substance abuse amongst young people, as adolescents are often more willing to listen and take advice from others with similar experience (Morojele et al., 2009). The Department of Basic Education has recognised this fact and has created a conducive environment for the implementation of peer education programmes within the school setting. Examples of these include Representative Council of Learners, peer education clubs through the life skills programme, and Girls Education Movement and Boys Education Movement (GEM/BEM).

4.1.11. Working with Parents/ Caregivers/ Families

Involvement of caregivers and families in programmes aimed at preventing substance abuse among adolescents are effective (Foxcroft et al., 2003; UNODC, 2004a). The Department therefore encourages the role of parents, caregivers, families and SGB's as part of an accountability and responsibility system in the collective effort to curb the scourge of drug and substance abuse. Through the HIV and AIDS Life Skills Education Programme, advocacy campaigns are run with school communities to address issues, such as HIV and drug and substance use. This must be extended to include parent-child behaviour change programmes.

4.2. Content of the Programme

4.2.1. Focus on Protective Factors, in Addition to Risk Factors

The majority of youth do not abuse substances, despite living in high risk environments. Eighty nine percent (89%) of learners have never tried an illegal drug such as heroin, mandrax, or "tik", 87% have never used cannabis, 70% have never smoked, and 50% have never used alcohol (Reddy et al., 2010). Interventions should therefore focus on reducing risk factors, as well as promoting protective factors that offer resilience to drug use. Such thinking of reducing risk and promoting protective factors underpins the thinking of the CSTL Programme.

4.2.2. Focus on both Legal and Illegal Substances

Adolescents often experiment with legal substances, such as tobacco and alcohol which are just as harmful as illicit drugs and often serve as gateway drugs to the use of illegal drugs. Education should therefore focus on both legal substances, such as tobacco, alcohol and over-the-counter medication, as well as illegal substances. In fact, the impact of alcohol abuse on society has been identified by the Inter-Ministerial Committee as requiring urgent intervention.

4.2.3. Redressing the Norm

In situations where the extent of drug use amongst peers is overestimated, the provision of accurate statistics regarding the actual use of substances by youth has positive results as it corrects the misperception that "everybody is doing it" (Morojele et al., 2009; UNODC, 2004a).

4.2.4. Interactive Methods

Education around substance abuse should involve interactive teaching methods. Discussions and questioning, as well as critical analysis of materials such as alcohol advertising should be encouraged. The National Policy Framework for Teacher Education and Development in South Africa acknowledged these pedagogical concerns and the need to be addressed during teacher pre-service and in-service training.

4.2.5. Avoid Exclusively Information-based Programmes

Prevention programmes that focus exclusively on educating learners about substances and their effects have proven to be ineffective (UNODC, 2004a). Instead, information should be incorporated alongside Life Skills training, where the focus is on intra- and inter-personal skills, assertiveness, and the ability to resist pressure from peers (Morojele et al., 2009). CAPS further allows for the integration of drug and substance abuse into co-curricular activities and through peer-to-peer programmes where learners are allowed to define and discuss drugs and substance use and encouraged to find solutions to the problem. External community partners such as NGO's and local police are engaged through awareness campaigns which involve activities such as public marches, sporting events, choir competitions, drama, debates and essay competitions.

4.2.6. Clarify Values with Learners

Exploring learners' goals for the future and where they would like to be in 2 to 5 years time, has been found to have positive results in preventing risky behaviour, such as substance abuse (Foxcroft et al., 2003; UNODC, 2004a).

4.2.7. Avoid Scare Tactics

The use of scare tactics has been shown to be ineffective. Campaigns based on exaggerated information and fear arousal (e.g. the depiction of a body in the gutter with a needle in the arm) are likely to be dismissed by adolescents as untrue and lacking integrity (UNODC, 2004a).

5. Chapter 5: Strategy

This section outlines the main strategic goals and objectives, the four pillars making up the strategy, and the roles and responsibilities assigned to ensure effective implementation of the strategy. Programmes on drug and substance use are mainly articulated through Goal 25 of Action Plan to 2014, namely, 'Use the school as a location to promote access amongst children to the full range of public health and poverty reduction interventions' (DBE, 2010).

5.1. Strategic Goals

The main goals of the strategy are to:

1. Retain learners in school; and
2. Create a safe learning environment that contributes towards quality education

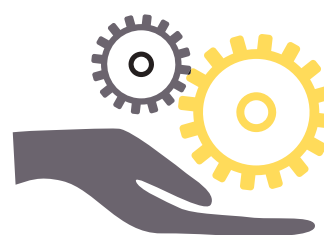
5.2. Strategic Objectives

The main objectives of the strategy are to:

1. Ensure that schools are alcohol and drug free zones;
2. Increase knowledge, life skills and confidence amongst learners so that they are less likely to engage in problematic alcohol and drug use; and
3. Effectively manage alcohol and drug use related problems amongst learners in order to enhance learning outcomes and learner retention.

5.3. Pillars of the Strategy

The strategy consists of 4 pillars. These focus on the enabling environment, primary prevention, early detection, and treatment, care and support. The education system is particularly concerned with the prevention of substance abuse amongst learners, and serves as a referral link for those learners who require treatment, care and support.



ENABLING ENVIRONMENT



PRIMARY PREVENTION



EARLY DETECTION



TREATMENT, CARE & SUPPORT

FOUR PILLARS OF THE STRATEGY

5.3.1. The Enabling Environment



The following are important in ensuring an environment that is conducive to the effective development and implementation of programmes to combat alcohol and drug use in the basic education sector.

Policy

1. *Development of clear and integrated policies for the basic education sector:* Policies should take cognisance of the legislative framework that is already in place, as well as programmes run by other government departments (such as Ke Moja Drug and Substance Abuse programme run by DSD) and by other directorates within the DBE (such as the School Safety Programme). These should be incorporated into policy development, where applicable. Furthermore, policies should be clear and easily understandable to the whole school community, including parents.
2. *Allow for regular review of policy and legislation:* Policies should be reviewed on a regular basis so that they can be adjusted alongside new knowledge in the alcohol and drug use field and address unintended consequences where these may arise.
3. *Implement policies to combat substance abuse in schools:* District officials and school principals need to ensure that policies regarding alcohol and drug use are fully implemented in schools for all stakeholders. For example, schools that rent out their premises for after-school events should not allow alcohol and drugs to be consumed on the premises. Consideration must also be given to the implementation of smoking policies in schools for educators, taking into account that it is both a workplace and a public space that is governed by tobacco control legislation.

Institutional

1. *Engender political support and commitment:* Programmes are likely to be most effective when supported by various role players. These include politicians, national, provincial and district officials, members of the school governing body, and community leaders, including traditional leadership.
2. *Establish or strengthen support teams in schools:* Each school should have a team consisting of staff and external stakeholders, which is responsible for overseeing, managing and referring learners with substance abuse problems. These support teams may be incorporated into the School Based Support Teams of the CSTL Programme or the School Safety Committee.
3. *Make available human and financial resources:* Adequate financial and human resources need to be available to ensure sustained implementation and evaluation of policies and programmes. Provinces should make provision for programme resources through the provincial budgeting process.

4. *Advocate for more age-appropriate services and greater funding to support these:* Currently there are limited numbers of treatment facilities for youth, as well as inadequate numbers of social workers, psychologists and counsellors to support youth with alcohol and drug use-related problems.
5. *Keep accurate records of alcohol and drug use in schools:* Each school should keep records of learners who have alcohol and drug use-related problems and the steps taken to assist learners. Referral lists of individuals referred for counselling for alcohol and drug use-related problems need to be kept. District officials are responsible for collating these statistics on a regular basis.
6. *Ensure that relevant research is disseminated:* Research regarding alcohol and drug abuse should reach the relevant officials, so that it can inform programme development.
7. *Monitor and evaluate programmes:* Prevention and management programmes implemented in schools should be monitored and evaluated on a regular basis, and adjusted accordingly. Data on alcohol and drug use should be routinely collected through the Education Management Information System. Programmes that are proven to be effective should be consolidated and distributed across districts and provinces.

Partnerships

1. *Co-ordinate multi-sectoral and inter-institutional responses:* Adequate co-ordination between, and within, the various government departments, as well as with external organisations such as NGOs, CBOs, research institutions, and universities is essential to ensure the pooling and rational use of resources.
2. *Participate in lobby groups in the community:* Linking up with lobby groups and task teams, such as local drug action committees, will allow schools to lobby on issues affecting the management of substance use by learners in schools. For example, schools could lobby regarding unlicensed outlets such as shebeens and advertising located near schools, or district officials could participate in task teams to strengthen alcohol legislation.

5.3.2. Primary Prevention



Curricular

1. *Implement school-based alcohol and drug use prevention programme:* The following should be held in mind when developing and implementing school-based prevention programmes:
 - The programmes should be developmentally, locally and culturally relevant;
 - The programmes must be infused throughout the primary and secondary school Life Skills and Life Orientation learning areas;

- Life skills such as interpersonal skills, self-esteem, assertiveness and resistance skills are key to preventing high-risk behaviours, such as alcohol and drug use and sexual risk behaviours;
- Programme content should be based on relevant theory and evidence-based research.

Co-curricular

2. *Information and awareness campaigns:* These should be targeted at the whole school community. The following should be kept in mind when implementing these campaigns:

- Avoid the use of fear messaging, “just say no” campaigns and simplistic messages;
- Information should be factual and evidence-based, and should not be exaggerated;
- Focus on short-term negative effects of alcohol and drug use which learners will be able to witness in their own life, or the lives of those around them, such as discolouring of teeth, trembling hands, difficulty concentrating;
- Create awareness of the problems associated with legal drugs (tobacco, alcohol);
- Create awareness of the links between alcohol and drug use and other high-risk behaviours, such as risky sexual behaviours, crime, violence and poor school performance; and
- Dispel myths about recreational drug use being normative, safe, acceptable and glamorous.

3. *Implement co-curricular activities and safety interventions, such as peer education clubs:* Activities such as sport, music, art and drama offer positive alternatives to youth. In addition, peer-to-peer programmes can help shift social norms on alcohol and drug use.

4. *Implement drug free sport programmes:* Learners and coaches should be made aware of the risks of using both legal and illegal performance enhancing drugs and linkages should be made with other government departments such as the Department of Sports and Recreation and institutions managing doping in sport.

5. *Involve families and communities in school-based prevention programmes:* Where possible, families and communities should be involved in prevention and awareness campaigns.

5.3.3. Early Detection



1. *Establish and partake in early warning systems to prevent the spread of alcohol and drug use:* Officials should participate in provincial and local networks, such as those held by SACENDU, so that information regarding new alcohol and drug use trends can be disseminated to schools and district officials.
2. *Train educators and parents to identify warning signs:* Teachers, and where possible, parents, should be

trained to identify the early signs of alcohol and drug abuse and dependence.

3. *Train educators and district officials to conduct drug testing in accordance with the guidelines:* Educators and officials should be trained on the correct testing devices to be used, the correct steps to be following when using the drug testing devices and analysing results, and the procedures surrounding testing.

4. *Implement drug testing in schools where there is reasonable suspicion that learners are using drugs:* Drug testing should be implemented in schools where educators have received sufficient training. Drug testing is not intended as a punitive action. Rather it is meant to aid learners in receiving the required treatment, care and support.

5.3.4. Treatment, Care and Support



1. *Establish strong referral systems to access treatment, care and support:* Schools should have a strong referral network in place, so that learners and educators who abuse, or are dependent on, alcohol and drugs can be referred to the appropriate resources for assistance. Districts and schools should also establish links with the Department of Social Development (DSD) so that learners and educators have easy access to state-funded inpatient and outpatient facilities.

2. *Create awareness of treatment, rehabilitation and counselling services:* Schools should ensure that their learners and staff are aware of the available services in their district and province.

3. *Address barriers such as transport costs and stigma that limit access to treatment facilities:* Where feasible, schools should assist in addressing barriers which may prevent access to treatment for learners and educators. This will be effectively addressed through partnerships created with the Department of Social Development, local drug action committees and the treatment and care centres in the proximity of the schools.

4. *Set up systems to ensure continuation of education during treatment:* Learners should not be deprived of education during their period of treatment. Measures should be taken to ensure that learners are able to continue with their studies during this time.

5.4. Support Structures, Roles and Responsibilities

Support structures should be in place to ensure implementation of the strategy, as well as to assist integration at a national, provincial, district, and school level. Where relevant structures already exist, such as Safe School Committees, the structures and roles listed below

should be incorporated into them, rather than creating additional structures.

5.4.1. Incorporation into the Care and Support for Teaching and Learning (CSTL) Framework

In accordance with the CSTL Framework, the following structures (discussed below) should exist to support integration at national, provincial, district and school levels. The roles and responsibilities of the various structures as defined in White Paper 6 and the National Support Pack are as follows:

National Task Team: The function of the national task team is to provide strategic direction and guidance to the CSTL. This team comprises officials at the Department of Basic Education and other government departments. Relevant NGOs and academic institutions should be co-opted on an ad-hoc basis to participate in the National Task Team.

Provincial Task Team: Provincial Task Teams co-ordinate and guide CSTL activities across the province. These task teams should include Department of Education personnel. Partners from other government departments and civil society may be co-opted as required.

District-Based Support Team: These teams are central to the implementation, monitoring and evaluation of programmes. They should assist in building the capacity of schools to address barriers to learning and in drawing on expertise found in local communities.

School-Based Support Teams: These teams operate at the level of the school to co-ordinate learner support services. They are made up of educators, parents/ caregivers and learners (where applicable). Where appropriate, these teams are strengthened by expertise from the local community, and are supported by the district-based support teams (DBE, 2010b).

The relevant officials from national, provincial, district and school level should be incorporated into these CSTL structures to address prevention and management of alcohol and drug abuse in schools.

5.5. Roles and Responsibilities

In line with the pillars of the strategy outlined above, the following table lists the responsible role-players associated with each part of the strategy.

Table 4: Roles and responsibilities of role-players

Role-player	Responsibilities	Involvement of Other Stakeholders
Department of Basic Education	Develop integrated policies on alcohol and drug use prevention and management in schools	Stakeholders (e.g. other government departments, teacher unions, NGOs, CBOs, professionals, research institutions) in the alcohol and drug abuse field should be provided with an opportunity to influence policy development
	Allow for regular review of policy and legislation	Stakeholders (e.g. other government departments, teacher unions, NGOs, CBOs, professionals, research institutions) in the alcohol and drug use field should be provided with an opportunity to influence policy review
	Engender political support for strategies & programmes	Provincial & district officials also have a role to play in this regard
	Co-ordinate multi-sectoral and inter-institutional responses	The Department of Social Development plays a key role in this regard, as it houses the secretariat for the Central Drug Authority (CDA), which is responsible for co-ordinating the country's response to alcohol and drug use. Provincial task teams, DBSTs and SBSTs will also perform a similar function at their relevant levels

Role-player	Responsibilities	Involvement of Other Stakeholders
Department of Basic Education	Ensure sufficient financial & human resources at national level	National Treasury and development partners such as UNODC and UNICEF plays an important role in this regard
	Advocate for more age-appropriate services and greater funding to support these	NGOs, CBOs and treatment centres should also advocate for greater financial and political support in this regard
	Ensure that relevant research is disseminated	Research institutions such as the MRC and HSRC produce relevant South African research
	Monitor & evaluate programmes in schools	This is done in collaboration with provincial and district officials and universities and research institutions
	Participate in early warning systems and disseminate the relevant information	Stakeholders, such as SACENDU, track alcohol and drug abuse trends and hold bi-annual meetings to share the information. Provincial and district officials must participate in such sessions
	Train provincial, district and educational officials to conduct drug testing	This should be done in collaboration with experts in the field who are able to train on the correct procedures.

Role-player	Responsibilities	Involvement of Other Stakeholders
Provincial Departments of Education	Develop implementation plans for the national strategy	The national department should provide support to provinces, where required
	Co-ordinate multi-sectoral and inter-institutional responses	Co-ordinate with stakeholders (e.g. other government departments, teacher unions, NGOs, CBOs, professionals, research institutions)
	Ensure adequate allocation of financial & human resources in the provinces	Provincial Treasury and development partners such as UNODC and UNICEF play an important role in this regard
	Collate records regarding alcohol and drug use in schools	This is done in co-ordination with district officials.
	Implement alcohol and drug use prevention programmes	This is done in collaboration with district officials and schools. The national department can assist in identifying evidence-based programmes
	Participate in early warning systems and disseminate the relevant information	Stakeholders, such as SACENDU track alcohol and drug abuse trends and hold bi-annual meetings to share the information
	Train educators & parents to identify early signs of alcohol and drug dependence	This is done in collaboration with school and district officials, as well as experts/ NGOs/ CBOs
	Train provincial, district and educational officials to conduct drug testing	This should be done in collaboration with experts in the field who are able to train on the correct procedures.

Role-player	Responsibilities	Involvement of Other Stakeholders
District Officials (District Based Support Teams)	Link with other government departments, NGOs and CBOs to implement programmes	Other government departments such as DOSD, and NGOs and CBOs are involved. Provincial officials provide support.
	Participate in lobby groups in the community	Links should be made with lobby groups such as community policing forums
	Implement policies to combat alcohol and drug use in schools	This should be done in collaboration with schools
	Keep accurate records of alcohol and drug use in schools	This should be done in collaboration with schools
	Implement alcohol and drug use prevention programmes	This should be done in collaboration with schools
	Involve families & communities in prevention & awareness campaigns	This should be done in collaboration with schools
	Train educators & parents to identify early signs of alcohol and drug dependence	This is done in collaboration with schools, provincial officials and experts in the field
	Train education officials to conduct drug testing	This should be done in collaboration with experts in the field who are able to train on the correct procedures.
	Implement drug testing in schools	This should be done in collaboration with schools
	Establish or strengthen existing referral systems	Links can be set up with CBOs, NGOs, public institutions and mental health professionals in the area

Role-player	Responsibilities	Involvement of Other Stakeholders
School Principals/ School-based Support Teams	Link and partner with lobby groups, NGOs and CBOs in the community to implement programmes	Lobby groups, such as community policing forums NGOs, CBOs and District officials should provide support.
	Implement policies to combat alcohol and drug use in schools including the schools code of conduct	District officials should provide support in this regard
	Keep accurate records of alcohol and drug use in schools	Proper records as outlined by SIAS framework need to be followed i.e. Learner Profiles, Institution/ School based Support teams files on learners
	Implement information and awareness campaigns at schools	This can be done in collaboration with experts.
	Implement alcohol and drug use prevention programmes	District officials should provide support in this regard
	Implement co-curricular and safety interventions	This can be done with CBOs and NGOs
	Involve families & communities in prevention & awareness campaigns	Families of learners and the school community should be involved, led by the School Governing Body

Role-player	Responsibilities	Involvement of Other Stakeholders
School Principals/ School-based Support Teams	Establish or strengthen Institution / school-based support teams	District officials and DBSTs to provide support.
	Establish or strengthen existing referral systems	Links can be set up with CBOs, NGOs, public institutions and mental health professionals in the area
	Train educators & parents to identify early signs of alcohol and drug dependence	This can be done in collaboration with experts/ NGOs/ CBOs in the field
	Implement drug testing in schools	District officials should provide support in this regard
	Create awareness of treatment, rehabilitation & counselling services	This can be done with the support of DOSD, municipalities and NGOs and CBOs
	Address barriers such as transport costs and stigma that limit access to treatment facilities	This can be done with the support of DOSD, municipalities and NGOs and CBOs
	Set up systems to ensure continuation of education during treatment	This should be done in collaboration with treatment centres that host learners

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