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DEPARTMENT OF SOCIAL DEVELOPMENT

NO. 4058 **10 November 2023**

Prevention of and Treatment for Substance Use Disorders Policy

I, Lindiwe Zulu, the Minister responsible for Social Development hereby intend to develop Prevention of and Treatment for Substance Use Disorders Policy as contained in the Schedule.

Interested parties are invited to submit comments in writing on the proposed policy **within 30-days from the date of publication of this notice** to the Director-General: Social Development, Private Bag X 901, Pretoria, 0001, or e-mail: VathiswaD@dsd.gov.za or MogotsiK@dsd.gov.za or SizaM@dsd.gov.za (for the attention of: Mr Kalaeamodimo Mogotsi or Ms Vathiswa Dlangamandla or Ms Siza Magangoe.)

Copies of the draft Policy can be obtained from the Government Printer Pretoria, or from reception at 134 Pretorius Street, Pretoria, or from the website of the Department of Social Development **www.dsd.gov.za**

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MS LINDIWE D ZULU, MP
MINISTER OF SOCIAL DEVELOPMENT
DATE: 11/10/2023

ANNEXURE B

social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA

Prevention of and Treatment for Substance Use Disorders Policy

SECRET

ACRONYMS

ADAC-SA	Alcohol and Drug Advisory Council of South Africa
AIDS	Acquired Immune Deficiency Syndrome
AOD	Alcohol and other Drug Use
ATS	Amphetamine-type stimulants (e.g. ecstasy tablets and 'tik')
CDA	Central Drug Authority
CBO	Community-based Organisation
CSOs	Civil Society Organisations
DSD	Department of Social Development
DoH	Department of Health
EBP	Evidence based practices
EC	Eastern Cape
FASD	Foetal Alcohol Spectrum Disorders
FS	Free State
GBV	Gender-based Violence
GP	Gauteng
HIV	Human Immunodeficiency Virus
HED	Heavy Episodic Drinking
KZN	KwaZulu-Natal
LDACs	Local Drug Action Committees
LP	Limpopo
MEC	Member of the Executive Committee
MP	Mpumalanga
NC	Northern Cape
NDMP	National Drug Master Plan

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NPS	New Psychoactive Substances
NW	North West
OUD	Opioid Use Disorder
OST	Opioid Substitution Therapy
SACENDU	South African Community Epidemiology Network on Drug Use
SACSSP	South African Council for Social Services Professions
SANCA	South African National Council on Alcoholism and Drug Dependence
SAQA	South African Qualifications Authority
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SUDs	Substance Use Disorders
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNODC	United Nations Office on Drugs and Crime
UNGASS	United Nations General Assembly Special Session on the World Drug Problem
WC	Western Cape
WHO	World Health Organization

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FOREWORD BY THE MINISTER OF SOCIAL DEVELOPMENT

South Africa, like other countries, is adversely affected by drug use and substance use disorders. Substance abuse threatens the democratic order, national safety and security, social cohesion and communities. The substance use disorders (SUDs) has placed a health and socio-economic burden on South African society that the country cannot afford. Its influence reaches across social, racial, cultural, language, religious and gender barriers and, directly or indirectly affects everyone. Research has highlighted the link between SUDs and premature death; dysfunctional family life; risky sexual behaviour; infectious diseases, such as tuberculosis, hepatitis and HIV/AIDS; cancers and foetal alcohol syndrome; crime (particularly crimes of violence, GBV, property crimes and crimes associated with the supply of or trafficking in substances); absenteeism and school failure; and loss of productivity, unemployment and other economic effects.

It is devastating that alcohol and drugs have become easily accessible in the country. This may be attributed to among others, marketing and advertising of alcohol; porous borders; emergence of new psychoactive substances that are not under international control, as well as designer drugs that are easily affordable.

Drug dependency is categorised as a complex, multifactorial health disorder characterised by a chronic and relapsing nature with social causes and consequences that can be prevented and treated through effective scientific evidence-based treatment, care and rehabilitation programmes, including community-based programmes. This requires strengthening the capacity for aftercare, and social reintegration of individuals with substance use disorders, including (when appropriate) assistance for effective reintegration into the labour market and other similar support services.

The aim of the Policy on the Prevention of and Treatment for Substance Use Disorders thus is to enhance service delivery for the prevention and treatment of substance use disorders. It set out feasible strategies for the management of substance use disorders. The Policy further suggests sectoral interventions that are informed by the United Nations General Assembly Special Session on the World Drug Problem (UNGASS) operational recommendation outcomes (2016), which include among others, operational recommendation on demand reduction and related measures including prevention and treatment, as well as other health related measures.

This Policy framework is underpinned by three pillars which are: the Demand reduction pillar- aimed at preventing the onset of substance abuse or dependence as well as eliminating or reducing the effect of conditions conducive to the use of dependence-forming substances; the Supply reduction pillar - aimed at reducing the supply of both legal and illegal drugs. Supply reduction pillar is the responsibility of law enforcement;

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and the Harm reduction pillar which includes treatment of substance use disorders and related activities aimed at reducing harm caused by use and abuse of substances in communities. It involves reducing the damage caused by substance abuse to individuals and communities. The reduction of harm caused by substance use and abuse can be achieved through prevention, early intervention, treatment and other related measures, aftercare and reintegration services.

The Policy framework advocates for the implementation of evidence-based prevention, treatment and support services. These services are to replace less effective prevention services, treatment and recovery support services with approaches that have a sturdier foundation of scientific support. Developing services that remove barriers to recovery and enhance individual's recovery capital. This Policy framework will thus be translated into a legislation that will guide the sector in the delivery of integrated, evidence-based programmes, services and projects.

I am confident that the restructuring of the monitoring and coordinating structure formerly known as Central Drug Authority (CDA), will strengthen the concerted efforts by all stakeholders to address the scourge of substance abuse.

Substance abuse is an intersectoral challenge demanding various organs of state to play their roles. The inter-collaboration between government, civil society organisations, academia, medical professionals, civil society, policy makers, law enforcement, activists, service users, and the wide array of public and community-based resources, can results in a comprehensive solution for addiction disorders. I therefore would like to urge all stakeholders, to play their roles towards addressing the challenges of SUDs as per their constitutional mandates.

Ms L Zulu, MP
Minister of Social Development
Date:

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ENDORSEMENT BY THE DEPUTY MINISTER OF SOCIAL DEVELOPMENT

The landscape of drug demand reduction is changing. The UNODC indicates that of those who use psychoactive substances, a significant number will develop substance use problems or Substance Use Disorders (SUDs). SUDs contributes significantly to global and national illness, disability, and death. To mitigate the scourge of SUDs, there is a need for interventions that aimed at addressing stigma towards people using substances.

I therefore want to acknowledge that some existing strategies for tackling substance dependence have been remarkably successful in achieving recovery for those affected. The evidence is however clear that substance dependence is a chronic, relapsing, medical disorder. In order for the country to reach the affected, the strategies to address the SUD problem in the country needs to change from the one that is punitive to the one that is not punitive and more socially inclusive.

Social inclusiveness will thus entail breaking the stigma attached to Substance Use Disorders and addiction dilemma. The involvement of people who are afflicted by SUDs in treatment planning, recovery and recovery management is paramount. This will in turn increase access to SUD prevention, treatment services and related measures. As well as, the provision of quality treatment and continuum of care. This policy framework present the challenges faced by the sector, it also present sector interventions towards the drug demand reduction quandary with the aim of advocating for social inclusiveness of those affected by SUD problem.

Substance Use Disorder is a cross-cutting issue that impacts on intergovernmental relations and thus requires a concerted effort from all stakeholders. The successful implementation of this policy framework will ensure the delivery of effective, evidence based programmes and services.

Ms H I Bogopane Zulu

Deputy Minister of Social Development

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EXECUTIVE SUMMARY

This Policy framework on the Prevention of and Treatment for Substance Use Disorders (*the Policy*) recognises that the abuse of substances – such as alcohol, illicit drugs and prescription medicine – has reached alarming levels in South Africa.

The objectives of *the Policy* are:

- to embrace a balanced, integrated and evidence-based approach to domestic substance use, abuse and dependency (substance use disorders);
- to invest in building safe communities through appropriate evidence-based prevention and treatment strategies; and
- to devise SUD impact minimisation strategies.

South Africa's alcohol consumption rates is among the highest across the globe. South Africa is one of the 10 countries consuming the most alcohol (WHO 2018). Alcohol remains an important primary substance of abuse among people accessing drug treatment centres (SAMRC, SACENDU 2021). In 2000, population attributable fractions (PFAs) for alcohol in South Africa were estimated at 43.9% for road traffic injuries, 41.2% for epilepsy, 17.3% for hypertension, 4.4% for ischaemic heart disease and 25.2% – 40.4% for cancer. The burden of alcohol on the social and public health system, as well as the economy is critically understated. The country has been painfully reminded about the impact of binge drinking amongst young people, the recent events in the Eastern Cape, in Enyobeni Tavern where a number of under-age drinking left a devastating tragedy in the country with a loss of many young lives. This then has demonstrated an urgent need for policy and programmes to curb the abuse of Alcohol.

This Policy framework provides for intervention that seeks to deliver a solution to harm caused by substance abuse. It provides for mechanisms aimed at supply, demand and harm reduction through prevention, early intervention, treatment, re-integration and aftercare programmes.

It provides for the registration and establishment of treatment centres and the repositioning of the Central Drug Authority (CDA). It takes into cognisance that there are various role players that need to provide positive intervention on the harms and social ills associated with substance abuse.

It focuses on substance abuse harms as well as supply and demand reduction as three pillars that must be strengthened in order to deal effectively with the challenges of substance abuse. It also creates a mandate for stakeholders in the field of substance abuse to align their activities in the fight against the scourge of substance abuse. It does so while taking into account that substance abuse is not only a social development challenge, but an intersectoral one that needs to be addressed collectively – hence the National Drug Master Plan, which is a national strategy provides room for every organ of state and civil society to play its role.

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It thus revised a CDA structure that seeks to bring everyone together onto the same platform in order to address the challenges brought about by substance abuse. It provides an opportunity for everyone to focus on the issue of substance abuse in their daily agendas.

It is envisaged that revised structure will upscale the initiatives to address the problem of alcohol, tobacco and other drug use in the country.

On the other hand, *the Policy* does not intend to be an exhaustive catalogue of matters that are linked to alcohol, tobacco and other drugs, as well as Substance Use Disorders and thus pays a particular focus on the social impact, taking into cognisance the commercial determinants of alcohol harms. This is in recognition of the fact that prevention of supply of illicit substances is the mandate of the security cluster. While *the Policy* does not seek to infringe on the space that falls outside the mandate of the Department of Social Development, it has become clear that weak/uncoordinated regulation is increasingly causing harm. *The Policy*, does, however, highlight the role that each government department should play in order to address alcohol and other drug use based on each government department's mandate. Furthermore, this policy is informed by and aligned to the WHO most effective interventions to reduce the harms caused by alcohol and other drugs.

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PREAMBLE

The development of this policy has taken place within the following context:

WHEREAS the Department of Social Development treats substance abuse and substance use disorders as a national and global challenge;

AND WHEREAS substance abuse is an intersectoral challenge demanding several organs of state to play their roles as per their constitutional mandates;

RECOGNISING that substance dependence is a complex, multifactorial health disorder characterised by a chronic and relapsing nature with social causes and consequences that can be prevented and treated through interventions including effective scientific evidence-based drug treatment, care and rehabilitation programmes; and that effective regulation of substances would contribute effectively to prevention measures;

UNDERSTANDING that in some instances the mandates seem to be conflicting as the economic cluster seeks to ensure that the economy of the Republic of South Africa is boosted through approval of licences for liquor outlets and advertisement of liquor products;

ALSO UNDERSTANDING that on the other hand, the health cluster is required to reduce the consumption of alcohol as it impacts negatively on health and safety, as well as being one of the gateway substances to illicit drugs.

FURTHER UNDERSTANDING that addiction is a chronic, relapsing brain disease characterised by compulsive substance seeking and use, despite harmful consequences. Therefore, a preventable disease that is long lasting, but can be managed through the implementation of thoroughly researched integrated and balanced harm reduction measures and initiatives;

ACKNOWLEDGING THAT that there is legislation prepared by other organs of state dealing with limiting the promotion and advertising of alcohol in order to reduce the widespread harmful aspiration to increased consumption;

ACCEPTING THAT there are further challenges brought about by the recent judgement on the possession and use of cannabis for recreational purposes by adults in their private space; and another judgment on the possession of cannabis by children. These judgements add to the already out-of-control situation regarding substance abuse, as the combined use of cannabis and alcohol is the greatest gateway to the use of other illicit drugs;

FURTHER ACCEPTING that there is a direct link between gender-based violence, femicide and the use of alcohol and other drugs and that gender-based violence and femicide have been declared as a second pandemic, after COVID-19, in the Republic of South Africa;

UNDERSTANDING THAT substance abuse is a cross-cutting problem experienced throughout society and impacts negatively on the economy thus there is a need to engage everyone in all the spheres of government; and

THUS taking into account the outlined issues and context, this policy seeks to strengthen and innovate existing frameworks and mechanisms, and to provide new solutions needed to prevent and deal effectively with substance abuse as well as its resultant challenges.

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NOW THEREFORE this policy provides as follows.

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1. TABLE OF FIGURES

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2. GLOSSARY OF TERMS

Explanatory notes

Since there is some scientific and legal ambiguity about the distinctions between "drug use", "drug misuse" and "drug abuse", the term that is used in *the Policy* is "drug use"; and the term "substance use". Substance use incorporate all licit and illicit substances.

The term "misuse" is used to denote the non-medical use of prescription drugs.

The terms 'drug', and 'psychoactive substance' are used interchangeably in *the Policy*, so also the terms 'use' and 'consumption'.

The term substance use disorders (SUDs) is used in *the Policy*. The continuum is from mild, moderate or severe substance use disorder as per the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Both Substance use disorder, or substance dependence, is preferred over the term "addiction". This refers to a cluster of physiological, behavioural and cognitive phenomena that develop after repeated substance use and that typically include a strong desire to take the substance, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to substance use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

For the purpose of *this Policy*, the definitions, set out below, apply:

Act		For the purposes of *this Policy*, Act refers to the Prevention of and Treatment for Substance Abuse, Act No 70 of 2008.
Addiction		A chronic, relapsing brain disease that is characterised by compulsive substance seeking and use, despite harmful consequences (National Institute on Drug Abuse NIDA, 2010).
Binge drinking		Is the consumption of an excessive amount of alcohol in a short period of time.
Case Management		A set of administrative, clinical, and evaluative functions that helps clients find and use the resources they need to recover from a substance use or other problem; the coordination of professional social services to assist people with complex needs, often for long-term care and protection.
Co-occurring disorders (COD)		Having both a substance use disorder and a mental or medical disorder.
Community recovery capital		Encompasses community attitudes/policies/resources related to addiction and recovery that promote the resolution of alcohol and other drug use problems.
Continuum of care		The range and type of treatment and other services a person may receive over time. Continuum of care describes service

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		delivery systems in which treatment for SUD typically involves some phase of care beyond the initial acute care episode.
Demand reduction		Demand reduction is a general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive substance use. It is applied primarily to illicit drugs, particularly with reference to education, treatment and rehabilitation strategies as opposed to law enforcement strategies aimed at preventing production and distribution of drugs (known as supply reduction).
Designer Drugs		Designer drug is a term used to describe new psychoactive substances (NPS) which are created by modifying the molecular structure of an illicit drug to a certain degree to get around existing drug laws.
Substance use		Substance use is defined as the human consumption of psychoactive substances, i.e. the use of any substance that has the potential to affect perception, mood, cognition, behaviour or motor function when taken into a living organism. This includes alcohol, tobacco, over-the-counter (OTC) and prescription medicine as well as inhalants, cannabis, heroin (including 'nyaope/ whoonga, 'tik'' which is heroin mixed with other materials and often smoked with cannabis), cocaine and methamphetamine.
Early intervention		A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. It is directed particularly at individuals who have not developed a physical dependency or major psychosocial complications.
Evidence-based practices		Those practices for which the evidence is strongest (based on clinical trials and robust research) and most accepted and that are most likely to have significant impact on improving care.
Gender-based violence (GBV)		GBV is the general term used to capture violence that occurs as a result of the normative role expectations associated with the gender and biological sex assigned to a person at birth, as well as the unequal power relations between the sexes and genders, within the context of a society. GBV includes physical, sexual, verbal, emotional, and psychological abuse or threats of such acts or abuse, coercion, and economic or educational deprivation, whether occurring in public or private life, in peacetime and during armed or other forms of conflict, and may cause physical, sexual, psychological, emotional or economic harm.
Harm reduction		A harm reduction philosophy emphasises the development of policies and programmes that focus directly on reducing the social, economic, and health related harm resulting from the

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		use of alcohol and other drugs. Harm reduction interventions are evidence-based public health and safety knowledge to prevent and support people who use alcohol, tobacco and other drugs.
Illegal drugs		Also referred to as illicit drugs, these relate to substances that are declared illegal through laws and enforcement efforts to restrict the production, distribution and consumption thereof.
Legal drugs		Substances that are considered legal drug in South Africa include alcohol and tobacco, the two most common legal psychoactive drugs that can lead to substance use disorders and account for significant harm to individuals and society. The legal status of cannabis has recently been changed.
Medications		Medication protects one from diseases. But when medications are not used as per doctor's instruction, they can lead to many problems.
Multi-disciplinary team		A team of professionals who render medical and psycho-social substance abuse related services, which include the following: social workers, professional nurses, medical doctor, occupational therapists, psychologists, child and youth care workers.
Psychoactive substances		Include legal drugs, illicit or illegal drugs, designer drugs, alcohol, tobacco and some medications.
Treatment of substance use disorder		Management of a substance use disorder using an evidence-based psychosocial and/ or biomedical intervention by an appropriately trained provider.
People with drug use disorders		Designates people whose substance use is harmful to the point where they may experience dependence/ substance use disorders and/or require treatment.
Prevention		Prevention seeks to delay or prevent the onset of substance use and can be categorised as: Universal interventions target the general population and are not directed at a specific risk group. Selective interventions target those at higher-than-average risk for substance abuse; individuals are identified by the magnitude and nature of risk factors for substance abuse to which they are exposed e.g. prevention of underage alcohol consumption Indicated interventions target those already using or engaged in other high-risk behaviours to prevent heavy or chronic use
Psychoeducation		Education provided to clients who have a mental or substance use disorder. Psychoeducation is also provided to clients' family members. A primary goal of psychoeducation is to help

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		the clients and his or her family better understand and learn to cope effectively with the disorder.
Recovery		The sum of personal and social resources at one's disposal for addressing drug dependence and chiefly, bolstering one's capacity and opportunities for recovery. It is a process of change whereby individuals work to improve their own health and wellness and live a meaningful life in a community of their choice, while striving to achieve their full potential.
Recovery management		Recovery management is the context in which the continuum of care is examined. Recovery management model of care shifts the focus away from discrete episodes of treatment, or acute care, towards a long-term client-directed view of recovery.
Reintegration services		Services aimed at the successful reintegration into society of persons who have completed treatment or have received substance abuse related services. Reintegration means an ongoing professional support to a service user after a formal treatment episode ended, aimed at successful reintegration of the service user into society, workforce, family and community life.
Screening, brief intervention and referral for treatment		Screening, Brief Intervention, & Referral to Treatment (SBIRT) is an evidence-based approach to deliver early intervention and treatment services for persons with Substance Use Disorders (SUDs), and those at risk of developing a SUD.
Service user		Any person who receives prevention of and treatment for drug use and abuse related services (which include prevention, early intervention, treatment, rehabilitation, reintegration and aftercare).
Substance use		Occurs when a person uses drugs or alcohol despite negative consequences. It is defined as excessive use of a drug (such as alcohol, narcotics or cocaine), and the use of a drug without medical justification.
Substance use disorders		Substance use disorder (SUD) is a condition in which the use of one or more substances leads to a clinically significant impairment or distress. It describes a problematic pattern of using alcohol or other drugs that results in impairment in daily life or noticeable distress.
Supply reduction		Supply reduction is a general term that refers to policies or programmes aimed at stopping the production and distribution of drugs, particularly law enforcement strategies for reducing the supply of illicit drugs.

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3. INTRODUCTION

Psychoactive substance use and substance use disorders (SUDs) are major problems around the world and take a toll on global health, and on social and economic functioning (UNODC 2021).

South Africa, like other countries, is adversely affected by substance use (inclusive of alcohol and tobacco use) in terms of health and incumbent socio-economic impact on individuals, families and the broader society. Substance use can have a negative effect on individuals, families, communities and society (Nutt et al. 2010). Illegal drug markets threaten the democratic order, national safety, security and social cohesion (UNODC 2021). Punitive approaches to people who use drugs contribute to stigma towards people who use drugs, which contributes to human rights violations and illness (WHO 2016). Alternatives to incarceration for possession and personal use of drugs are recommended to reduce harm and break cycles of recidivism (WHO 2016). The country is thus required to develop and implement a coordinated and comprehensive response to reduce the negative impact of substance use.

The Department of Social Development (DSD) is a key stakeholder responsible for dealing with substance use in the country. The mandate of DSD in this regard, is to implement demand reduction (prevention) and substance dependence reduction [drug use disorder (DUD) treatment] strategies, as advocated for by the United Nations Office of Drugs and Crime (UNODC) and the United Nations General Assembly Special Sessions (UNGASS), 2016 outcome document. The approach also aligns to the African Union's Plan of Action on Drug Control and Crime Prevention (2019 - 2023), which includes reducing harm associated with substance use and implementing alternatives to punishment for substance use. These strategies are implemented through numerous efforts such as the development and implementation of legislation, policy and programmes, as well as the mainstreaming of substance use into various components of the department's work.

In light of changing trends in drugs, drug markets and effective prevention, treatment and harm reduction interventions, it is critical for the sector to continuously review and strengthen its policies and programmes to maximise positive impact and efficiencies.

The Policy seeks to provide a comprehensive framework for addressing challenges faced by the sector in dealing with the prevention and treatment of substance use disorders and reduction of harm, through a coordinated and multi-pronged approach. It presents a variety of sectoral interventions aimed at effectively addressing demand, treatment, rehabilitation, recovery, aftercare and social reintegration as well as initiatives and measures to minimise the adverse impact on health and wellbeing of those that are afflicted by substance use.

The Policy provides guidelines that give effect to substance use prevention, treatment and harm reduction. *The Policy* further seeks to ensure that services are responsive to changing substance use trends and that services are effectively managed. The intention of *the Policy* therefore, is to embrace a balanced, integrated and evidence-based approach to substance use in South Africa.

This *Policy* framework will be implemented by means of amending the Act, 70 of 2008. The implementation of *the Policy* will involve the national, provincial and local spheres of government. The National Drug Master Plan will be amended accordingly to give

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effect to the implementation of *the Policy*. Integration and inter-sectoral collaboration should serve as a cornerstone for implementation of interventions because some substance use disorders require biomedical interventions and the use of alcohol, tobacco and other drugs is associated with trauma, violence - including violence against women and children, chronic diseases. Service providers should render evidence-based services.

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4. SITUATIONAL ANALYSIS

4.1 International overview

The United Nations Office on Drugs and Crime estimates that in 2019 275 million people used drugs in the past year, among whom 36.3 million people had a drug use disorder (UNODC 2021). Global trends in the prevalence of past year use and the prevalence of drug use disorders have remained fairly constant since 2016. However, the number of people who use drugs in Africa is expected to rise by 40% (from 2018 levels) by 2030 (UNODC 2021). Increased drug availability, economic development, population growth and urbanisation account for increasing drug use in the continent (Donnenfeld 2019).

The use of alcohol, illicit drugs, over-the-counter and prescription medication, and tobacco affects the health and well-being of millions of people throughout the world. Moreover, alcohol and tobacco consumption and the burden of alcohol and tobacco-related diseases is significant in most countries. The harmful use of alcohol and tobacco ranks among the top five risk factors for both communicable and non-communicable diseases, disability and death (UNODC 2015).

Global statistics on alcohol, tobacco and illicit drug use indicate that, in 2015, alcohol and tobacco use cost the globe more than a quarter of a billion disability adjusted life years (DALYs)(Society for Study of Addiction 2018). Alcohol consumption is the leading risk factor for death and disability in sub-Saharan Africa and is the leading risk factor for disability-adjusted life-years lost (DALYs) among African male adolescents aged 15–24 years.

There are about 1.14 billion smokers in the world smoking about 7·41 trillion cigarette-equivalents of tobacco in 2019 (Reitsma et al 2019). Globally, 8 million people die of tobacco-related diseases annually, about 1.2million of these are non-smokers who are exposed to second-hand tobacco smoke (WHO 2021). Tobacco use is the leading cause of preventable death and the second leading risk factor for the global burden of disease with 80% deaths due to tobacco occurring in low-and-middle-income countries (Öberg 2011; Blecher 2013).

Cannabis remains the world's most widely used drug. In 2019, 200 million people reported cannabis use; 4% of the global population aged 15 - 64 years (UNODC 2021). Recently, a range of cannabis products with higher levels of delta-9-tetrahydrocannabinol (the main psychoactive ingredient in cannabis) have been introduced into global markets (UNODC 2021).

Opioids (including heroin and other opiates derived from the opium poppy and pharmaceutically developed opioids) cause the greatest amount of death and disability linked to illicit drug use. Over 70% of years of life lost due to disability and premature death in 2019 related to drug use disorders were due to opioids (UNODC 2021). Almost 50 000 people died from opioid overdoses in the United States (mostly linked to fentanyl) in 2019 (UNODC 2021). Globally, an estimated 62 million people used opioids for non-medical purposes in 2019 (UNODC 2021). The number of opioid users across the world has almost doubled in the past decade, with significant increases in the number of people using opioids in Africa (UNODC 2021). Heroin remains the most widely used opioid in eastern and southern Africa, and is also the most widely injected drug (Eligh 2020).

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Amphetamine type stimulants (including methamphetamine) were used by 27 million people in 2019 (UNODC 2021). In 2018, amphetamine use disorders accounted for approximately 1 million disability adjusted life years (DALYs) globally (25-fold lower than DALY's due to opioid use disorders) (UNODC 2021). Increased trade in methamphetamine is also being reported in East and Southern Africa (Eligh 2021).

Approximately 20 million people used cocaine in 2019. Global cocaine output doubled between 2014 to 2019. Cocaine use in Africa (0.25% of adults 15 - 64 years) is relatively lower than the global average (0.4%) (UNODC 2021).

The use of novel psychoactive substances (NPS) in low and middle income countries is growing. These substances include synthetic cannabinoid, receptor agonists, synthetic cathinones, phenethylamines, piperazines, tryptamines, aminoindanes and NPS opioids. The health related harms depend on the class and group of substances. Harms at the individual level are influenced by characteristics of user, dosage, toxicity of substance, route of administration, combination with other substances and environmental factors (UNODC 2021).

The risk of blood borne infectious diseases such as HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) is high in the context of needle and syringe reuse and sharing (WHO 2016). Globally, 11 million people inject drugs, among whom 1.4 million live with HIV and 5.6 million live with hepatitis C (UNODC 2021).

Evidence suggests that structural and social factors are important contributing factors to the adverse health consequences associated with drug use (Csete et al. 2016). Women who use drugs face a range of issues that affect the potential harms related to drug use (e.g., higher levels of stigma and discrimination, higher levels of violence), and have unique substance use service needs (e.g., gender-responsive services, integration with sexual health, acknowledgement of care giver roles)(UN Women 2014). Young people who use drugs also face additional risks in light of substance related effects on neurobehavioral development, as well as limited access to accurate information and drug services that cater for their needs (UNODC 2021).

4.2 South African overview

South Africa is experiencing endemic proportions of alcohol, tobacco and other substance use. The prevalence of substance use disorders (SUDs) in South Africa is high, with an estimated 13% of the general population meeting diagnostic criteria for a lifetime SUD (Herman et al, 2009). Alcohol, tobacco and other drugs (AODs) have become major causes of social, economic and health problems in the country. The social and economic cost of illicit drug and alcohol use in the country has been estimated at 6.4% of the annual gross domestic product (Matzopoulos, Truen, Bowman, & Corrigall, 2014) The percentage of the South African population using drugs is summarised in Figure 1.

Many people with substance use disorders are arrested and enter the criminal justice system. A recent study done in two correctional centres (one in Tshwane and the other in Polokwane) reflect ongoing substance use within prison settings. Non-injectable drugs were used by 20.7% of inmates in the Tshwane centre and 8.9% in the

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Polokwane centre (with 4.5% and 1.0% of inmates in the respective centres reporting injecting drug use while in the correctional centre) (Aurum Institute 2020).

Figure 1 South Africa's Illicit Drug Use Profile Ages 15-64 (UNODC 2016)

#	Drug group	Estimated % of population	Global rank
1	Cannabis	3.65%	100th
2	Cocaine	1.02%	32nd
3	Amphetamine (excluding ecstasy)	1.02%	27th
4	Ecstasy	0.31%	71st
5	Opioids	0.50%	62nd
6	Opiates	0.41%	34th
7	Prescription opioids	0.09%	27th

Substance use prevalence, trends and related harms
Data on substance use prevalence and trends is limited, and comes from surveillance data from the South African Community Epidemiology Network on Drug Use (SACENDU) and other research. SACENDU collects data from 82 drug treatment centres (across all provinces) and 13 community-based harm reduction service providers (in 9 municipalities across 5 provinces) that are part of the national network. Data is collected and reported bi-annually. Household surveys and other research provides additional insights into substance use prevalence and trends in the country.

SACENDU treatment data only reflects the proportion of people with a substance use disorder that access treatment. Similarly, harm reduction service coverage data is limited to the selected districts where these services are provided.

Alcohol, tobacco, cannabis, heroin, cocaine, methamphetamine are commonly used substances, with some geographical variations. Poly-drug use is also common. Data points to a high prevalence of substance use among children and youth, mostly alcohol and cannabis, but also some heroin and methamphetamine in people under the age of 20 years (SAMRC, SACENDU 2021).

In the first half of 2020, 6 327 people accessed drug treatment services across 82 treatment centres, and 15 131 were reached by community-based harm reduction service providers (SAMRC, SACENDU 2021).

Alcohol

Alcohol is the most widely used psychoactive substance in the country. South Africa is one of the 10 countries consuming the most alcohol (WHO 2011). Alcohol remains an important primary substance of use among people accessing drug treatment centres (i.e. ranging from 11% in the WC to 21% in EC in January to June 2020) (SAMRC, SACENDU 2021).

Alcohol is widely available. According to the South African Medical Research Council, there is a liquor outlet for every 190 persons in South Africa. The prevalence of harmful alcohol use is up to 30% among certain groups**.** Approximately 70% of alcohol consumed is malt or sorghum beer.

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Heavy episodic drinking is common. People living in rural areas in South Africa, particularly those with lower socio-economic status, have higher prevalence of heavy episodic drinking (UNODC 2017). Greater volumes of alcohol consumption and higher frequency of consumption has been documented among people who consume alcohol at on-licensed premises compared to those who drink at off-licenced premises in urban and peri-urban settings. Higher frequency of drinking at on-licensed premises has been noted among people with lower levels of education and lower socio-economic status compared to off-licensed premises. (Londani, *et al.* 2021)

Alcohol is widely used among young people. Data from the 2016 South African National Demographic and Health Survey found that at least one in every four young person had consumed alcohol by the ages of 15–19 (SAMRC 2016). According to the 2011 Youth Risk Behaviour Survey conducted among grade 8 - 11 learners in public schools, about half the learners had ever consumed alcohol, about a quarter had engaged in binge drinking in the 30 days prior to the survey, and about 12% had initiated consumption before the age of 12 years (Reddy *et al.* 2013). A study conducted in Tshwane Metropole found that more than half of young participants (n = 287, aged 16–25) were heavy episodic drinkers (Harker *et al.* 2020). Increases in consumption among young people are to be expected, given young people's increased access to alcohol beverages, increased affordability, and aggressive marketing targeting this group (Harker *et al.* 2020; Morejele *et al*. 2018)

Alcohol is a major contributor to the burden of disease in South Africa (Petersen Williams et al. 2019). Alcohol accounts for harms to individuals and society (WHO 2018).

A 2018 study found that 62,300 people died from alcohol-attributable causes in South Africa in 2015, just over 170 per day (Probst et al., 2018). South Africa has very high rates of hazardous alcohol consumption among drinkers, and these rates of hazardous drinking appear to be on the rise (Ferreira-Borges, Parry, & Babor, 2017). For example, in a cross-sectional analysis, researchers found an increase in the proportion of drinkers reporting binge drinking, an indicator of hazardous alcohol consumption, from 9.8% in 2005 to 13.2% in 2012 (Probst, Simbayi, Parry, Shuper, & Rehm, 2017).

Alcohol plays a substantial role as a risk factor for disease and injury. In 2000, population attributable fractions (PFAs) for alcohol in South Africa were estimated at 43.9% for road traffic injuries, 41.2% for epilepsy, 17.3% for hypertension, 4.4% for ischaemic heart disease and 25.2% – 40.4% for cancer. For the injury burden, alcohol was responsible for 20.2% and 40.9% of unintentional and intentional injuries respectively (Schneider, Norman, Parry, Bradshaw, Pluddemann, 2007). As well, risky drinking patterns place additional burdens on individuals. For instance, the relative risks of hypertension compared to abstainers are 1.4 for low drinkers; 2.0 for moderate drinkers, and 4.1 for heavy drinkers (Schneider et al, 2007). Additionally, the country has among the world's highest reported prevalence rates of fetal alcohol spectrum disorders (FASD) per 10,000 population (Popova, Lange, Probst, Gmel and Rehm, 2017).

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Whilst alcohol consumption has substantial health and injury consequences, it also has a negative impact on social and economic outcomes. Harmful alcohol use affects both social and personal relationships and is a risk factor for gender-based violence. Alcohol and substance use has been reported to have an impact on the risk or prevalence of violence against women and children. Physical, sexual, emotional and economic violence have been reported to be the types of violence directed at women and children (WHO, 2013). In South Africa, 65% of women experiencing spousal abuse reported that their partner always or sometimes used alcohol before the assault. Alcohol associations with interpersonal violence, crime, health and harmful behaviours resulting in detrimental social impacts are well documented (Matzopoulos et al. 2013).

According to micro-level studies done locally and in other countries, the negative social impacts of alcohol misuse result in long-term health issues, job insecurity, and deteriorating family relations, which are felt more severely amongst families at the lower end of the socioeconomic scale (Rehm et al., 2009; Rehm & Parry, 2009). Harmful use of alcohol also reduces job productivity, employment, and ultimately income levels (Harker Burnhams, Parry, Laubscher & London, 2014).

Additionally, drinking can impair how a person performs as a parent, as well as how he /she contributes to the functioning of the household. Children can suffer from foetal alcohol spectrum disorders (FASDs), when mothers drink during pregnancy. After birth, prenatal drinking can lead to child abuse and numerous impacts on the child`s social, psychological and economic environment. The impact of drinking on family life can include mental health problems for other family members such as anxiety, fear and depression (WHO, 2011).

According to the World Health Organization's Global Status Report on Alcohol and Health published in 2018, 83.6% of households that reported violence, recounted alcohol intoxication by the perpetrator. Studies linking alcohol consumption and intimate partner violence have found that 45% of men were drinking while committing these acts.

From an economic perspective, the negative impacts of harmful alcohol consumption have also been documented. Matzopoulos et al. (2014) highlighted the importance of calculating the economic costs associated with alcohol consumption and the contribution this makes to informing alcohol management policies and laws (Matzopoulos, Truen, Bowman, & Corrigall, 2014). The literature further suggests that the costs associated with alcohol consumption are multifaceted. For example, van Walbeek and Blecher (2016) explain the misuse of alcohol as generating an internal cost (use of the misuser's resources) and an external cost (the cost inflicted on others). Internal costs include higher medical expenses, increased insurance premiums, lower eligibility for loans, lower wages, lost employment opportunities, and higher legal expenses than for person having lower or no alcohol consumption (van Walbeek C & Blecher, 2016). The bigger cost category is external costs, which include the labour costs associated with lower work productivity, absenteeism, unemployment, and early retirement (Matzopoulos et al., 2014). In 2009, a summary detailing both internal and external costs attributable to alcohol in South Africa, divided into tangible and intangible costs, was estimated. The final estimate was 246– 281 billion rand annually. Whilst tangible costs are in the region of R38 billion, total intangible costs are much higher, and premature mortality and morbidity cost estimates are also high

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(Matzopoulos et al., 2014). As a proportion of the GDP, the total costs related to alcohol were estimated at 10 - 12% of the 2009 gross domestic product (GDP).

Alcohol use is also associated with COVID-19 in several ways. Alcohol consumption is associated with a number of communicable and noncommunicable diseases that can make a person more vulnerable to catching COVID-19. Alcohol use can contribute to mental illness, with prevalence of anxiety and depression elevated during COVID-19, partly related to lockdowns, and associated death and disability caused by COVID-19. The ban on alcohol sales and restrictions on movement/work during levels 4 and 5 of the national COVID-19 lockdown led to a 60%-70% reduction in hospital visits and admissions related to trauma, with a surge in trauma-related hospital visits following the easing of restrictions related to the sale and distribution of alcohol (Parry et al: 2020).

The alcohol harms in South Africa amongst young people are further acknowledged by the President of South Africa Mr Cyril Ramaphosa (News 24, 2022), whereby the President indicated that the increase in social acceptability of young people drinking has become a serious problem in the country more especially with regard to the situation that has just happened in Ngobeni Tavern in the eastern Cape. Where the majority of the drinking population are already classified by the WHO as binge drinkers. He further alluded that alcohol use amongst adolescents is associated with impaired functioning, absenteeism form learning, alcohol related injuries, suicidal thoughts and risky behaviours.

Link between Alcohol and other Social Ills

Alcohol is one of the highest risk factors for death and disability in South Africa (Parry, et al: 2019). Since the start of South Africa's COVID-19 lockdown in March 2020, the sale of alcohol was restricted, in order to mitigate the harmful effects of alcohol. This action was seen necessary in freeing up needed hospital beds and reducing alcohol related injuries and death. During levels 4 and 5 of the lockdown, which included a ban on the sales of liquor from both on and off-consumption outlets and substantial restrictions on movement/work, there was a 60%-70% reduction in hospital visits and admissions related to trauma (Parry et al: 2020). Parry (2020) noted: "Following the easing of restrictions to level 3 on 1 June 2020, a noticeable surge in trauma-related hospital visits has been observed. This has been anecdotally attributed to easing of restrictions related to the sale and distribution of alcohol".

In support of the above, Crime statistics indicate that the consumption and abuse of alcohol is a causative factor in hundreds of social ills such as murder cases recorded during the period of 1 July to 31 September 2020.

SAPS also indicated that over a thousand incidences of murder, attempted murder, rape and assault took place at, in, or outside liquor outlets such as bars, taverns,

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shebeens and nightclubs. A total of 829 assault cases and 747 rape cases were related to alcohol use while 179 attempts of murder were alcohol induced. These reports paint a picture of a country that is not only faced with the spread of COVID-19, but also with heavy episodic drinking that leads to alcohol-related traumas and disorders as well as to the resurgence of COVID-19.

Alcohol abuse results in serious economic, social and health losses in South Africa. According to the World Health Organization's Global Status Report on Alcohol and Health published in 2018, about a third of South Africans 15 years and older are current drinkers (have consumed alcohol in the past 12 months), and almost 60% of those engage in binge drinking. The research also shows that 83.6% of households that reported violence, recounted alcohol intoxication by the perpetrator. Studies linking alcohol consumption and intimate partner violence have found that 45% of men were drinking while committing these acts.

A study conducted by Londani, *et al.* (2021) which sought to identify factors associated with drinking behaviour in on- and off-licensed premises (typical occasion quantity and frequency) among adults in the City of Tshwane, South Africa. Indicates that 'the majority of the participants consumed alcohol in off-licensed premises (64% vs. 36%). However, participants who consumed alcohol at on-licensed premises were more likely to drink more alcohol and more frequently (weekly). Additionally, participants who consumed alcohol in above-average sized containers were more likely to consume six or more drinks and drink weekly. Being of high socio-economic status was associated with drinking weekly at off-licensed premises, while being less educated was associated with a significantly higher frequency of drinking at on-licensed premises'. Londani (2021) further made recommendations that …interventions to reduce alcohol use should target specific drinking behaviour at on- and off-licensed premises, for example, regulating the availability of alcohol in big-sized containers and the need for cutting down on quantity of alcohol and frequency of drinking for South African males who drink at on- and off-licensed premises.

Alcohol and burden of disease: Alcohol is a major contributor to the burden of disease in South Africa (Petersen Williams et al. 2019). Alcohol accounts for some of the harms to individuals and society (WHO 2018).

A 2018 study found that 62,300 people died from alcohol-attributable causes in South Africa in 2015, just over 170 per day (Probst et al., 2018). South Africa has very high rates of hazardous alcohol consumption among drinkers, and these rates of hazardous drinking appear to be on the rise (Ferreira-Borges, Parry, & Babor, 2017).

Alcohol and social outcomes: According to micro-level studies done locally and in other countries, the negative social impacts of alcohol misuse result in long-term health issues, job insecurity, and deteriorating family relations, which are felt more severely amongst families at the lower end of the socioeconomic scale (Rehm et al., 2009; Rehm & Parry, 2009). Harmful use of alcohol also reduces job productivity,

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employment, and ultimately income levels (Harker Burnhams, Parry, Laubscher & London, 2014).

It is thus clear that it is imperative for the country to curb alcohol abuse and the resultant alcohol-related trauma, injuries and economic losses through tried and tested strategies (WHO ref) including:

- Reducing access to alcohol;
- Outlawing drinking and driving;
- policing of public drinking and unlicensed premises;
- alcohol policy evaluation to enable revised legislation and contemporary intervention;
- Curbing advertising of alcohol to ensure it is not visible to persons under the age of 18
- Regulating size of containers and packaging/labelling (only to permit advertising of factual information and not promote lifestyle); and
  intensifying availability of counselling and medically assisted treatment for persons struggling with alcohol dependency.
- raising the price (through excise and Minimum Unit Pricing), limiting access through reduced trading hours and densities.
- increasing taxes on alcoholic beverages.
- enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media.
- and enacting and enforcing restrictions on the physical availability of retailed alcohol.

The Social Impact Work Stream – which consists of the Department of Basic Education, Department of Social Development, Department of Transport, Department of Trade, Industry and Competition, and South African Police Services – made the following recommendations to the National Joint Committee and Intelligence Structure, and the National Coronavirus Command Council in charge of managing the COVID-19 pandemic:

- Introduce minimum unit pricing controls, possibly in the order of R8.00 to R10.00/standard unit of alcohol (12 g or 15 ml of pure alcohol) and/ or increase tax of which a percentage could be earmarked for health promotion and development as part of implementing the NHI and UHC;
- Industry to develop a system to track alcohol products back to source of sale/manufacture to prevent selling by unlicensed outlets and sale of counterfeit or illicit products. This needs to be coupled with compulsory ID presentation with all purchases to shift the retail culture and reduce sales to underage youth;
- Limit container sizes of beer and cider allowed for sale to no more than 500 ml and wine and spirits to no more than 750 ml; diminish drink-driving by enforcing

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a maximum blood alcohol chart levels for drivers of 0.02 g alcohol/100 ml of blood (or breath equivalent);

- Improved labelling of alcohol products to include the standard drinks contained in the container:
  - List the content;
  - improve warnings against drinking during pregnancy;
  - Improve visibility of labels; and
- Make alcohol-related trauma a notifiable condition at trauma units and set up mechanisms to facilitate using clinical assessment tools (or biomarkers like skin testing).

As part of a cluster of interventions to reduce the harms caused by alcohol in South Africa, it is proposed that evidence based programmes are developed to fight the scourge of alcohol abuse in the country.

EVIDENCE BASED PROGRAMMES TO ADDRESS ALCOHOL HARMS

South Africans are the highest alcohol consumers in Africa and one of the highest in the world. The World Health Organisation (WHO: 2014: 290; 2018: 102) ranks South Africa amongst the countries with the riskiest patterns of alcohol consumption. South Africa experiences substantial and far-reaching Alcohol-Related Harms (ARH), affecting both the health and safety of South Africans and the well-being of our society and economy. Although less than a third of South African adults drink alcohol, some drinkers consume large amounts quickly ('heavy episodic' or 'binge' drinking). This is highly destructive to our communities. Particularly young people, until recently mainly young men (WHO (2014: 128), participate in such risky behaviour. There is thus an urgent need to address this malaise through alcohol-related harms reduction interventions.

These harms are wide-ranging, multifaceted, and inter-generational. They affect individuals, households, and communities, negatively impacting human wellbeing, health, safety, and the ability to contribute productively to society and the economy. Indeed, research indicates that alcohol-related harms cost South Africa some 10-12% of GDP per year, significantly more than the economic contribution of alcohol production and trade (Matzopoulous, et al., 2014:127). We thus require a multisectoral approach to reduce these harms through prevention, mitigation, and reduction carried out by a wide range of public, private and community-based contributors.

In 1999, the South African Constitutional Court (Constitutional Court case number CCT12/99) clearly delineated the regulation of alcohol, as a licit product, between the national, provincial, and local spheres of government. However, reducing the harms related to the consumption of alcohol are not as distinctly allocated. No single sphere of government or department alone can deal with the complex range of harms. While the Constitutional Court clarified the responsibilities for regulating and managing

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alcohol, more than 20 years later the South African public now urgently deserves a concerted programme of prevention and reparation of alcohol-related harms.

The government departments which are custodians of public health and safety and champions of social development must collaborate to contribute a safer, happier, and healthier society for future generations. This policy document offers suggestions for building an alcohol harms interventions.

Strategies to address Alcohol Harms in South Africa

A core principle of good governance and regulation is that there should be no conflict of interest in decision-making or implementation of alcohol harm reduction services and related activities. This principle applies to government departments, as well as to the private sector. Regulators should undertake their duties in the public interest, always considering the public at large over those with vested interests.

Given the severity of alcohol-related harms in South Africa, we cannot afford uncertainty. Extensive peer-reviewed research world-wide and locally (DNA Economics: 2011) shows that, when the alcohol industry is involved in policy-making and harm reduction initiatives, there is no evidence of effective interventions. One of the World Health Organisation's four central principles for ARH-reduction is thus to avoid conflicts of interest, in policy and alcohol harm reduction initiatives, WHO (2022).

International experience demonstrates that there should be no opportunity for influence, manipulation, acknowledgement, branding, or mixed messages from alcohol companies. The scientific evidence is sufficiently clear, and should not be abused by hired communications companies or non-profit organisations of alcohol beverages industries (E.g. aware.org in South Africa or the Portland Group in the UK), casting aspersions or doubt to impede effective interventions (Michaels: 2020). An unambiguous mandate will assist to avoid conflicts of interest and to ensure effective, rapid implementation of the programmes, based on the WHO 'ten best buys'.

Strategies and priorities to be supported are:

a. **Research** (research and ongoing monitoring of alcohol consumption and associated harms among adults and youth, through periodic household and school surveys; monitoring of alcohol-related trauma and health consequences, as well as alcohol-related crimes). Research on the health, social and economic consequences of alcohol use.
b. **Implementation and evaluation** of projects to address alcohol-related harms resulting in lessons learned and to be taken forward to ensure effective alcohol harms reduction.
c. **Monitoring** of national progress in terms of implementation of WHO SAFER strategies to reduce harmful use of alcohol focusing on price, availability, marketing of alcohol, drink-driving countermeasures and treatment and brief interventions.
d. **Communication**, awareness raising, education/training youth (who are the main binge drinkers), and particularly young women (who are the target of industry growth strategies).
e. **Prevention and early intervention** (stand-alone programmes that are age specific to focus on behaviour modification.

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f. **Treatment** (detoxification, rehabilitation, alcohol-related screening and brief interventions.
g. **Aftercare services** (focusing on continuum of care and relapse prevention).

To reduce the serious harms related to alcohol, programmes need to be strengthen and developed to address the South Africa unique situation on widespread alcohol abuse. Multi -stakeholders concerted efforts and connected interventions are thus required.

Tobacco

Tobacco use remains the leading causes of premature morbidity and mortality in South Africa despite previous efforts which yielded some success in reducing tobacco use in the country in the past (Ayo-Yusuf, Omole 2021). Data from the South African Demographic and Health Survey show that tobacco use prevalence in South Africa is about 22% while prevalence of cigarette smoking is 21.5% (SAMRC 2016). Annually, 42,100 South Africans die of tobacco induced diseases (Tobacco Atlas and Groenewald et al 2000) which range from chronic obstructive pulmonary disease (COPD), various cancers, diabetes, cardiovascular diseases, asthma, among other non-communicable diseases (WHO 2021). Exposure to second-hand tobacco smoke (SHS) is also a risk factor for many tobacco-induced diseases and about 48% of non-smokers are exposed to SHS in public places and at home in South Africa (Ngobese et al 2020). Tobacco smoking also exacerbates communicable diseases like tuberculosis, HIV and COVID-19.

In the Drakenstein Child Health Study conducted in South Africa, about 18% of infants at birth were found to have urine cotinine levels indicative of active smoking while 30% had levels indicative of exposure to secondhand smoke (Vanker et al. 2018). Prenatal exposure to tobacco smoking (infants of women who smoke while pregnant) lead to the following pregnancy and birth outcomes intrauterine growth retardation, low birth weight, preterm birth, congenital malformations, still birth, lower lung function at birth and impaired lung growth in early life and susceptibility to diseases of the respiratory tract (Berlin et al. 2018; Westwood et al. 2021). Children exposed to secondhand smoke are at risk of developing conditions like attention Deficit Hypersensitivity Disorder (ADHD)(He et al. 2020), asthma and wheeze and increased cancer risk (Burke et al. 2012).

Young South Africans are targeted by the tobacco and electronic cigarette industry. A 2021 study by Agaku et al found that almost 50% of the 240 identified electronic cigarette shops (vape shops) were strategically located within a 5km radius of a higher educational institution (Agaku et al 2021). They also found that proximity to vape shops was associated with ever using e-cigarette among young adults aged 18–29 years. The extant tobacco law of South Africa does not regulate electronic cigarettes, but a new tobacco bill released for public comment in 2018 seeks to regulate e-cigarettes once passed.

Cannabis

Cannabis is the most used non-regulated drug in South Africa (SAMRC, SACENDU 2021). Approximately 9% (2.2 million people) of the South African population use

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cannabis, more than double the global average of 4% (that is more than double) (CDA annual Report 2014/15).

SACENDU data shows that cannabis is the most common substance of use among clients accessing treatment centres in GT, KZN, Central region (FS, NW, NC) and the Northern region (MP & LP). Across sites, between 25% (WC) and 50% (GT) of persons attending specialist treatment centres had cannabis as their primary or secondary drug of use, compared to between 5% (KZN) and 29% (WC) for the cannabis/mandrax (methaqualone) aka 'white-pipe' combination. Cannabis was also reported as the most common primary substance of use among persons who are younger than 20 years across all sites, with exception of the WC where MA dominated (SAMRC, SACENDU 2021).

The legalisation of cannabis has far-reaching implications for society in general. Adult individuals are now permitted to use, possess and cultivate cannabis in private; and for personal consumption. However, the use (including smoking) of cannabis in public or in the presence of children or non-consenting adults is not permitted.

Methaqualone (aka Mandrax)

Methaqualone is a sedative and hypnotic medication that is typically sold in the form of a tablet. Mandrax can be taken orally or the tablet is crushed and mixed with cannabis (known as 'white pipe') and smoked (drugaware.co.za). Harm related to abuse of mandrax includes slurred speech, convulsions, reduced heart rate, numbness of finger and toes and death through cardiac or respiratory arrest (rehabs.in). The proportion of persons who attended specialist treatment centres between January - June 2020, with cannabis/mandrax as their primary substance of use remained very low in all sites. However, it is still relatively common as a secondary substance of use, especially in the WC. Across sites, between 5% (KZN) and 29% (WC) of persons attending specialist treatment centres reported cannabis/mandrax as their primary or secondary drug of use (SAMRC, SACENDU 2021).

Opioids

Heroin is the most commonly used opioid. Nyaope and whoonga are street names for a heroin-based drug that is common across South Africa. Increases in heroin related treatment admissions to SACENDU-linked services has been documented. Since 1994, treatment demand for heroin use has grown from <1% to 32% in 2020 (SAMRC, SACENDU 2021; Burnhams 2020).

Data also suggests a significant increase in the overall proportion of clients at SACENDU drug treatment centres reporting injection drug use, from 1.6% in 2013 to 3.5% in 2017 ($p < 0.001$) (Burnhams et al. 2020).

Heroin use remains problematic across all SACENDU treatment sites. Mostly, heroin is smoked, but across sites 27% KZN, 21% NR, 12% WC and 19% GT of persons who reported heroin as primary drug of use, reported injecting it. There was a significant increase in the proportion of persons injecting heroin in KZN (from 14% to 27%). For the period January to June 2020, between 19% (EC) and 38% (GT) of persons attending specialist treatment centres reported heroin as a primary or secondary substance of use. Between January to June 2020, 15 131 people who inject drugs

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(almost all use heroin) were reached by harm reduction services across 8 metropolitan areas (SAMRC, SACENDU 2021).

The South Africa Demographic & Health Study (SADHS) reported that 1.9% of the survey population had misused codeine-containing medicines in the past year (Department of Health, 2019). Treatment demand data shows that between January and June 2020, there were 266 persons (4% of total admissions) who were treated for misuse of codeine (SAMRC, SACENDU 2021). Availability and use of fentanyl, and opioids in South Africa has not been widely reported. Tramadol is a commonly used analgesic in South Africa, with limited documentation of misuse.

Accurate data on opioid-related overdoses, non-accidental injury (including self-harm) in South Africa does not exist. Over a third (38%) of participants in a small study (n= 66) on overdose experiences among people who inject drugs in 3 cities reported overdosing in the previous year, and two-thirds (76%) of participants knew someone who had overdosed. Heroin was mostly used, but poly-drug use was also reported (Wilson et. al. 2021). A high burden of infectious diseases has been documented among the estimated 82 500 people who inject heroin in South Africa (Global Initiative Against Transnational Organized Crime, 2021). HIV, hepatitis B and hepatitis C prevalence among people who inject drugs across three major metropolitan areas was found to be 21.8%, 5% and 54.7%, respectively (Scheibe et. al, 2020). The increasing prevalence of infective endocarditis has also been documented (de Villiers et. al, 2019). Harms associated with long term use of codeine include depression, dysphoric mood states, constipation and dependence (Cooper, 2013).

Cocaine

Treatment admissions for cocaine-related problems have remained low across sites over the past few reporting periods and there are few persons younger than 20 years who are admitted for cocaine-related problems (SAMRC, SACENDU 2021).

Cocaine is a stimulant that increases levels of alertness, attention, and energy. Short term effects include reduced appetite, increased heart rate and blood pressure, contracted blood vessels, depression, anxiety, paranoia and disturbed sleeping patterns (Fonseca & Ferro, 2013). Consuming high doses and with consistent use, cocaine can cause psychosis (McKetin et al. 2013), convulsions, seizures and even sudden death. Long-term effects include permanent damage to blood vessels of the heart and brain, severe tooth decay, auditory hallucinations, respiratory failure and addiction (Goldstein et al., 2009).

Methamphetamine (aka Tik' or 'Crystal')

SACENDU Treatment admissions for Methamphetamine (MA) as a primary substance of use are generally low except in the WC (44%) and in the EC (17%). MAwas the most common primary drug reported by persons in the WC in 2020a, increasing significantly compared to the last period (29%). The proportion of persons who reported MA as a primary or secondary drug was significantly higher in the EC (25%) and the WC (59%), compared to other sites. Among persons under 20 years, the

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proportion of patients reporting MA as a primary or secondary substance of use over time increased significantly to 52% (compared to 11% in 2019a) (SAMRC, SACENDU 2021).

Methamphetamine is a stimulant that increases the dopamine levels in the brain. Short term effects include reduced appetite, wakefulness, feelings of motivation and increased energy levels. The potential harms of methamphetamine are dose dependent. At high doses and with consistent use, methamphetamine can cause psychosis (McKetin, R., Lubman, D. I., Baker, A. L., Dawe, S., & Ali, R. L. 2013), sleep deprivation (Vrajová, et al. 2014) and cardiovascular disease and stroke (Kevil et al. 2019). These side effects are often exacerbated by concurrent use of other unregulated drugs.

Methamphetamine is the second most injected drug after heroin. Injecting drug use without the availability of sterile injecting equipment contributes to the spread of blood-borne viruses including HIV and HCV. Methamphetamine increases sexual drive and has been shown to play a role in the transmission of sexually transmitted diseases (UNODC 2019).

The World Drug Report (2017) indicates that "the transmission of infectious diseases such as HIV and hepatitis C and the occurrence of drug overdoses are some of the risk factors that lead to the level of mortality among people who inject drugs being nearly 15 times higher than would normally be expected among people." This is supported by the South African National Strategic Plan for HIV, TB and STIs (2017–2022) which indicates that people who abuse alcohol and illegal substances are amongst population groups that are most likely to be exposed to or to transmit HIV and/or TB. In addition, certain groups are particularly vulnerable to progressing from TB infection to TB disease and/or drug resistant TB. These include among others smokers, alcohol and substance users.

In 2021, there were 139 specialist substance use treatment centres registered with the Department of Social Development. Specialist substance use treatment centres provide a range of psychosocial services. Detoxification services are provided at some centres and specialised detoxification units at a few specialist public sector facilities. Opioid substitution maintenance therapy (OST) is available in the private sector and in selected programmes funded by one municipality (City of Tshwane) and international donors in 5 health districts (two additional districts will start OST services in 2021) (SAMRC, SACENDU 2021). Needle and syringe services with integrated behaviour change interventions are implemented by civil society organisations across 9 health districts (SAMRC, SACENDU 2021). Community-based overdose prevention and treatment services are limited, with some initial training completed with staff operating needle and syringe outreach services and OST service providers SAMRC, SACENDU 2021). HIV testing and referral for treatment is done at selected DSD drug treatment centres. Community-based harm reduction service providers provide integrated HIV and TB screening and treatment/ linkage to treatment. Integrated HBV and HCV testing, vaccination and treatment have been piloted and proven feasible in several community-based harm reduction service settings (Saayman et al. 2021).

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Moreover, there is the SUD treatment gap – the treatment admissions nationwide show that the number of people who have access to treatment for substance use disorders is not in line with the demographics of the country. A national audit that was conducted in 2016 at treatment centres and halfway houses indicated that the majority of treatment centres are located in urban areas (DSD, 2016). This renders accessibility to treatment services difficult, particularly in marginalised and disadvantaged communities and among women.

The national drug treatment audit report further indicates that the intake of women at treatment centres nationally is far less than that of males. This is attributed to the fact that the majority of treatment centres cater for adult males. Furthermore, centres that admit women do not provide treatment programmes that cater for women's needs such as pregnant women and women with minor children. These "mixed" programmes are not gender-sensitive and staff are not trained to deal with the needs of women, needs that are in some ways more complex than those of men. Dada, *et al.* (2018) on the AOD use among women highlighted… the importance for the development of gender-sensitive interventions for the prevention and treatment of AOD problems among women.

Furthermore, the need for opioid substitution maintenance therapy greatly exceeds demand, with waiting lists reported in all centres where this service is provided, and demand for this service in many areas where it currently does not exist. During the COVID-19 pandemic, over 1 076 homeless people with opioid dependence in Tshwane and 240 in eThekwini were placed onto methadone to manage opioid withdrawal; very few of whom had previously had access to methadone (INHSU 2021). Currently 1% of people who inject drugs have access to OST (SAMRC SACENDU 2021). WHO and UNODC recommends that all people with an opioid dependence should have access to OST, and recommends high OST coverage (>40%) to have population level impact for HIV and viral hepatitis epidemic control (UNODC 2012).

Comprehensive framework necessary

The above situational analysis indicates that drug use, abuse and dependency is a complex, multifactorial health disorder that requires commitment from various organs of state, civil society, policymakers, parliamentarians, educators, the scientific community, academia, target population, individuals in recovery from substance use disorders and their peer groups, families and private sector to work together.

The Policy therefore seeks to provide a comprehensive framework to address challenges faced by the sector in dealing with the scourge of drug use and addiction. It presents a variety of sectoral interventions aimed at effectively strengthening prevention, treatment, rehabilitation, harm reduction, reintegration and aftercare as well as initiatives aimed at minimising the adverse public health and mitigating the consequences of drug abuse among communities.

In ensuring the implementation of *the Policy*, South Africa has to fulfil its international obligations as a member of the UN. The international and national instruments that inform *the Policy* are outlined in the next section.

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5. LEGISLATIVE AND POLICY FRAMEWORK

5.1 International instruments

5.1.1 UN Single Convention on Narcotic Drugs, 1961, as amended by the Protocol of 25 March 1972

This convention aims to combat narcotic drug abuse through coordinated international action and it specifies two forms of intervention and control that work together namely:

- Limiting the possession, use, trading in, distribution, import, export, manufacturing and production of drugs exclusively to medical and scientific purposes.
  Combatting drug trafficking through international cooperation to deter and discourage drug traffickers.

5.1.2 UN Convention on Psychotropic Substances, 1971

The convention establishes an international control system for psychotropic substances. It responded to the diversification and expansion of the spectrum of drugs of abuse and introduced controls over a number of synthetic drugs according to their abuse potential on one hand, and their therapeutic value on the other.

5.1.3 UN Convention on the Rights of the Child, 1989

This convention provides for the growth and well-being of a family as a fundamental group of society and the natural environment for the growth and well-being of all its members, particularly children should be afforded the necessary protection and assistance so that the family can fully assume its responsibilities within the community.

5.2 National instruments

5.2.1 The Constitution of the Republic of South Africa, 1996

The Constitution, as the supreme law of the country, is the basis within which all legislation should be developed. The Bill of Rights which is enshrined in the Constitution is a cornerstone of democracy in South Africa. Among other things, it affirms the rights of all people in our country and the democratic values of human dignity, equality and freedom. This requires that services should be provided taking into account the spirit and purport of the Bill of Rights.

5.2.2 The Prevention of and Treatment for Substance Abuse Act, 2008 (Act No 70 of 2008)

The Act provides for:

- a comprehensive national response for the combatting of substance abuse;
- mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and re-integration programmes;
- the registration and establishment of treatment centres and halfway houses;

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- the committal of persons to and from treatment centres for their treatment, rehabilitation and skills development in such treatment centres;
  the establishment of the National Drug Committee; and matters connected therewith.

5.2.3 The Drugs and Drug Trafficking Act, 1992 (Act No 140 of 1992)
The Act provides for:

- the prohibition of the use or possession of;
- dealing in drugs and acts relating to the manufacture or supply of certain substances;
  reporting of information to the police; and the exercise of powers of entry, search and seizure and detention in specified circumstances.

5.2.4 The Medicines and Related Substance Control Act, 2002 (Act No 59 of 2002)
The Act provides for:

- the registration of medicines and other medicinal products to ensure their safety for human and animal use;
- the establishment of a Medicines Control Council for the control of medicines and the scheduling of substances and medical devices; and promotion of transparency in the pricing of medicines.

5.2.5 The Road Traffic Amendment Act, 1998 (Act No 21 of 1998)
The Act provides for the mandatory testing of drivers for alcohol and drugs. The Act also defines the legal limits for alcohol (ethanol) in the blood and breath of drivers and thereby sets the standard by which drivers can be charged or prosecuted for driving under the influence (DUI) of intoxicating substances.

5.2.6 he Child Justice Act, 2008 (Act No 75 of 2008)
The Act provides for the diversion of cases out of the criminal justice system and to ensure effective rehabilitation and reintegration to prevent children from reoffending.

5.2.7 Other relevant instruments

- Mental Health Care Act, 2002 (Act No 17 of 2002)
- Health Act, 1977 (Act No 63 of 1977)
- Tobacco Products Control Act, 1999 (Act No 12 of 1999)
- Liquor Act, 2003 (Act No 59 of 2003)
- Prevention and Combatting of Trafficking in Persons Act, 2008 (Act No 7 of 2008)
- Pharmacy Act, 1974 (Act No 53 of 1974)
- Customs and Excise Amendment Act, 1994 (Act No 19 of 1994)
- Children's Act, 2005 (Act No 38 of 2005 as amended)
- Criminal Procedure Act, 1977 (Act No 51 of 1977)
- Child Justice Act, 2008 (Act No 75 of 2008 as amended)

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- Correctional Services Amendment Act, 1992 (Act No 122 of 1992)
- South African Police Service Act, 1995 (Act No 68 of 1995)
- Domestic Violence Act, 1998 (Act No 116 of 1998)
- Immigration Act, 2002 (Act No 13 of 2002)
- Social Services Professions Act, 1978 (Act No 110 of 1978 as amended)
- Nursing Act, 1978 (Act No 50 of 1978)
- Health Professionals Act, 1974 (Act No 56 of 1974)
- Human Rights Commission Act,1994 (Act No 54 of 1994)
- Non-Profit Organisations Act, 1997 (Act No 71 of 1997)
- South African School Act, 1996 (Act No 84 of 1996)
- Sexual Offences and Related Matters Act, 2007 (Act No 32 of 2007)
- Institutes for Drug-free Sport Act,1997 (Act No 14 of 1997)
- National Youth Development Agency Act, 2008 (Act No 54 of 2008)
- National Road Traffic Act, 1996 (Act No 93 of 1996)
- Prevention of Organised Crime Act, 1998 (Act No 121 of 1998)
- Promotion of Access to Information Act, 2000 (Act No 2 of 2000)
- Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 (Act No 4 of 2000)
- Public Finance Management Act, 1999 (Act No 1 of 1999)
- Probation Services Act, 1991 (Act No 116 of 1991)
- Occupational Health and Safety Act, 1993 (Act No 85 of 1993)
- Employment Equity Act, 1998 (Act No 55 of 1998)
- Labour Relations Act, 1995 (Act No 66 of 1995)
- Prevention and Combatting of Trafficking in Persons Act, 2013 (Act No 7 of 2013)
- Municipal Finance Management Act, 2003 (Act No 56 of 2003)
- Basic Conditions of Employment Act, 1997 (Act No 75 of 1997)
- White Paper on Local Government (2010)
- White Paper on Social Welfare Services (1997)
- Norms and Standards for the Delivery of Social Welfare Services (2007)
- White Paper on Transforming Public Service Delivery (1997)
- Integrated Service Delivery Model (2000)
- Integrated School Safety Strategy (2012-2017)
- National Drug Master Plan (2019-2024)
  Minimum Norms and Standards for In-Patient Treatment Centres (2005)

6. PURPOSE OF THE POLICY

The Policy framework on the Prevention of and Treatment for Substance Use Disorder seeks to amend the Prevention of and Treatment for Substance Abuse Act, 2008 (Act No 70 of 2008).

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In addition, the *The Policy* seeks:

To embrace a balanced, integrated and evidence-based approach to domestic substance use, and abuse; to invest in building safe communities through appropriate substance abuse prevention and impact minimisation strategies; to control the demand and supply of substances; and to effectively control substances for therapeutic use and the emergence of new psychoactive substances.

Furthermore, *the Policy* is aimed at ensuring that drug demand reduction related services within the social development sector are rendered in a coordinated, regulated and effective manner; that roles and responsibilities are defined, and that all drug demand reduction interventions are guided by the principles outlined in the next section.

7. OBJECTIVES

The objectives of the Policy on the Prevention of and Treatment for Substance Use Disorder, are:

- Address challenges faced by the sector in dealing with the problem of substance abuse.
- To embrace a balanced, integrated and evidence-based approach to the domestic alcohol and drug use and abuse.
- To invest in building safe communities through appropriate alcohol and other drugs prevention and impact minimisation strategies;
- Facilitate the development, implementation, monitoring and evaluation of responsive interventions for the prevention and treatment of substance abuse.
- Provide a platform for functioning, involvement and participation of various stakeholders in the prevention of and treatment for substance abuse.
- Address the identified gaps in the legislation.

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8. POLICY PRINCIPLES

The following principles underpins the 'Policy':

Human Rights
Service providers should provide services within the context of the Bill of Rights as enshrined in the Constitution of the Republic of South Africa.

Access to services
Services and programmes should be available and accessible to all, especially in under-resourced areas.

Availability
Substance abuse related services should be within reach of all people that do not have coverage. Given the vastness of some provinces, there is a need to expand services to other areas such as rural communities. Services should be easily accessible to everyone regardless of age, gender, sexual orientation, colour, religion, culture, language, socio-economic status, geographic location without any form of discrimination. Notwithstanding the fact that current instruments take into account the above mentioned, issues of diversity including disability, language and religion need accommodation during provision of services.

Level of education should be taken into consideration as many indigent service users dropped out of school at a young age and are illiterate. This would require the adaptation of programmes to accommodate the needs of this specific group. Provision of vocational skills services/training should be part of treatment and prevention services

Affordability
Substance abuse prevention and treatment services should be affordable to service users taking into account their socio-economic status. The DSD must, in consultation with National Treasury and any other relevant organ of state, determine a fee structure for substance abuse related services for both public and private treatment centres. A standard funding model should be developed and costed. Consideration should be given to integrating treatment services in the PHC – these are more accessible to communities.

Appropriateness
All services rendered to service users and to persons affected by substance abuse should be provided in an environment that recognises the needs of such persons including educational, social, cultural, spiritual, economic and physical. Services should be of required quality and quantity.

Equity
The disbursement of public resources should be based on needs, priorities and historical imbalances.

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Balanced approach
Equal emphasis and even distribution of resources should be adopted in order to ensure effectiveness of services aimed at addressing substance abuse.

Consultation and participation
Service providers should consult with service users on substance abuse matters including quality and type of services to be provided. In order to take control of their own challenges and development, service users should also be provided with information, knowledge and opportunities to fully participate in all activities aimed at combatting substance abuse.

All interventions aimed at combatting substance abuse should involve persons affected by substance abuse in order to create a healthy environment for recovery.

Evidence-based practices
Service providers should develop and implement interventions that are informed by evidence-based research.

Coordination and collaboration
The Alcohol and Drug Regulatory Council should enhance and strengthen measures to improve coordination and collaboration among stakeholders, to set concrete objectives and clear timelines for strengthening the drug-control framework.

Accountability and compliance
All service providers should be accountable for the type of services that they provide. They should also comply with all relevant legislation and policies in the delivery of services aimed at combatting substance abuse.

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9. SECTOR CHALLENGES

Link between substance abuse, other social challenges and fragmented services

Substance abuse is a precursor to other social ills such as violence; crime, GBV, injuries and premature death; and chronic diseases such as HIV/AIDS, hepatitis, TB, and foetal alcohol spectrum disorders. This is a clear indication that substance abuse cannot be dealt with in isolation. Even though drug abuse is linked to other social ills and chronic diseases, provision of services is still fragmented at present.

Availability of alcohol and drugs

Alcohol and drugs have become easily accessible. This may be attributed to among others, marketing and advertising of alcohol and legal drugs; porous borders; emergence of new psychoactive substances that are not under international control, as well as designer drugs that are easily affordable.

New psychoactive substance and designer drugs

The emergence of new psychoactive substances has been one of the prominent trends in drug markets in recent years. These substances are not under international control and there is lack of scientific research on their health effects. As a result, there is lack of innovative prevention measures and sharing of best practices among countries in dealing with these drugs. In addition to new psychoactive substances, South Africa is also experiencing an escalation of concoctions such as nyaope and whoonga.

Nyaope and whoonga are street names for heroin, often mixed with other regulated and unregulated substances. In South Africa, it is usually sprinkled on cannabis and/or tobacco and the mixture is rolled into a cigarette or ‘joint’ and smoked. Treatment for these drugs therefore becomes a challenge because of their contents. Furthermore, nyaope and whoonga have become popular amongst children, youth and the unemployed because they are cheaper than drugs which are sold in pure form.

Unbalanced approach in services

Emphasis is not equally placed in the provision of services aimed to address substance abuse. Treatment services still receive the most emphasis, followed by prevention, and then early intervention services. Reintegration and aftercare services receive the least attention. Whereas aftercare is an essential component for relapse prevention, currently there is less focus on aftercare. There also seems to be a disjuncture between treatment and aftercare, and aftercare services are mostly unstructured. As a result, treatment gains become compromised.

Continuum of care

Implementation of treatment practices that are not evidence-based

Lack of understanding of substance abuse and its causal factors remains a challenge for effective treatment. Some people, including service providers who are not trained

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in substance abuse and addiction, believe that substance abuse is a self-inflicted problem or is associated with witchcraft or ancestral spirits. As a result, people who hold such beliefs apply methods that are not evidence-based, as part of treatment. This not only puts service users' lives at risk, but it also creates a notion that substance abuse treatment does not work.

Lack of proper assessment

Lack of proper substance use disorder (SUD) assessment by some service providers can result in inappropriate interventions. In some instances, service users are admitted to treatment centres even though they could benefit from community-based treatment services or SBIRT. This results in the unnecessary institutionalisation of people. Moreover, unnecessary institutionalisation may result in people who actually require residential treatment being unable to access treatment.

Lack of accessibility and affordability of treatment services

Due to the few number of state-owned public treatment centres in the country, treatment services are mainly provided by non-governmental organisations and by private treatment centres. Non-governmental organisations rely on state funding in order to sustain provision of services. Therefore, if there is no funding or inadequate funding, provision of services becomes a challenge. Private treatment centres on the other hand are not regulated in terms of the treatment fees that they charge. As a result, most private treatment centres are charging exorbitant fees that are not affordable to underprivileged communities.

The Department of Social Development has established state-owned treatment centres in all provinces especially where there are none. However, most of these treatment centres are located in urban areas and are not easily accessible to the majority of people, especially those who reside in rural areas.

Non-uniformity of treatment period and fees

Practices are more or less the same among state-owned treatment centres in terms of the processes involved in treatment. However, there is no uniformity in the duration of treatment as well as treatment fees that public and private treatment centres charge. This makes it difficult for DSD to determine whether treatment provided by respective state-owned treatment centres is effective and of good quality.

Provision of generic treatment without attending to individual treatment needs of service users

Assessment and monitoring of treatment centres has indicated that the majority of treatment centres tend to render generic treatment programmes which have the same duration and focus, regardless of the types of substances that services users are admitted for and whether a service user had previously undergone that treatment or not.

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Non-availability of a centralised admission information management system for state-owned treatment facilities

There is no system to track whether service users had previously been admitted to any other state-owned treatment centre or not. Treatment centres therefore rely on information obtained from service users and there is no way of verifying such information. Therefore, treatment interventions might be provided on the basis of incomplete or unverified information which in turn could impact negatively on the success of treatment.

Unregistered treatment facilities

The country has in recent years experienced a growing number of unregistered facilities that claim to provide treatment services. Establishment of treatment centres is not a problem per se if it is done within the confines of the law. The main concern for the department, however, is that the majority of unregistered facilities are operating outside the law as they are not registered by the department to provide treatment services. The fact that these facilities are not registered means that they are not regulated.

Transfer/escorting of involuntary service users to designated treatment centres

Existing legislation does not provide for the transportation of a service user from court to a designated treatment centre after a court order has been granted. This is often a challenge when it comes to the social worker who has the responsibility to ensure that a service user is committed to a designated treatment centre. *This Policy* seeks to address this grey area. In cases where service users are to be transferred to a designated treatment centre and such persons pose a risk to self-harm or harm of the transporting officer, the transporting officer must request the escorting services of the SAPS.

The intention therefore is to mandate SAPS through a legislative provision in the same context as in section 40 of the Mental Health Care Act through the intended amendment to undertake the task of transfer/ escorting of the service user from court to a designated treatment centre. The assessment of the condition of the service user regarding the potential risk of harm shall be the determining factor as to whether transfer or escorting by the SAPS is desirable under the circumstances.

Security risks associated with offenders in treatment facilities

The Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008) currently places on treatment centres responsibility for the security of offenders who require treatment services. This poses a risk because treatment centre managers are not equipped to deal with security issues and such provision is in conflict with security related legislation. The Act also falls short of categorising offenders to be transferred to treatment centres and therefore poses a security risk for the state.

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Lack of specialisation and capacity
The majority of service providers in the field of drug use and drug abuse do not have specialised training to deal with the problem. Social workers are not trained to deal specifically with substance use disorders, seeing that, in the past, academic institutions offered only generic social work training.

Currently, there are only a few academic institutions that offer drug use disorder training at post-graduate level. As a result, the majority of social workers find themselves overwhelmed when they have to intervene cases of drug use disorders. In addition to dealing with substance use disorder cases, social workers at service points also deal with other cases which makes it difficult for them to focus on interventions aimed at addressing drug use and abuse. These challenges impact negatively on the quality of service that they provide.

Lack of accredited training
The country is experiencing challenges in that professional work such as social workers interventions, early drug use intervention, treatment for drug use disorder, rehabilitation and aftercare services are also provided by so-called addiction counsellors who are only qualified by experience and their training if any is mostly not accredited. Moreover, a number of organisations also utilise volunteers and peer educators to provide outreach and prevention programmes. Such volunteers and lay counsellors are mostly not trained to provide prevention services or their training is not accredited.

Reliance on service providers who do not have the necessary training in providing drug use and abuse services as mentioned above is a risk as service providers may do more harm than good through provision of poor quality services. As a result, this could create a perception that interventions aimed at addressing substance abuse are not effective.

Lack of officials dedicated to the monitoring of registered treatment facilities
DSD does not have a dedicated unit that deals solely with the assessment, registration and monitoring of treatment centres. This responsibility lies with the line function which has many other responsibilities such as programme development, policy development and implementation. Furthermore, due to high numbers of registered treatment centres versus the available human resource capacity, monitoring of treatment centres becomes inadequate. This is exacerbated by the growing number of unregistered facilities which places an additional burden on officials who also have to ensure that these unregistered facilities do not continue to operate illegally.

Inadequate resources
Reports indicate that the problem of substance abuse is growing rapidly in the country. Allocation of resources to implement programmes and services aimed at addressing substance abuse is, however, conservative. Without allocation of more resources

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which are also dedicated to addressing the problem, substance abuse would remain prevalent.

Inability to implement certain provisions of the current legislation
Some gaps and unclear provisions in the Prevention of and Treatment for Substance Abuse Act, (Act 70 of 2008) hinder the implementation of the Act. Such provisions include the transfer and re-transfer of prisoners to and from treatment centres; non-prescription of penalties for non-compliance of service providers with legislation and duties and powers of staff of public and private treatment centres and halfway houses.

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10. SECTOR INTERVENTIONS

This Policy framework on Prevention of and Treatment for Substance Use Disorders suggests sectoral interventions that are informed by the United Nations General Assembly Special Session on the World Drug Problem (UNGASS) operational recommendation outcomes (2016), which include among others, operational recommendation on demand reduction and related measures including prevention and treatment, as well as other health related measures.

The UNGASS outcome document of 2016 advocates key pillars of addressing drug abuse, namely demand reduction, supply reduction, treatment of substance use disorder, and activities aimed at reducing harm caused by substance use and abuse in communities. Various stakeholders in the field of substance abuse are responsible for the implementation of these pillars in addressing the problem of substance abuse in the country, in line with their respective mandates.

- **Demand reduction pillar** is aimed at preventing the onset of substance abuse or dependence as well as eliminating or reducing the effect of conditions conducive to the use of dependence-forming substances;
- **Supply reduction pillar** is aimed at reducing the supply of both legal and illegal drugs. Supply reduction pillar is the responsibility of law enforcement; and
- **Harm reduction pillar** which includes treatment of substance use disorders and related activities aimed at reducing harm caused by use and abuse of substances in communities. It involves reducing the damage caused by substance abuse to individuals and communities. The reduction of harm caused by substance use and abuse can be achieved through prevention, early intervention, treatment, aftercare and reintegration services.

The core mandate for the DSD, in terms of the three pillars, is demand reduction and treatment of substance use disorders and related activities to reduce harm caused by substance use and abuse. The department implements these pillars through collaborative partnerships with other relevant stakeholders in the field of substance abuse such as other government departments; non-governmental organisations; faith-based organisations and civil society organisations.

Through the provision of prevention, early intervention, treatment, aftercare and reintegration services, DSD is reducing the demand for substance use and the resultant damage caused.

Certain services, as described below, should be implemented by the sector as part of preventing and treating substance abuse and its related problems. It is important for these services to be given the same level of emphasis in order to avert a situation where one service receives more focus and resources than the other. Equal emphasis on all the services would ensure that service users, their families or caregivers and communities have access to a range of services appropriate to their developmental and therapeutic needs.

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Furthermore, increased provision of human and financial resources by all key stakeholders responsible for prevention and treatment for substance abuse is critical for ensuring that services are strengthened, are more accessible, affordable and effective.

10.1 DEMAND REDUCTION: PREVENTION OF ALCOHOL AND OTHER DRUG ABUSE

Entails taking effective and practical primary prevention measures that protect people in need, particularly children and youth, from drug use initiation by providing them with accurate information about the risks of drug abuse. However, sharing of information alone does not account to changes in behaviour. There is no evidence that indicates sharing of knowledge alone changes behaviour. What is needed is universal prevention programmes targeting different age trajectories that seek to prevent or delay the onset of substance use. Long-term, sustainable programmes that have shown effectiveness should be promoted.

The Policy should achieve this through the provision of evidence-based psychoeducation, awareness raising, skills development interventions and prevention programmes.

This should include but not be limited to: promoting skills and opportunities to choose a healthy lifestyle; develop supportive parenting and healthy social environment; and by ensuring equal access to education and vocational training. Effective and practical measures to prevent progression to severe drug use disorders through appropriately targeted early interventions for people at risk of such progression, should be put in place.

Prevention seeks to delay or prevent the onset of substance use and can be categorised as:

Universal interventions target the general population and are not directed at a specific risk group. Universal prevention measures address an entire population (national, local, community, school, or neighborhood) with messages and programs aimed at preventing or delaying the use of alcohol, tobacco, and other drugs. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals with the information and skills necessary to prevent the problem. The entire population is considered at risk and able to benefit from prevention programs.

Selective interventions target those at higher-than-average risk for substance abuse; individuals are identified by the magnitude and nature of risk factors for substance abuse to which they are exposed. Selective prevention measures target subsets of the total population that are considered at risk for substance abuse by virtue of their

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membership in a particular segment of the population. Selective prevention targets the entire subgroup, regardless of the degree of risk of any individual within the group.

Indicated interventions target those already using or engaged in other high-risk behaviors to prevent heavy or chronic use. Indicated prevention measures are designed to prevent the onset of substance abuse in individuals who do not meet the medical criteria for addiction, but who are showing early danger signs.

The mission of indicated prevention is to identify individuals who are exhibiting problem behaviors and to involve them in special programs (https://dhss.delaware.gov/dhss/dsamh/files/pds.pdf).

Prevention

Prevention services refer to all activities aimed at preventing initial use of psychoactive substances and the delay of the onset of problematic use of such substances. Effective drug prevention contributes significantly to the positive healthy functioning of children, young people, adults, families, schools, workplaces and communities. It is thus critical for the sector to redirect more resources towards provision of evidence based prevention programmes /services in order to curb the onset and escalation of substance abuse.

Prevention may be provided primarily as a community-based service or as part of treatment and aftercare. Prevention should target all age groups, as well as vulnerable groups. SACENDU report (January – June 2019) indicates a significant increase in alcohol, cannabis, heroin and poly-substance use related admission for persons younger than 20 years across sites (different provinces). This is an indication that prevention services should start at an early age. All prevention activities that target children and adolescents should also target their families and/or primary caregivers.

Government departments should ensure an increased availability, coverage and quality of scientific evidence based prevention measures and tools that target relevant age and risk groups in multiple settings.

Vulnerable groups such as family members of individuals who abuse alcohol and other drugs, youth in conflict with the law and/or who display risky behaviours, marginalised and impoverished communities where there may be high levels of drug dealing and illegal liquor outlets, children living/or working in the streets, people with disabilities, unemployed people, pregnant women, women, older persons, people affected and infected by HIV and child-headed households should be prioritised for prevention services. When a family member has substance use disorder, the family system changes because all of its elements and functions are affected. Thus, prevention intervention should include among others, family programmes that focuses on empowering families, parents and significant others.

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Prevention interventions should be based on the following fundamental principles:

- Evidence based.
- Enhance protective factors whilst reducing risk factors.
- Target all forms of substance abuse including abuse of legal and illegal substances.
- Age-specific; developmentally appropriate and culturally sensitive.
- Family-focussed.
- Equip parents and/or caregivers with skills to reinforce anti-substance abuse norms within families.
- Identify risky behaviours and be able to deal with such risky behaviours.
- Should be sustainable.
- Adhere to International Standards for Drug Prevention by UNODC.

Without compromising treatment interventions, the sector should strengthen provision of prevention interventions through the development of norms and standards, and of accredited interventions. The result will be that these risk factors will be effectively addressed so that the initiation of substance use can be discouraged. This will also entail that the progression to dependency by those who have started using substances, will be averted.

The National Department of Social Development should facilitate the development of evidence-based, proactive and responsive prevention programmes. The programmes should reach youth in school, as well as out of school, through drug abuse prevention programmes and public awareness-raising campaigns; including by using the internet, social media and other online platforms.

The department should focus on promoting the wellbeing of society as a whole through the elaboration of effective scientific evidence-based prevention (EBPs) strategies centred on and tailored to the needs of individuals, families and communities.

Burnhams *et al.* (2009) point out that EBPs are not widely adopted by prevention programmes aimed at preventing AOD abuse among young people. More specifically, the prevention programmes available often lack continuity and are presented in the absence of evidence on their effectiveness. They further asserted that the lack of funding for AOD prevention is a major limitation for the adoption of EBPs as is the lack of appropriately trained and regulated service providers. Implementing programmes that meet best practice standards require a steady flow of income and trained prevention workers. Without this income, it is difficult to implement sustainable programmes and retain qualified and skilled personnel.

Recommended strategies to assist in improving substance abuse prevention services are as follows:

- Implementing EBPs requires AOD prevention workers to be adequately trained in AOD issues, in EBPs, and also in prevention science.

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- Prevention workers should be kept abreast of new research and programme developments within the substance abuse field and other related fields.
- Regular and ongoing supervision of prevention workers offers the opportunity of identifying the learning needs of prevention workers.
- Monitoring outputs and ensuring the delivery of a quality service.
- Provide workers with the necessary training and supervision, especially given the scientific complexity of these services.
- Minimum norms and standards for effective practice and the accreditation of individual prevention workers and the prevention services should be developed.
- Establish a regulatory regime for prevention services. An organisational framework that helps to facilitate improvements in service effectiveness and quality. (Burnhams *et al.*:2009)

In support of the above UNODC (2015) notes that the national drug prevention system should be evidence based and should be chosen on the basis of an accurate understanding of what the situation really is. The development of a substance use system of care and related prevention responses at provincial and local level are essential, and should be conducted through a strategic planning process. This process should be based on the results of a comprehensive needs assessment or establishing information collection system.

Information/ Data to be collected will include:

- population level data on the prevalence of substance use;
- drivers of substance use in a specific setting;
- existing prevention responses and their reach, appropriateness and effectiveness;
- availability and use of existing treatment services; and
- distribution of substance use harms across a specific area/population

The prevention pillar of this policy is aligned to the GBVF Pillar Two: Prevention and Rebuilding of Social Cohesion. With a emphasise to effectively address prevention of risk factors that drive gender based violence, femicide and violence. Drugs and substance abuse are some of the risk factors that have to be addressed in order to mitigate the scourge of GBVF. This will be done through integrated substance abuse and GBV prevention programmes. GBVF Layered Approach for Effective
Prevention will be incorporated in the substance abuse prevention services (NSP GBVF, (2020-2030).

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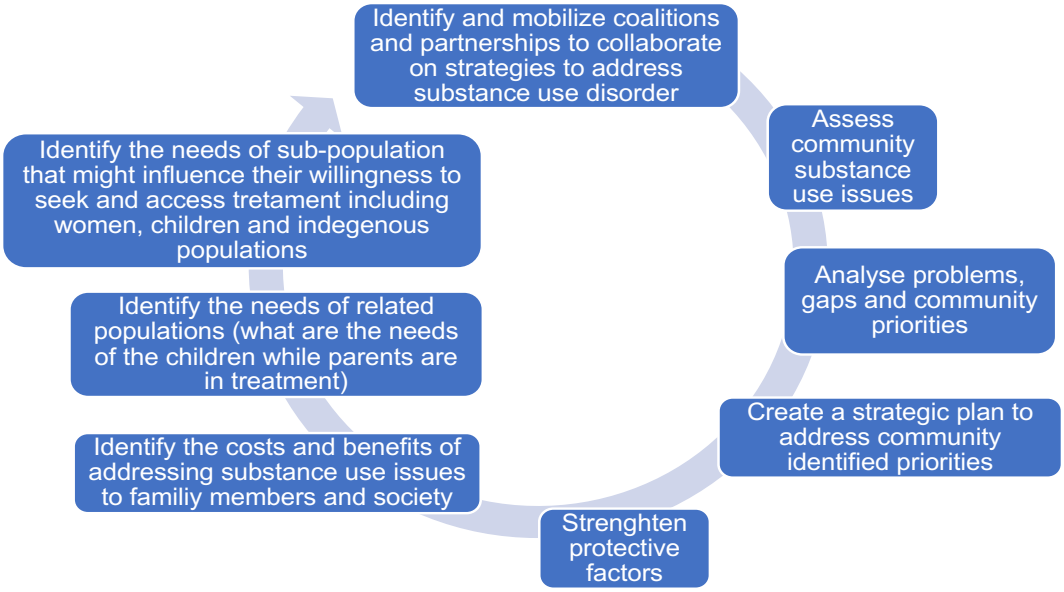
Figure 2: Developing a System of Care



Early intervention

Screening for risky substance use is critical for determining the nature of substance use by individuals. DSD in consultation with relevant stakeholders should therefore adapt internationally validated screening tools such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) for the sector. SBIRT is an evidence based tool. Service providers should be trained on the use of these tools; this will ensure that the screening process becomes standardised.

Babor *et al*. (2007) asserted that …Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening for persons with substance use disorders and those at risk. Several research studies were conducted in South Africa to determine the feasibility and acceptability of Screening and Brief Interventions in to address Alcohol and Other Drug Use among people who have SUDs problem. Petersen Williams *et al.* (2015) conducted a study on Screening and Brief Interventions for Alcohol and Other Drug Use among pregnant women attending midwife obstetric units in Cape Town, South Africa. The results of the study indicates that… 'Health care providers agreed that there is a substantial need for screening, brief intervention, and referral to treatment for substance use among pregnant women and believe such services potentially could be integrated into routine care'. Myers *et al.* (2012) conducted a study on "Feasibility and Acceptability of Screening and Brief Interventions to Address Alcohol and Other Drug Use among Patients Presenting for Emergency Services in Cape Town, South Africa. The study indicates that …although with limited additional resources, peer-led SBIs for AOD use are feasible to conduct in South African emergency services and are acceptable to patients and emergency personnel.

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Screening is a process that identifies people at risk for the 'disease' or disorder. It is a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation. Screening instruments does not enable a clinical diagnosis to be made, but rather merely indicates whether there is a probability that the condition looked for is present (Colombo Plan Drug Advisory Programme: UTC 2017).

WHO has developed other two screening instruments which are:

AUDIT- a 10-item screening tool developed to identify individuals whose alcohol consumption has become hazardous or harmful to their health.

The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), identifies substance use and related problems in primary and general medical care settings. It was developed as a component of the screening process to be used with a brief intervention.

The above thus support that the provision of early intervention services should facilitate early identification of substance use and reduce or eliminate risky use of substances prior to onset of addiction. As such screening tools that are validated should be used by service providers.

Early intervention should be provided as a community-based service, at Primary Health Care (PHC) levels, trauma units and target individuals who are misusing, consuming substances and those who display problems related to substance abuse such as:

- driving under influence of alcohol and/or drugs;
- individuals who have experienced alcohol or drug related injuries;
- binge drinkers;
- children and adolescents found in possession of drugs at school;
- individuals found in possession of drugs; or
- those who present alcohol or drug related health problems.

It should be the responsibility of families and /or caregivers, schools, police, health personnel and significant others to refer individuals who are found in possession of drugs or who display alcohol or drug related problems.

Early intervention services should be provided by social workers and other professionals who are trained to deal with substance abuse and to provide support to families and/or caregivers, significant others and community members.

The fundamental principles of early intervention services are:

- Building rapport with service users.
- Identification of risk and protective factors.
- Display of empathy and concern by service providers.

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- Non-confrontational approach.
- Provision of advice and information in order for service users to make their own choices.
- Working in partnership with service users to facilitate behaviour change.
- Structured and time-bound.
- Facilitation of change through the use of therapeutic techniques such as reflective listening, affirmations and open-ended questions.
- Use of motivational techniques.
- Monitoring service users' progress to ascertain whether set goals aimed at behaviour change are being met or not. If goals are not met, a service user should be referred to intensive treatment or other professionals for identified needs.

10.2 TREATMENT OF SUBSTANCE USE DISORDER, REHABILITATION, RECOVERY AND SOCIAL REINTEGRATION

Substance Use Disorder is categorised as a complex, multifactorial health disorder characterised by a chronic and relapsing nature with social causes and consequences that can be prevented and treated through effective scientific evidence-based treatment, care and rehabilitation programmes, including community-based programmes. This requires strengthening the capacity for aftercare, and social reintegration of individuals with drug use disorders, including (when appropriate) assistance for effective reintegration into the labour market and other similar support services.

Treatment Services and Harm Reduction related activities

Treatment services are aimed at reducing the negative health and social consequences associated with alcohol and other drug abuse. Therefore, treatment services are suitable for individuals who are dependent on psychoactive drugs. Addiction is a complex disease that affects people in various degrees. Therefore, there are population groups with special needs and should be catered for when delivering services. Such population groups include amongst others women, adolescents, LGBTIQ, elderly, criminal justice system clients, people with physical disabilities, people who use drugs and people who inject drugs.

Structural barriers such as location of treatment centres and SUD services should be eliminated to ensure that treatment services are easily accessible and affordable by those who require the service. Moreover, Service Providers should have programmes that address social stigma in their settings/or communities. Social stigma can affect the population groups with special needs recovery and recovery management. Social stigma and discrimination can act as a barrier to access treatment services. As such, treatment providers need to be sensitive to stigma related issues and should make a concerted effort to reduce the discrimination that people with SUD encounter.

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For treatment services to be effective, service providers should take into account aspects such as age, gender, cultural diversity, and other common co-occurring mental and medical disorders. Additionally, treatment should be aligned to evidence-based practices (EBP) for treatment interventions.

Evidence based practices (EBP), are practices for which the evidence is strongest and most accepted and that are most likely to have significant impact on improving care. The practice should be safe, effective, client centred and efficient (Colombo Plan Drug Advisory Programme: 2017).

Providers of treatment services should conduct feasibility studies in order to determine the need for the service and also ensure that there is no oversupply of treatment centres in one location.

Treatment services should be based on the following fundamental principles:

- Identification of risky and protective factors through multi-disciplinary assessment.
- Evidence-based treatment practices.
- Multi-disciplinary team approach.
- Structured and time-bound.
- Addressing multiple needs and not just substance abuse problem.
- Provision of various treatment methods as no individual treatment is appropriate for everyone.
- On-going assessment and modification of treatment plans where necessary in order to meet service users' changing needs.
- Taking into account age, gender and cultural elements of service users.
- Involvement of family members and/or caregivers during treatment to facilitate successful reintegration.

Although family involvement is not a specific treatment model, research suggests that family involvement in treatment enhances outcomes.

Components of a comprehensive drug use treatment should include amongst others families' services and/or significant others in treatment (see figure 4). Family involvement programmes are intended to increase the families understanding of drug use disorders and create a conducive environment for recovery.

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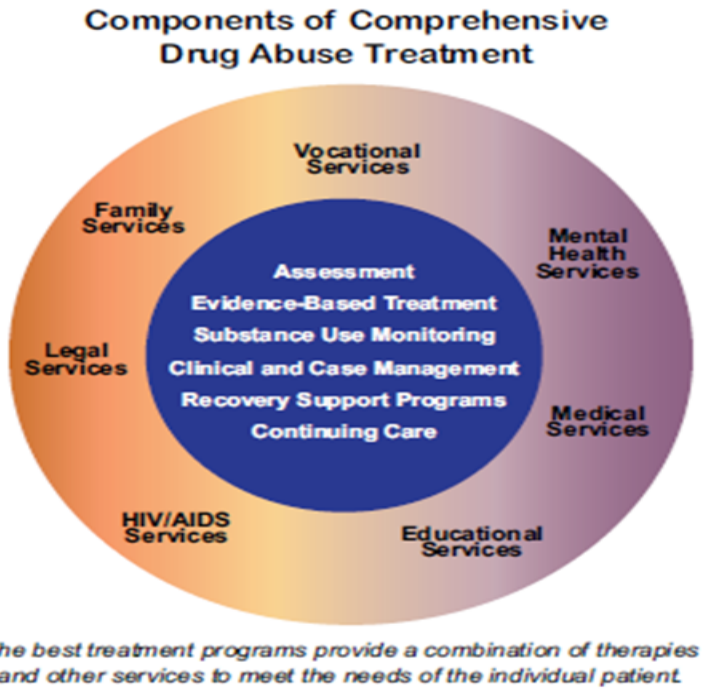
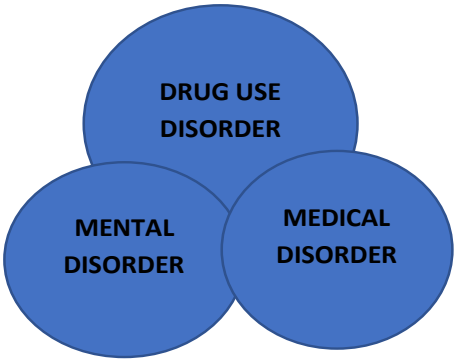
Figure 3: Components of Comprehensive Drug Abuse Treatment



Treatment programmes should be tailor-made for individual needs in order to enhance the recovery process and management. When screening and assessing service users it is essential to screen for co-occurring drug use disorders as well as mental and medical disorders.

Figure 4: Common Co-occurring Disorders



A 2010 report by the UN Commission on Narcotic Drugs stresses that reviews of the research have consistently found high rates of co-occurring drug use and mental

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disorders in the global population. In general, research has found that about 45% of those with a drug use disorder also have at least one mental disorder. Treatment centres must increase testing for co-occurring medical, mental and drug use disorders. It is mandatory for treatment centres to test service users for co-occurring medical disorders such as HIV, TB, COVID-19, viral hepatitis – and this should be legislated as a requirement.

Children abusing substances or affected by substance use disorder
Section 191 of the Children Act, (Act No 38 of 2005) applies in the context of changes envisaged. Children that are dependent on drugs must be treated in separate treatment facilities and apart from adults, whether within treatment centres or in facilities designated for children. Compliance for programme purposes should be assessed and monitored on an ongoing basis.

Health and social consequences of drug use among women
Women encounter significant systemic, structural, social, cultural and personal barriers in accessing treatment for drug use disorders. At the structural level, the most significant obstacles include lack of childcare and punitive attitudes towards mothers and pregnant women with substance use disorders.

Women with children often need to secure childcare to participate in outpatient and community-based treatment programmes as they may not have enough money to pay for childcare costs, transport or the treatment itself; this can be a significant hindrance for women to access treatment services. It is thus essential that community-based treatment programmes integrate child day care services into drug treatment. These services should be made available for women with drug use disorders only.

Women with drug use disorders often enter treatment with a history of emotional and physical abuse. Most women with drug use disorders also suffer from trauma, psychiatric disorders, in particular, anxiety, depression or post-traumatic stress disorder. Medical and psychiatric co-morbidities among women may be more severe than among their male counterparts.

Therefore, treatment centres that render drug use services to women should develop gender specific responsive treatment programmes. There should be increased efforts to bring women into treatment and improve their access to drug use treatment services.

Interventions that saves lives, and reduce morbidity should be developed such as the package of services for harm reduction and integrated package of health services for people who use drugs (viral hepatitis, HIV, TB, STIs). The department of Health to led on the interventions that saves lives and package of health services for people who use drugs (viral hepatitis, HIV, TB, STIs).

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Recovery and recovery management

Treatment for drug use disorders places emphasis on recovery, which includes recovery management and continuum of care. Recovery from drug abuse addiction is a process of change through which an individual achieves abstinence and improved health and quality of life.

A comprehensive program of recovery management should include the following elements:

Client empowerment
Ensuring that those in treatment participate fully in their treatment and recovery planning. In also means that people in recovery are included in the planning, design, and evaluation of the treatment programme.

Assessment
Assessment includes identifying both the problems and the strengths of individuals and their families. Recovery management is a strength-based model, so assessing strengths is a critical aspect of assessment.

Recovery resource development

Creating a full continuum of treatment and recovery support services. This includes linking personal, professional, and indigenous community resources into recovery management teams.

Recovery education and training

This refers to enhancing the recovery based knowledge and skills of individuals in recovery, their families, service providers, and the larger community.

Ongoing monitoring and support

This includes continued support and check-ups, and keeping minimal and periodic contact with former clients. Ongoing monitoring and support are part of a recovery oriented system of care.

Recovery advocacy

Advocating for social and institutional policies that counter the stigma and discrimination of service users, also advocating for systems that promote long-term recovery.

Evidence-based treatment and support services

Replacing less effective treatment and recovery support services with approaches that have a sturdier foundation of scientific support. Developing services that remove barriers to recovery and enhance individual’s recovery capital.

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Treatment setting

Treatment may be provided as an in-patient, outpatient or on a community-based treatment service. The type of service required by individuals is dependent on the nature, identified treatment needs and extent of their dependency on substances. Proper assessment is also critical for determining the type of treatment required by each service user and its duration. Since treatment for substance abuse is a specialised field, it should thus be provided by service providers who have recognised qualifications and who are registered with their respective professional bodies.

In-patient treatment should be provided as a residential service and out-patient treatment as a community-based service. Treatment services can either be voluntary or involuntary. There is, however, a belief that involuntary treatment is not effective. Therefore, on-going evaluation and impact assessments should be conducted to assess the effectiveness of treatment programmes.

Treatment duration

The duration of a treatment programme/period should be at least a minimum of three-four months/12- 16 weeks, and the extension of the duration for treatment will be based on the assessment and screening of service users to ensure their treatment needs are addressed holistically. This will ensure the standardisation and uniformity of the duration of treatment for public and private treatment centres.

The Treatment Centres Forum

The Policy also seeks to establish the Treatment Centres Forum (the Forum). The Treatment Centres Forum shall be composed of treatment centre representatives who are authorised and able to take decisions on behalf of their respective treatment centres.

The role of this forum shall be to identify areas for the improvement of treatment services in the country and to evaluate efforts to improve treatment. The forum shall also assist in ensuring that a tracking system – that monitors admission and readmissions in treatment centres – is fully effective and functional.

Reintegration and aftercare

Reintegration and aftercare services should be based on the following fundamentals:

- Evidence-based practices.
- Structured programmes.
- Involvement of family members and/or caregivers to facilitate successful reintegration.
- Addressing multiple needs and not merely substance abuse.
- On-going assessment and modification of aftercare plans where necessary in order to meet service users' changing needs.

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- Taking into account age, gender, religion, language and cultural elements of service users.

Reintegration
For effective treatment to be achieved, reintegration services should form part of treatment and service users' individualised treatment plans.

Reintegration services should address issues that may have contributed to service users' substance abuse and also mitigate structural and environmental factors that might negatively impact recovery. Reintegration services involving more than one service provider should be coordinated by a case manager in order to ensure proper management of service users' recovery process.

Aftercare
This service is critical for all service users who undergo treatment as it is intended to strengthen their capacity for recovery and thus prevent relapse.

A multi-disciplinary pre-assessment that includes a risk assessment should serve as a guide for referral to aftercare services. Aftercare should be provided as a community service and should include but not be limited to counselling, support services and skills development. Aftercare counselling should only be provided by professionals or trained and accredited service providers. Such services should be structured and progress thereof be monitored to determine efficacy.

Referral to aftercare services should take place prior to discharge from treatment. Service providers, who work within the communities in which service users reside, should be formally informed about progress of service users on treatment and also about their imminent discharge in order for them to ensure provision of aftercare services and monitor their recovery process.

On the other hand, treatment centres should also be provided with feedback about the prognosis of service users who have been discharged and undergone aftercare services in order to assess the effectiveness of their interventions. There should be clear referral systems in place for services users who lapse or relapse while receiving aftercare services.

After-hours programmes, dedicated trained personnel and infrastructure are some of the requirements that should be considered for provision of aftercare services.

Support groups should be established to provide support to service users who have completed treatment programme in order for them to maintain sobriety. Service users may be involved in support groups within their communities. Such support groups can be established by and run by volunteers.

The manager of a treatment centre may release and must release, if so directed by the director-general, an involuntary service user on discharge licence subject to such conditions as the manager may stipulate. Statutory/involuntary service users who

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have relapsed during aftercare services, should by all means remain in the community and be supported by means of out-patient services prior to revocation of their release/discharge licences from inpatient treatment centres. Voluntary service users should be motivated to seek further treatment.

10.3 Substance Use Treatment Quality

In high-income countries (HIC), performance measurement systems are widely used to monitor the quality of health services, identify targets for quality improvement, and evaluate activities intended to improve performance. Most of these systems rely on process data extracted from administrative databases, mainly due to the cost and inconvenience of collecting outcome data as well as evidence of certain process indicators (such as treatment engagement and retention) predicting outcomes. South Africa has lacked a system for monitoring substance use service quality, although the South African Medical Research Council has developed a performance measurement system for SA's Substance use treatment system known as the Service Quality Measures (SQM) initiative. It is important that measuring treatment service quality becomes part of a bouquet of service offered to people receiving substance use treatment services.

11. SUPPLY REDUCTION

Supply reduction is the responsibility of law enforcement. It aims at protecting the safety and assuring the security of individuals, societies and communities by intensifying efforts to prevent and counter the illicit cultivation, production and manufacture of and trafficking in narcotic drugs and psychotropic substances, as well as drug-related crimes and violence. Currently, there are 118 narcotic drugs, their preparations and 115 psychotropic substances listed in the UN Schedules of the 1961 and 1971 Convention, respectively.

The fundamental features of supply reduction are:

- Prevention of drug-related crimes.
- Effective drug-related crime prevention and law enforcement.
- Addressing links with other forms of organised crime, including money-laundering, corruption and other criminal activities.
- Promotion of comprehensive supply reduction efforts that include preventive measures addressing, inter alia, the criminal justice and socio-economic factors that may facilitate, drive, enable and perpetuate organised crime and drug-related crime.
- Monitoring of current trends and drug trafficking routes.
- Strengthening of coordinated border management strategies.

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Together with departments such as Department of Social Development, Department of Basic Education, and the Department of Transport, law enforcement agencies also play an integral role in terms of reducing drug demand in the country.

Law enforcement agencies are called to improve the availability and quality of statistical information. They are called to improve the analysis of illicit drug cultivation, production and manufacturing; drug trafficking; money-laundering and illicit financial flows. Quality statistical information should be submitted for inclusion in reports of the United Nations Office on Drugs and Crime and the International Narcotics Control Board, in order to better measure and evaluate the impact of such crimes and further enhance the effectiveness of criminal justice responses globally.

Supply reduction interventions for consideration related to alcohol:

- limiting the availability of alcohol; [reducing access]
- policing of public drinking;
- Improved labelling, and visibility of labels of alcohol products to include the standard drinks contained in the container:
    - List the caloric content;
    - improve warnings against drinking during pregnancy;
- censoring of advertising of alcohol and packaging/labelling (only permit advertising of factual information about product and not lifestyle);
- Industry to develop a system to track alcohol products back to source of sale/manufacture to prevent selling by unlicensed outlets and sale of counterfeit or illicit products. This needs to be coupled with compulsory ID presentation with all purchases to shift the retail culture and reduce sales to underage youth;
- Reduce drink-driving by enforcing a maximum blood alcohol chart levels for drivers of 0.02 g alcohol/100 ml of blood (or breath equivalent);

Supply reduction interventions for consideration related to tobacco that have an impact at the population level (Flor et al. 2021):

- Smoking and advertising bans
- Enhanced health warnings
- Increased tobacco taxes

12. ESTABLISHMENT AND REGISTRATION OF SERVICES, PROGRAMMES AND FACILITIES

Prevention, early intervention, in-patient, out-patient, aftercare programmes, halfway houses, services and treatment facilities (including those established by government) must be registered by DSD in terms of the prescribed legislation, before they can start operating. All treatment services that are established by government and others (e.g. DSD, local government, DoH, NGOs and NPOs) are to be registered. Once registered, such services, programmes and facilities should be monitored regularly to ensure compliance with registration requirements. No person may establish or manage any treatment centre maintained for treatment, rehabilitation and skills development of service users or in which such persons receive mainly physical, psychological, spiritual

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or social treatment unless such treatment centre is registered in terms of the prescribed legislation.

In order to effectively address the current problem of unregistered facilities as well as non-compliance with legislative provisions that inform registration, DSD should establish specialised units – at both national and provincial spheres of government – to assume responsibility for assessment, registration and ongoing monitoring of treatment centres and services.

Furthermore, DSD should determine conditions for registration and develop clear guidelines and penalties for non-compliance with legislative provisions. The legislated guidelines must also stipulate the period for which an application is made, process for registration, and turnaround period for a registration certificate to be issued. This will eliminate challenges that have been identified, such as applicants (in this case NGOs and NPOs, and private sector) having to wait many years for their registration application to be concluded.

The Department of Health, DSD and local government play a pivotal role in the registration of substance abuse treatment centres. The ministers responsible for the departments and organs of state that are mandated to ensure the provision of a suitable environment, and effective and efficient treatment services, must take reasonable measures within the scope of their line function and avail resources (monetary and human resources) to ensure the registration of treatment centres.

The Department of Health should ensure provision of, registration and monitoring of detoxification services and medical component services in all public drug treatment centres. DSD, DoH and local government should establish a registration 'team' at national, provincial, regions and local municipalities. Such a team is to consist of officials who are equipped to register and monitor drug treatment centres based on the minimum norms and standards required by each sector; this to be done on a quarterly basis.

Reporting and provision of statistics for drug use and treatment services

All services that are registered in terms of the prescribed legislation must provide services users' admission and discharged statistics and reports on a monthly basis to the Provincial DSD. Provincial DSD is also then mandated to send the provided statistics to the National DSD office bimonthly. DSD should also identify a legal structure that should be responsible for accreditation of programmes and services. To ensure standardisation of the duration/period of drug use treatment, the duration of treatment programme/period should be at least a minimum of three months/12 to 16 weeks, and the extension of the duration for treatment will be based on the assessment and screening of service users to ensure their treatment needs are addressed holistically.

Provincial DSD must provide quarterly statistics to National DSD. These statistics must stipulate the number of established, disestablished, assessed, registered, and

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monitored services (prevention, early intervention, in-patient, out-patient, aftercare programmes, halfway houses, and treatment facilities).

All services registered under the prescribed legislation on substance abuse shall be mandated to participate in the data collection surveillance system, the drug epidemiology surveillance system will be used to measure the extent, nature and impact of substance use in the country.

Research and information management

Research and information management are critical elements for the development of evidence-based policies and programmes. The international standards on drug prevention clearly indicate that an effective national drug prevention system should be evidence- based and should be chosen on the basis of an accurate understanding of what the situation really is (UNODC: 2015).

South Africa is well resourced in terms of institutions that are conducting research in the field of substance abuse. However, accessing this research information is a challenge because there is no centralised information management system. Secondly, some research institutions are not funded by DSD and are thus not obligated to conduct research that is relevant to the sector. Without relevant research, it becomes difficult to develop policies and programmes that are responsive to sector challenges.

In order to address the afore-mentioned challenges, *the Policy* is advocating that DSD should fund research institutions where there is a need. By doing so, the department will be in a position to influence the research agenda of the identified institutions and have data sources for the development of responsive policies and evidence-based programmes.

DSD should also facilitate the development of and maintenance of a national information management system where relevant local and international research information on substance abuse can be stored. Such system should be searchable, include a variety of fields and be accessible to all service providers within the sector. Accessibility of research information would enable service providers to monitor substance abuse trends and thus ensure that their programmes respond to those trends. In support of the above Burnhams, N. H., et al. (2011) indicated that the provision of accurate, in-depth data on substance abuse trends and service needs has become increasingly important in light of the growing wave of substance abuse in South Africa.

Furthermore, provision of statistical data by organisations that provide substance abuse services should become one of the requirements for registration by DSD. This will enable DSD to have access to information on substance use and abuse trends as well as the level of accessibility of these organisations by communities.

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Capacity building, accreditation, and specialisation

Provision of substance abuse services and programmes requires specialised knowledge and skills. Training on substance abuse should be mandatory for all service providers in the field of substance abuse. DSD in consultation with the CSOs should therefore develop an integrated capacity building plan for all categories of service providers including social workers, addiction counsellors, lay counsellors and volunteers. The capacity building programme should include basic training on substance abuse. An accreditation policy should be developed by DSD to facilitate accreditation of training on substance abuse and service providers.

A number of organisations also utilise volunteers and lay counsellors to provide outreach and prevention programmes. Some of these service providers do not have any form of relevant training and others are themselves service users in recovery. As a result, such service providers may do more harm than good to recipients of services. DSD should address this problem by developing practice guidelines, norms and unit standards for training of such service providers. The unit standards should be developed in consultation with the South African Qualifications Authority (SAQA), the South African Council for Social Services Professions (SACSSP) and institutions of higher learning.

Institutions of higher learning should include specific training modules on substance abuse in their undergraduate curricula. Post-graduate programmes should also be provided by institutions of higher learning so that social workers who are already in the field may attend these programmes in order to improve their expertise. Experience in providing prevention and treatment services should be considered in order to determine the level of training that each service provider requires. Continuous professional development (CPD) points should also be aligned to any accredited training that service providers attend.

Substance abuse should be declared a specialised field of practice. The South African Council for Social Service Professionals should be involved in the process of declaring substance abuse a field of specialisation in order to guide DSD with regard to requirements thereof. Furthermore, the council should also facilitate regulation of other categories of service providers, such as addiction counsellors. This is intended to ensure that all service providers are subjected to the council's regulations, monitoring and disciplinary procedures.

DSD should also develop norms and standards for all levels of substance use prevention and treatment to ensure provision of quality services. Guidelines are to be developed to regulate treatment fees for all treatment centres in order to ensure accessibility of services and value for money in the continuum of care.

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13. INSTITUTIONAL ARRANGEMENTS

Restructuring and governance

DSD is the lead department in the field of substance abuse. However, the department provides substance abuse related services through partnerships with various stakeholders, namely other relevant government departments; non-government organisations, faith-based organisations and community-based organisations.

In addition to the afore-mentioned stakeholders, there are structures responsible for advisory and coordination of services aimed at addressing substance abuse, namely the Alcohol and Drug Advisory Council of South Africa (ADAC-SA) previously known as the Central Drug Authority (CDA), provincial drug action forums and local drug action committees.

13.1 ALCOHOL AND DRUG ADVISORY COUNCIL OF SOUTH AFRICA (ADAC-SA)

ADAC-SA will consist of 9 expert members, national civil society organisations and such other members as contemplated in the attached proposed structure.

The ADAC-SA Secretariat will be elevated into a directorate level within the Department of Social Development. This repositioning of the body formerly known as CDA will strengthen and improve its functioning and accountability so as to eventually execute its mandate appropriately.

This model would then entail the setting up of a directorate secretariat consisting of one director, two deputy directors and two assistant directors tasked with the responsibility of coordinating the objectives of the National Drug Master Plan (NDMP) at national, provincial and local level. Each of the two deputy directors and assistant directors suggested for this structure will be allocated provinces to coordinate and coordinate national departments responsible for combating of Alcohol, Tobacco and other Drugs in the country.

It is further recommended as part of this structure that the ADAC-SA then have a secretariat and administrative support staff in each province, headed by a deputy director to support the national directors operationally. The director of ADAC-SA Secretariat will provide reports from time to time to the Technical Committee for the Social Cluster.

Below is the illustration of the oversight and reporting structures

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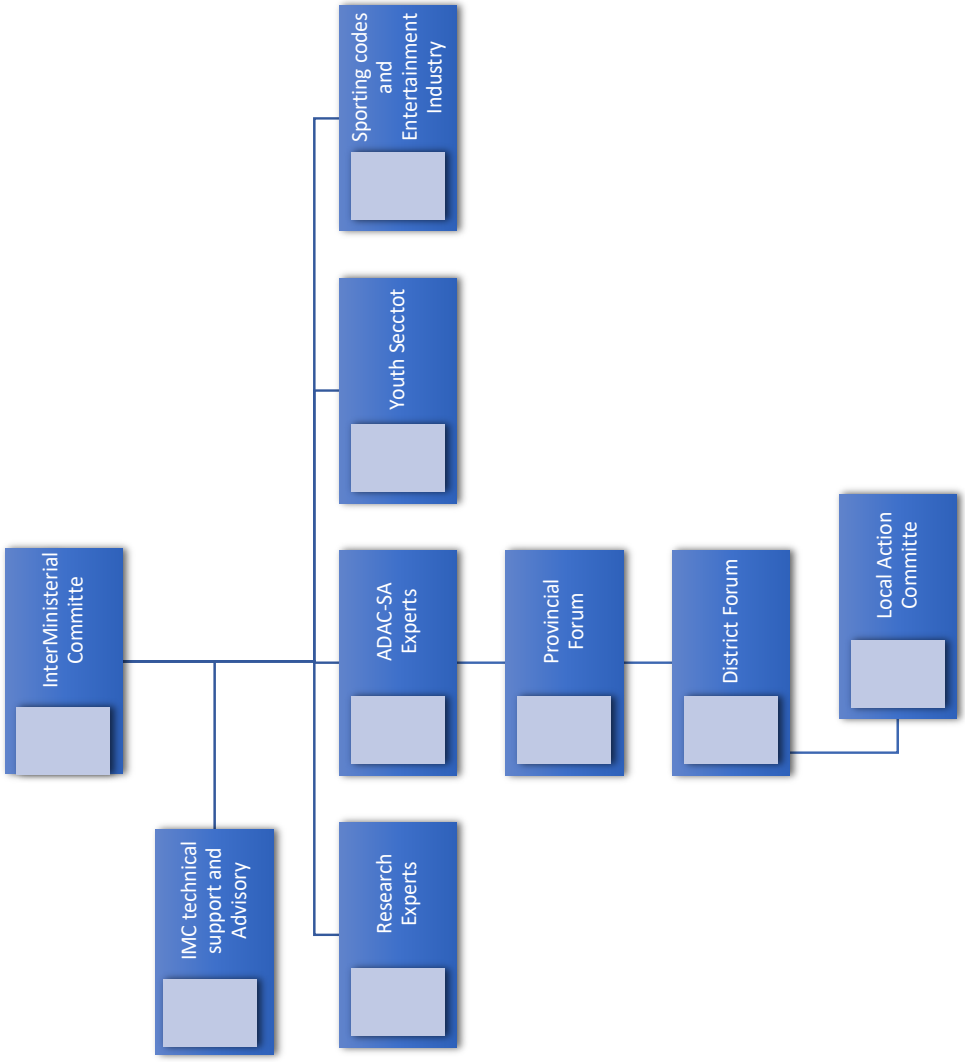
Figure 5: Institutional mechanisms: Alcohol and other Drugs Advisory Council of South Africa



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14. THE REPORTING MECHANISMS

14.1 Governance and accountability: The ADAC -SA

The ADAC-SA will be established in terms of the prescribed legislation. Hence the duties and functions of the ADAC-SA will be determined by legislation. The ADAC-SA term of office will be five (5) years in line with the National Drug Master Plan duration. The ADAC-SA term will also be linked to the government's Medium Term Strategic Framework (MTSF) cycle, to ensure that financial resources are aligned.

The ADAC-SA executive members will be appointed to consist of Technical Committee chairpersons (deputy director-general) of each relevant cluster department based on their mandate/and or (not lower than chief director level) from clusters (Social Protection, Community and Human Development cluster, Justice Crime Prevention and Security cluster, Economic Sectors, Employment and Infrastructure Development cluster); nine (9) experts with extensive knowledge in the field of substance abuse; GBV coordinating structures chairperson, appointed research institutions representatives, Higher Health (formerly HEAIDS) and SAHPRA. The ADAC-SA extended meetings will include 9 provincial forum chairpersons, the youth sector, Departmental technical Team Representatives/Government officials not lower than Director Level; and nominated national civil society organisations.

The ADAC-SA Chairperson must be accountable and report from time to time to the Minister of Social Development and the ‘IMC for Combating Substance Abuse’.

ADAC-SA expert group members must meet the following criteria:

- Members must have qualifications in social sciences, medical field, public health, theology, law, and education.
- Members must have an under-graduate degree and relevant experience in one of the following areas in the field of substance abuse:
  - research;
  - treatment services;
  - prevention services and early intervention services;
  - law enforcement;
  - medico-pharmacology;
  - monitoring, evaluation and impact assessment; and
  - aftercare and reintegration services.
- Members must have special knowledge and experience in the field of combatting substance abuse.
- Members must have a proven record in the field of drug use and abuse.
- Potential candidates must be South African citizens.

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Security clearances are to be conducted on qualifying candidates before recommendation by the Parliamentary committees and appointment by the Minister of Social Development.

In the government sphere of operation, there should be cluster departments and a substance abuse technical committee to support the relevant ministers responsible for combatting substance abuse.

These technical members shall form a forum that will drive day-to-day tasks aimed at combatting all substance abuse in South Africa.

14.2 Provincial Drug Action Committee/Forums (PDAF)
The PDAFs will operate at provincial level. They will establish secretariats and be well resourced. The PDAFs will develop individual provincial master plans in accordance with the National Drug Master Plan. Each PDAF will provide reports on a quarterly basis to the ADAC-SA. The provincial DSD will provide resources to the PDAFs.

14.3 District Drug Action Forums
The district forums will operate at the district/regional level of government. The main function of the district forums is to coordinate efforts of local drug action committees in a specific district. The district DSD will provide resources to the district forums.

The District Development Model is established in order to respond to the call by the President of South Africa. Each district is to align and integrate drug use and abuse delivery services under a single drug plan per district in accordance with the National Drug Master Plan.

14.4 Local Drug Action Committees (LDACs)
The LDACs will operate at municipal level. Members of the LDACs will be vetted and then provided with the necessary resources. The LDACs will develop individual action plans in accordance with the National Drug Master Plan (NDMP). Each LDAC will provide reports on a monthly basis to its respective PDAF. They will draw up an action plan and implement it at local level. Local municipalities are to provide resources to the LDACs.

15. STAKEHOLDER ENGAGEMENTS

In addition to the afore-mentioned coordinating structures, other government departments and stakeholders will be responsible for implementation of activities related to demand, supply and harm reduction.

The Policy recognises that the Department of Social Development delivers substance-related prevention and treatment services through partnerships with (i) provincial departments of social development; (ii) national and provincial departments of health; of justice and correctional services; safety and security; labour; sports and recreation; transport; trade, industry and competition; education; as well as SAPS, SAPHRA, organs of civil society such as non-government organisations, faith-based

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organisations, and community-based organisations. The partnerships are reflected on *the Policy*.

Department of Social Development

The Department of Social Development is one of the main departments that have a mandate to ensure the provision of effective prevention of and treatment for substance use disorders.

DSD is to develop an effective national drug prevention system consisting of various programmes. The prevention programmes should promote the well-being of society as a whole through the elaboration of effective scientific evidence-based prevention strategies that are centred on and tailored to the needs of individuals, families and communities on a non-discriminatory basis. DSD should work in collaboration with the departments of health, education and law enforcement when developing prevention initiatives.

The development of a substance abuse proactive prevention responses at national, provincial and local level are essential, and should be done through a strategic planning process. This process should be based on the results of a comprehensive needs assessment and information collection system.

DSD is also the lead department with regards to the registration of drug dependency treatment facilities and programmes. DSD should ensure the establishment of effective, scientific evidence-based drug treatment and rehabilitation programmes, including community-based programmes. The capacity of aftercare programmes, recovery and social reintegration of individuals with substance use disorder should be strengthened.

The DSD should:

- develop a comprehensive legislative and policy framework on substance abuse;
- ensure the development of a national strategy addressing substance abuse (NDMP);
- develop drug use prevention, early intervention, treatment and aftercare programmes;
- provide capacity building of stakeholders and service providers on legislation, policies and programmes;
- monitor and evaluate implementation of legislation, policies and programmes;
- develop and review norms and standards for prevention, early intervention, treatment, aftercare and reintegration in the field of drug use and drug abuse;
- establish public treatment centres;
- conduct 5 yearly national household surveys to monitor the prevalence of AOD use in the country;

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- provide funding for both prevention, treatment and aftercare to NGOs to implement drug use related programmes - granted that evidence based programmes are followed and service quality is measured; and
- liaise with national, regional and international organisations on substance abuse related matters.

DSD should work in collaboration with the Department of Health (DoH) in the provision of comprehensive, evidence-based treatment services. Although DSD is a lead department in the registration of drug dependency treatment facilities, DoH is also pivotal in the registration of such facilities. The Minister of Health is responsible for the assessment of, and registration of medical component services which include detoxification services in all treatment centres. As such, the Department of Health should ensure provision of, registration and monitoring of detoxification services and medical components services in all public drug dependency treatment centres.

The DSD, DoH and local government should establish a registration 'team' at national, provincial, regions and local municipalities. Such a team should ensure that officials are equipped to register and monitor substance use treatment centres based on the minimum norms and standards required by each sector. Registration and monitoring should be conducted on a quarterly basis.

The DSD should ensure that the relevant departments are informed about the application for registration of a programme, community-based services, inpatient, outpatient as well as halfway houses. DSD to advise the relevant departments and ensure the commitment of appropriate departments through informing the relevant ministries about the received application for registration. The application has to be assessed within 90 days of receipt and within that period the organisation/applicant should be informed about the results of the assessment for registration. Delays to conclude registrations should be avoided at all costs. The maximum timeframe to issue a final decision on the assessment for registration by DSD, DoH and local government is five (5) months, and not longer than five (5) months.

Department of Health

The Department of Health (DoH) is responsible for demand and harm reduction strategies. The DoH should develop and enforce legislation and policies aimed at reducing demand and harm caused by psychoactive substances including detoxification protocols.

The DoH should consider the development of effective measures aimed at minimising the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes, and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other blood-borne diseases associated with drug use.

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DoH should also collaborate with departments of basic education, of higher education, science and technology, and of social development in the provision of prevention, early identification and treatment services.

The Department of Health must put measures in place to deal with marketing and advertisement of alcoholic beverages.

Harm reduction interventions

The package of interventions recommended by WHO and UNODC should be provided to people who use and inject drugs, to reduce mortality and morbidity related to overdose and infectious diseases (WHO 2016). The department of Health to led in the provision of other harm reduction co-packages such as:

- Overdose prevention and management
- OST programmes
- Sexual and reproductive health services
- Non-abstinence focused low threshold community-based and run services for people who use drugs

Department of Sport, Arts and Culture

The department should develop a strategy for preventing drug use and abuse among occupational groups, with a particular emphasis on the risks associated with the environment within which they operate. The department should also use sport, arts and cultural activities as a platform to prevent use of illicit substances.

Furthermore, the department should develop and implement policies and strategies to prevent and detect use of substances that artificially enhance performance in sports. The department should conduct research and collaborate with international anti-doping organisations to harmonise and improve doping control standards and practices.

The department should also foster partnership with the Department of Basic Education to counter substance abuse in sport among school-going children.

Department of Basic Education

The department should develop and implement policies and strategies to combat substance use and abuse in schools. Moreover, the department should ensure integration with other relevant stakeholders and include issues related to alcohol and other drug use and abuse to form part of the curriculum.

Full-time therapeutic professional staff should be appointed in schools and educators should be capacitated on issues related to substance use and abuse.

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Department of Cooperative Governance and Traditional Affairs
The department should ensure active participation of local government and traditional authorities in the fight against alcohol and other drug use and abuse within communities.

Department of Higher Education, Science & Innovation
This department should develop and implement policies and strategies to prevent use and combat alcohol and drug use and abuse within institutions of higher learning. All levels of intervention should be made available at institutions of higher learning. This department should also ensure that institutions of higher learning provide specialist training for service providers in the field of substance abuse. There must prohibition of establishment of liquor outlets in institutions and premises of higher learning.

Department of Correctional Services
The department must manage drug use and misuse in prisons through security strategies to prevent drugs entering the correctional centres. It must focus on reducing the demand for drugs and reduce the harm caused by drugs in prisons through educational programmes and recovery programmes for inmates suffering from substance use disorder.

The Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008) currently places on treatment centres the responsibility of ensuring the safety and security of offenders who require treatment services. This poses a risk because treatment centre managers are not equipped to deal with security issues and such provision is in conflict with security-related legislation. The Act also falls short of categorising offenders to be transferred to treatment centres and therefore poses a security risk for the state. Therefore, the Department of Correctional Services has to develop measures for the treatment of substance use disorders within the prison setting. Treatment facilities are to be established within the correctional service system/setting for the treatment of prisoners/inmates.

The department is to formulate guidelines for the prevention of and treatment for substance use and abuse in correctional facilities. It is also mandated to reduce the demand for and supply of illicit drugs on its premises.

Department of Justice and Constitutional Development
In terms of demand reduction, the department (through the criminal justice system) refers offenders that require drug-related treatment to treatment through a variety of mechanisms. These mechanisms include diverting persons in need and non-violent offenders to treatment programmes, instead of letting them go through the court system.

South African Police Services
SAPS leads law enforcement activities pertaining to prevention, supply reduction and combatting drug related offences. The SAPS budget includes five key departmental programmes, namely Administration, Visible Policing, Detective Services, Crime

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Intelligence, and Protection and Security Services. All five programmes provide for drug demand and supply reduction strategies.

The objective of policing, in terms of the Constitution of the Republic of South Africa, 1996, is to:

- prevent, combat and investigate crime and illicit trade in alcohol;
- maintain public order;
- protect and secure the inhabitants of the republic and their property; and
- uphold the law.

SAPS also plays an integral role in terms of drug demand reduction in the country in a joint effort with other departments such as Department of Social Development, Department of Basic Education, and the Department of Transport.

This Policy seeks to address the transfer of involuntary service users from court to a designated treatment centre as per court order. In cases where service users are to be transferred to a designated treatment centre and such persons pose a risk to self-harm or harm of the transporting officer, the transporting officer must request the escorting services of the SAPS.

The intention therefore is to mandate SAPS through a legislative provision in the same context as in section 40 of the Mental Health Care Act through the intended amendment to undertake the task of transfer/escorting of the service user from court to a designated treatment centre. The assessment of the condition of the service user regarding the potential risk of harm shall be the determining factor as to whether transfer or escorting by the SAPS is desirable under the circumstances.

Department of Labour
This department should develop, monitor and evaluate implementation of workplace policies on substance abuse. The department should also form partnerships with other stakeholders in the field of substance abuse, in providing skills development programmes.

National Youth Development Agency
The National Youth Development Agency (NYDA) should assist government to plan comprehensive youth development policies which include among others alcohol and drug use and abuse, and related issues.

Department of Trade, Industry and Competition
The Department of Trade, Industry and Competition needs to regulate the restriction and limitation in terms of issuing liquor licenses and to reduce the availability of alcohol, especially in residential areas. According to the Medical Research Council, there is a liquor outlet for every 190 persons in South Africa, and the overall prevalence of alcohol abuse is likely to be as much as 30% among certain groups.

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The department administers the Liquor Product Act and its related policy. It must regulate the manufacturing, distribution of liquor products through the National Liquor Authority. The socio-economic cost of alcohol use disorders are huge on an individual, from loss of employment to chronic diseases that can lead to fatalities.

Alcohol abuse has been reported to have an impact on the risk or prevalence of violence against women and children. Physical, sexual, emotional and economic violence have been reported to be the types of violence directed to women and children. Alcohol related deaths and road traffic injuries are a leading cause of preventable death in South Africa.

The Department of Trade, Industry and Competition must not issue liquor licences in areas where liquor outlets are already in existence (this will curb the density of liquor outlets) and must shorten alcohol trading hours. The department should also consider the following:

- Increasing the age of purchasing and consuming of alcohol from 18 to 21 years.
- Placing a partial ban on marketing of alcohol beverages.
- Reducing the size of alcohol containers to smaller containers.
- Introducing uniform trading hours for alcoholic drinks.
- Closing liquor outlets located near schools.

The World Health Organisation (WHO: 2010) global strategy to reduce the harmful use of alcohol proposed the implementation of strategies to improve the health and social outcomes for individuals, families and communities. The global strategy focuses on 10 key areas of policy options and interventions at the national level.

The 10 areas for national action are:

- Leadership, awareness and commitment.
- Health services' response.
- Community action.
- Drink-driving policies and countermeasures.
- Availability of alcohol.
- Marketing of alcoholic beverages.
- Pricing policies.
- Reducing the negative consequences of drinking and alcohol intoxication.
- Reducing the public health impact of illicit alcohol and informally produced alcohol.
- Monitoring and surveillance.

South Africa as a member state of the WHO is called to adopt the above, in order to reduce the negative health and social consequences of the harmful use of alcohol.

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Department of Transport
The department should develop and enforce legislation and strategies to regulate consumption of substances by road users including drivers and pedestrians. The department should also capacitate educators on road safety so they can be in a better position to impart knowledge regarding road safety to learners.

Currently, the allowed legal blood alcohol limit for driving is less than 0.05g per 100ml of blood. The legal breath alcohol limit is less than 0.24 mg in 1 000 ml of breath.

The Department of Transport must consider reducing the legal limit for drinking and driving to a blood alcohol content to a lower level e.g. of 0.02% or below, taking into consideration that certain prescribed medication has some limited alcohol content.

South African Medical Research Council (SAMRC)
The Medical Research Council should conduct ongoing research on new psychoactive substances which are not controlled through international conventions, report findings to the ADAC-SA, as well as advocate for control of these substances.

Civil Society Organisations
Civil society organisations should conduct research in the field of substance abuse and advise government about alcohol and other drug abuse trends in order to influence policy development. They should capacitate community service providers to deal effectively with drug use and abuse problems, as well as provide a wide range of drug abuse related services to individuals, families and communities. Civil society organisations should also organise themselves into forums that go on to participate in provincial drug action forums and local drug action committees.

Communities
Community members should actively participate in the fight against alcohol and other drug use and abuse through their involvement in existing community structures that have been established for this purpose.

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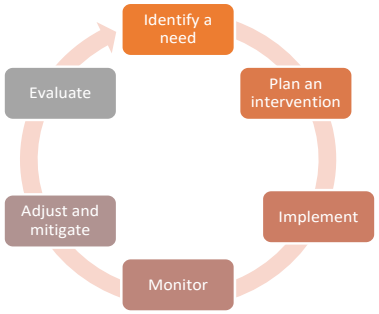
16. MONITORING AND EVALUATION

Monitoring and evaluation is a process, as depicted in figure 7, that helps improve performance and achieve results. The implementation plan and monitoring and evaluation framework for this Policy is attached as an annexure.

Figure 6: Monitoring and Evaluation Process



The DSD should monitor and evaluate progress and achievement with regards to implementation of *the Policy* on an ongoing basis. As part of monitoring, DSD should design and develop a monitoring system that would enable it to collect data on substance abuse services. In addition, qualitative and quantitative data collection methods should be implemented to evaluate outcomes and impact of interventions. When monitoring and evaluating programmes, M & E should extends beyond number of people reached to the quality of service provided to those reached and that should form the cornerstone of this policy M& E system.

Focus areas

Monitoring and evaluation should focus on the following areas:

- Access to services including barriers to service utilization and service coverage.
- Quality of services rendered and implementation of best-practices.
- Compliance with prescripts of legislation, policy and norms and standards.
- Capacity building of service providers.
- Monitoring of Provincial Drug Forums, District Forums and Local Drug Action Committees in terms of implementing the NDMP, progress and achievements.
- Resource allocation for substance abuse services.

The monitoring and evaluation framework for this policy is attached as **Annexure A.**

The purpose of the M&E Framework is therefore to develop a Theory of Change with logical framework and appropriate indicators for the different outputs and outcomes and stakeholders participating in the implementation of the Policy that can be used to collect data needed to:

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Guide the planning, coordination and managing of the implementation for the prevention of and treatment for substance use disorders.

Assess the effectiveness of:

- Access to services including barriers to service utilization and service coverage,
- Quality of services rendered and implementation of best-practices;
- Compliance with prescripts of legislation, Policy and norms and standards;
- Capacity building of service providers and;
- Resource allocation.
- Identify areas for improvement
- Assess if the interventions are making a difference
- Measure outcomes and impacts

17. OVERSIGHT STRUCTURES

Cabinet
Cabinet is one of the important organs of state in terms of policy making as well as monitoring implementation thereof. Through cabinet committees such as the Portfolio Committee for Social Development, Cabinet should advise DSD on the development of policy for addressing drug abuse and monitor implementation thereof to ensure effective service delivery.

National Council of Provinces
The National Council of Provinces (NCOP) as a structure that represents provincial interests should be responsible for monitoring relevant national and provincial departments for their effectiveness in combating substance abuse.

Ministers and members of executive councils
Ministers and members of executive councils of departments that have a role to play in combatting alcohol and drug abuse should monitor implementation of *the Policy* in accordance with their departments' mandates.

Alcohol and Drug Advisory Council of South Africa
The Alcohol and Drug Advisory Council of South Africa (ADAC-SA) should monitor implementation of *the Policy* by stakeholders to ensure that services are implemented in an integrated and collaborative manner. The ADAC-SA will be appointed in terms of the legislation and should also report to Cabinet on activities and progress made by various implementing structures.

Government departments
The Director-General of DSD should take a lead in monitoring implementation of *the Policy* since DSD is the lead department in the field of the prevention of substance abuse and treatment for substance use disorder. The directors-general of other

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relevant departments should also monitor implementation of *the Policy* in accordance with their departmental functions.

18. CONCLUSION

The rapid escalation of substance use in the country and changing trends in drug markets has necessitated the Department of Social Development to develop a policy that would enable the social development sector to better address these challenges.

Implementation of this policy on prevention of substance abuse and treatment for substance use disorder requires increased commitment from all the relevant stakeholders as the problem of drug abuse is cross-cutting and thus cannot be dealt with by any one entity.

There is also a need to maximise resources in order to ensure that this policy is effectively implemented. This policy should be translated into programmes that would enable the country to effectively deal with the harm caused by alcohol and other drug use and abuse.

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20. APPENDIX: NARRATIVE FOR FIGURE 6

Inter-Ministerial Committee (IMC) on combating substance abuse

The IMC provides political leadership for the overall response to substance abuse. The IMC will be chaired by the Minister responsible for Social Development. The IMC will meet as determined by the committee.

Objectives of the IMC

- To provide political leadership in response to the scourge of substance abuse.
- To provide strategic direction and leadership on demand reduction, supply reduction and treatment of Substance Use Disorders.
- To coordinate efforts related to combat substance abuse in the country.

Membership and Composition of IMC

Membership of the IMC will be determined by the president taking into consideration issues relating to supply reduction, demand reduction and treatment of substance use disorders.

Department Cluster Chairperson shall serve as advisors of IMC from the government sectors.

ADAC-SA experts: executive Chairperson and Deputy Chairperson plus 2 EXCO members shall provide technical advisory expertise to the IMC.

Cluster Departments

Clusters foster coherent and integrated measures to address the scourge of substance abuse. There are basically 5 clusters in government. This policy relates to only 3 clusters namely: JCPS, SPCHD and ESEID. The clusters to put the agenda addressing alcohol and other drugs as a standing item in the meetings.

Objectives of the Clusters

The main functions of the clusters are to ensure the alignment of government-wide priorities, facilitate and monitor the implementation of alcohol and other drug abuse programmes. The objective is to ensure proper coordination of all drug use and abuse government interventions. To provide a consultative platform on cross-cutting drug abuse priorities and matters being taken to Cabinet.

Membership and Composition

CLUSTER1: Justice, Crime Prevention and Security Cluster

The following are the departments within the JCPS Cluster that have a mandate to address substance abuse:

- Correctional Services
- Defence and Military Veterans
- Justice and Constitutional Development
- Home Affairs
- Police

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- State Security

CLUSTER 2: Social Protection, Community and Human Development

The following are the departments within the SPCHD Cluster that have a mandate to address substance abuse:

- Arts and Culture
- Basic Education
- Cooperative Governance and Traditional Affairs
- Health
- Higher Education and Training
- Labour
- Social Development
- Sport and Recreation
- Transport
- Women

CLUSTER 3: Economic Sectors, Employment and Infrastructure Development

The following are the departments within the ESEID Cluster that have a mandate to address substance abuse:

- Agriculture, Forestry and Fisheries
- Cooperative Governance and Traditional Affairs
- Economic Development
- Finance
- Higher Education and Training
- Labour
- The Presidency: Planning, Performance Monitoring and Evaluation
- Transport

Technical Committee

The main purpose of the Technical Committee is to provide technical advice to the clusters on drug abuse related matters. The Technical Committee shall meet at least once a month. The objective is to implement interventions in a coordinated manner and report to the Clusters. Relevant Ministers shall appoint Government representatives not lower than the Director Level to serve on the Technical Committee.

Special Group

The purpose of the special group is to serve as a platform to address issues of alcohol and other drug use and abuse amongst youth, artists and athletes from various sporting codes. .

Alcohol and Drug Advisory Council of South Africa (ADAC-SA)

The purpose of the ADAC-SA is to advise the 'IMC' on issues pertaining to substance abuse. The group will be responsible to set research agenda for the country and

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advise the IMC on matters pertaining to alcohol and other drug abuse (AODs). The ADAC-SA will meet at least once a quarter.

Membership and Composition

The ADAC-SA shall consist of 9 experts in the field of substance abuse, 3 chairpersons of Cluster departments/ and or Chairpersons of Clusters' technical committee for combating drug abuse, Chairperson of GBV coordinating structures, Research Institutions, HIGHER HEALTH (formerly HEAIDS) and SAHPRA. The Minister of Social Development shall appoint members of ADAC-SA based on the recommendation of, by the Portfolio Committee on Social Development.

ADAC-SA shall establish its executive committee and appoint its chairperson from the experts during its first meeting after appointment. ADAC-SA shall meet at least once a quarter.

The ADAC-SA experts' group members must have an under-graduate degree and relevant experience in one of the following areas in the field of substance abuse: research; treatment services; prevention services and early intervention services; law enforcement; medico-pharmacology; monitoring, evaluation and impact assessment, and aftercare and reintegration services.

Furthermore, members must have special knowledge and experience in the field of combating alcohol, tobacco and other drugs abuse; a proven record in the field of drug use and abuse and be a South African citizen.

A potential candidate who used drugs previously must provide three letters from different psychiatrists that proved that he/she has been rehabilitated and maintained recovery for three years or more. A security clearance will be conducted on candidates before recommendation by the parliamentary committees and appointment by the Minister of Social Development.

Provincial Drug Action Forum 'Chairperson's forum'

The Provincial Chairpersons shall represent the provincial forum members in the Alcohol and Drug Advisory Council of South Africa (ADAC-SA). Chairpersons of the provincial forum will form part of the extended ADAC-SA meeting.

Provincial Committees/forums

The PSAF will operate at the provincial sphere of government. It will establish secretariat and be well resourced. The PSAF will develop its Provincial Master Plan in accordance with the NDMP 2019 – 2024 Action Plan. Each PSAF will provide reports on a quarterly basis to the Alcohol and Drug Advisory Council of South Africa (ADAC-SA). The provincial DSD will provide resources to the PSAF. Members of the provincial substance abuse forum shall be reimbursed to attend meetings in accordance to the National Treasury regulations.

District forum

The district forum will operate at the district/regional level of government. The main function of the district forum is to coordinate efforts of local action committees in a specific district. The district DSD will provide resources to the district forum.

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Local Drug Action Committee

The LDACs will operate at municipal level. The LDAC will develop its Action Plan in accordance with the NDMP Action Plan. Each LDAC will provide reports on a monthly basis to the PSAF. They will draw up an action plan and implement it at local level. LDAC should be well resourced in order to coordinate local efforts and address the substance abuse problem.

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