OVERVIEW OF SOUTH AFRICAN DRUG REGULATION, LEGISLATURE, AND KEY REGULATORY BODIES[1]

Please Note:
This overview is compiled from teaching and research notes, drawing on source materials verbatim. This is purposefully done, so as to highlight the discursive frameworks on which these regulations draw. Please do not directly cite or quote from this document, but rather from the original source materials.

HISTORICAL BACKGROUND:

With the opening of South Africa's borders after the 1994 election, the drug scene radically changed, partly due to the introduction of new role players and markets.[2] The reintroduction of South Africa to the international stage brought about a tremendous increase in incidence of drug trafficking, vehicle theft, and hijacking, many of which can be linked to organised crime syndicates that have been found operating within the country.[3]

The potentially huge profits of the drug trade are presently encouraging an increasing number of criminals who are involved in more orthodox crimes such as robbery, extortion, gambling and prostitution, to extend their activities to drug trafficking on both a national and an international scale. This is already having serious social and security implications for South Africa and its neighbours, and the resulting disorder is capable of creating mass anxiety, which rarely is without political consequence.[4] South African society is characterised by high levels of poverty, unemployment and crime. Lack of opportunities in most disadvantaged communities compelled many youths to become involved in the illicit drug market. Drug dealing offers a simple and easy, albeit an illegitimate, way to wealth. It provides employment for those who are unemployed and under-educated. Because of the low level of skills and resources needed to enter the market, there are many candidates.[5]

LEGISLATION:

Much has been done on both a legislative and operational level to bolster the state's capacity to fight drug trafficking. Since 1995, various administrative and legislative measures have been introduced by the police and justice sectors that aim to improve the ability of the country to reduce the supply of illicit drugs and to apprehend drug dealers and traffickers. [6]

The following legislation has been enacted since 1992. All legislative prescriptions are copied verbatim.

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[2] Haefele, B. n.d. *Drug Trafficking in South Africa: Does the State have the Capacity to Counter the Potential Security Threat?* Centre for Military Studies, university of Stellenbosch: 107.
[3] Blackmore, F. 2003. A Panel Data Analysis of Crime in South Africa. *South African Journal of Economic and Management Sciences.* 6(3): 439.
[4] Haefele. n.d: 106.
[5] Haefele. n.d: 107.
[6] Haefele. n.d: 110-111.

The Drugs and Drug Trafficking Act 140 of 1992

What kinds of actions are considered illegal?

No person shall be allowed to:

- Manufacture and supply scheduled substances, which are substances used in the unlawful manufacture of drugs.
- Use or possess any substance which produces a dependency. The Act allows for a number of exceptions however. These are as follows:
    - the person is a patient and has received the substance from a medical practitioner as part of a medical prescription
    - They acquired or bought the substance for medical purposes.
    - They legally entitled to use or deal in such substances in his professional capacity e.g. as a dentist, vet, nurse, or pharmacist.
    - They are an employer of a person legally entitled to use or deal in such substances, and therefore does so as part of his professional duties.
    - Deal in drugs, or any substance that produces a dependency. The same exceptions apply to this law as those listed above.
    - Provide false information to the police related to a drug offence or hinder in any way a police investigation into a drug-related offence.

What information must be reported?

A person has a legal duty to disclose to a legal authority any information related to a drug offence. This duty overrides any rule or law which prohibits him from revealing information related to the business or affairs of another person.

If the owner or manager of a place of entertainment has reason to suspect that any person in that place has drugs in his possession or is dealing in drugs, he must report his suspicion to the police as soon as possible. If requested, he must also provide information about the person concerned to the police.

If any stockbroker or financial trader has reason to believe that property he has received from another person is involved in some kind of drug offence, he must report his suspicion as soon as possible to the police or legal authority. This duty overrides any obligation to secrecy.

How should investigations be conducted?

If a police officer has reason to suspect that drug-related offence has been committed, he has the power to search any premises, vehicle, vessel or aircraft which is suspected to contain the illegal substance. By the same measure, if a police officer suspects that any person has committed a drug-related offence, he has the power to search that person and to examine anything in that person's possession. A woman, however, may only be searched by a woman.

If a police officer suspects that any article which has been sent through the post contains an illegal substance, he may intercept that article and examine its contents. A police officer has the power to question any person who might be able to provide information about a drug-

related offence. He also has the power to examine any register, record or document and to make a copy of it, in the course of investigating a drug-related offence.

If a magistrate receives information given under oath which leads him to believe that a person has withheld information related to a drug offence, he may issue a warrant of arrest for that person. Such a person will then be sent to a place of interrogation where they will be detained until the magistrate orders their release. They will be brought before the magistrate within 48 hours of their arrest, and thereafter, not less than once every ten days.

What are the penalties for drug-related offences?

Any person who:

- Obstructs or fails to cooperate with a police investigation into a drug-related offence shall be liable to imprisonment for no longer than twelve months or a fine, or to both a fine and imprisonment.
- uses or possesses an illegal substance or tries to frame another person by placing such a substance in their vehicle or premises, is liable to a fine or to imprisonment for no longer than five years, or to a fine and imprisonment.
- Deals in an illegal drug is liable to a fine or to imprisonment for no longer than 10 years, or to a fine and imprisonment.
- Illegally manufactures a scheduled substance, or who use or possesses a dangerous dependency-producing substance, is liable to a fine or to imprisonment for no longer than 15 years, or to both a fine and imprisonment.
- Deals in a dangerous dependency-producing substance is liable to imprisonment for no longer than 25 years, or to both imprisonment and a fine.

What are the presumptions regarding liability?

- When prosecuting a drug-related offence, it shall be assumed that the person charged is not a health professional, or wholesale dealer in, or manufacturer of, pharmaceutical products, unless otherwise proven.
- If a drug was found in the immediate vicinity of a person, it will be assumed that it was found in the possession of that person, unless otherwise proven.
- If a person was found in possession of dagga exceeding 115 grams, or possessed an illegal substance while on school grounds or within 100 meters of such grounds, it will be assumed that the person dealt in dagga or the substance in question, unless otherwise proven.
- If a person is the owner, occupier or manager of cultivated land on which dagga plants were found, it will be assumed that the person dealt in dagga plants unless otherwise proven.
- If it has been proven that a person was in possession of property which was the proceeds of a defined crime, it will be assumed that the person knew that it was the proceeds of crime, unless he proves that he acquired the property in good faith and that he had no reasonable grounds for suspecting that the property was the proceeds of crime.

- If a drug offence was committed at a place of entertainment, it will be assumed that the manager, occupier or owner of that place had reason to suspect that such an offence had occurred, unless he proves otherwise.
- Any offence committed by an employee or agent shall be considered an offence committed by his employer or principal, unless evidence proves that he was not directly involved in, or did not actively permit, the offence, or that he took all reasonable steps to prevent the offence from being committed.

What will be forfeited when a drug offence is prosecuted?

Whenever a person is convicted of a drug-related offence, any substance, animal, vehicle, container or immovable property that was used in connection the offence, will be forfeited to the State for a period of 30 days. This will not affect any interest which any person other than the convicted person may have in the property, item or article.

If any person other than the convicted person claims through application that he has an interest in such an article, item or property, the State may return it to the applicant, or compensate him for it, if it has been disposed of. The application must be made within a period of three years from the date that the item, article or property was forfeited to the State.[7]

This Act allows charges to be brought under three separate provisions:

1. Section 3 (manufacture and supply)
2. Section 4 (use and possession)
3. Section 5 (dealing).[8]

The Act makes it an offence to supply certain substances to any person knowing or suspecting that the substances will be used for the manufacture of illegal drugs; prohibits any person from converting property that they know or suspect to be gained from the proceeds of drug trafficking, and makes dealing in dangerous and undesirable drugs an offence punishable by up to 25 years' imprisonment.[9] It also defines the duty to report certain information to the police, and how the police may use its powers to handle drug offences.[10]

Section 4 prohibits both use and possession, so it is possible to charge a person who is clearly under the influence even if no trace of the prohibited substance is found on their person. Possession of drug paraphernalia is also a common basis for requiring a blood test. The way this is generally done is by the taking of blood and urine samples by a District Surgeon. These are then sent to the National Forensic Labs for testing. The maximum sentence for the possession of drugs is 15 years. There are no prescribed minimum sentences.[11]

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[7] OSS Africa. *Summary of the Drugs and Drug trafficking Act, no. 140 of 1992*. n.d. Available: http://ossafrica.com/esst/index.php?title=Summary_of_the_Drugs_and_Drug_trafficking_Act%2C_no._140_of_1992

[8] Leggett, T. 2004.The Law. In *South African Drug Enforcement Handbook*. Institute for Security Studies:1

[9] Haefele. n.d: 110-111.

[10] OSS Africa. *Summary of the Drugs and Drug trafficking Act, no. 140 of 1992*. n.d. Available: http://ossafrica.com/esst/index.php?title=Summary_of_the_Drugs_and_Drug_trafficking_Act%2C_no._140_of_1992

[11] United Nations Office on Drugs and Crime. 2002. *South Africa Country Profile on Drugs and Crime 2002*. Hatfield: Regional Office for Southern Africa United Nations Office on Drugs and Crime: 45. Available:

Section 5 prohibits dealing in drugs and can be proven in a number of ways:

- a controlled 'buy and bust' operation can be conducted, as part of a planned and authorised anti-drugs operation; or
- a sale can be witnessed, in which money or other items of value are exchanged for money; or
- the accused can be found in possession of drugs under circumstances which make clear his intent to deal.[12]

Prevention and Treatment of Drug Dependency Act, No. 20 of 1992.

The Prevention and Treatment of Drug Dependency Act was established to provide for the establishment of a Drug Advisory Board; the establishment of programmes for the prevention and treatment of drug dependency; the establishment of treatment centres and hostels; the registration of institutions as treatment centres and hostels; the committal of certain persons to and their detention, treatment and training in such treatment centres or registered treatment centres; and incidental matters.[13]

The Act was amended by the Prevention and Treatment of Drug Dependency Amendment Act 14 of 1999 in order to delete a definition and define certain expressions; to establish the Central Drug Authority; and to provide for the assistance of the Drug Authority by a secretariat; and to provide for matters connected therewith.[14] Draft regulations were published in March 2012 for comment.[15]

The Department of Social Development is responsible for the administration of the Prevention and Treatment of Drug Dependency Act. The Act provides a legal framework for the establishment, management and monitoring of inpatient treatment centres in the country.[16] The Department of Social Development, through the support of the UN's Office on Drugs and Crime, developed a manual, *Minimum norms and Standards for Inpatient Treatment Centres*, to assist these centres to standardize services, facilitate transformation and improve service quality. The minimum standards will provide the policy, guidelines, minimum requirements and quality assurance for service providers to ensure that the rights of

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https://vula.uct.ac.za/access/content/group/f4c75605-540a-4b96-842c-1d29a92f3436/country_profile_southafrica.pdf

[12] Leggett. 2004: 4 – 5.

[13] LegalB's Resources for Africa. n.d. *South Africa National Legislation Overviews: Prevention and Treatment of Drug Dependency Act, No. 20 of 1992.* Available: http://www.legalb.co.za/SANatTxt/1992_000/1992_020_000-Ove-v19920313.html

[14] Polity. 1998. *Prevention and Treatment of Drug Dependency Amendment Act 14 of 1999*. Available: http://polity.org.za/article/prevention-and-treatment-of-drug-dependency-amendment-act-no-14-of-1999-1999-01-01

[15] Sabinet Law. 2012. *Prevention of and Treatment for Substance Abuse Act: Regulations to be finalised Soon*. Available: http://www.sabinetlaw.co.za/social-affairs/articles/prevention-and-treatment-substance-abuse-act-regulations-be-finalised-soon

[16] Department of Social Development. 2007. *Minimum Norms And Standards For Inpatient Treatment Centres*: 3. Available: http://www.capetown.gov.za/en/drugs/Documents/Drugs_IN_PATIENT_NORMS_AND_STANDARDS_-_FINAL_19112007112240_486.pdf

chemical dependents (and their families) are protected and that especially young people at risk (and their families) receive the best possible service.[17]

The applicable legislation to in-patient norms and standards is as listed below:

- Basic Condition of Employment Act, 2002 (as amended) (Act No.10 of 2002)
- Child Care Act, 1983 (as amended) (Act No. 74 of 1983)
- Child Justice Bill 2003
- Correctional Service Amendment Act, 1992 (Act No.122 of 1992)
- Domestic Violence Act, (Act No. 116 of 1998)
- Drug Trafficking Act, 1992 (Act No.140 of 1992)
- Employment Equity Act
- Heath Act, 1977 (Act No. 63 of 1977)
- Health Professional Act, 1974 (Act No. 56 of 1974)
- Labour Relations Act, 1995 (Act No.66 of 1995)
- Medicine and Related Substance Control Act, 2002 (as amended)(Act No. 59 of 2002)
- Mental Health Care Act, 2002 (Act No. 17 of 2002)
- Non-Profit Organizations Act, 1997 (Act No. 71 of 1997)
- Nursing Act, 1978 (Act No. 50 of 1978)
- Occupancy Health and Safety Act, 1993 (Act No. 85 of 1993)
- Pharmacy Act, 1974 (Act No. 53 of 1974)
- Prevention and Treatment of Drug Dependency Act, 1992 (Act No. 20 of 1992)
- Probation Services Act, 1991 (Act No. 116 of 1991)
- Promotion of Equality and Prevention of Unfair Discrimination Act, 2002 (Act No. 52 of 2002)
- Public Management Act,1999 (Act No. 1 of 1999)
- SA Constitution Act, 1996 (Act No. 108 of 1996)
- SA School Act, (Act No. 84 of 1996)
- Social Work Act, 1978 (as amended) (Act No. 110 of 1978)
- Criminal Procedure Act, 1977 (Act No. 51 of 1977, Section 296)
- Tobacco Products Control Act, 1999 (as amended) (Act No. 12 of 1999).[18]

The following minimum standards are set out in the manual:

MINIMUM STANDARD LEVEL 1: PREVENTION

Standard: Prevention (outreach, awareness programmes)
Standard statement: Patients/Clients and their families receive services and/or have access to resources that maximize existing strengths and develop new capacities that will promote resilience and increase their ability to benefit from developmental opportunities.
Outcome: Target groups are prevented from becoming chemically dependent.
Programme practice: As a first priority, service providers demonstrate that measures are taken within communities and families that strengthen vulnerable families and young people and develop resilience; are early warning mechanisms and processes for young people and families at risk, and which can immediately link them to resources; promote prevention programmes aimed at reducing and preventing the harmful effects of the use of alcohol and other drugs.

[17] Department of Social Development. 2007: 7.
[18] Department of Social Development. 2007: 11.

LEVEL 2: EARLY INTERVENTION

Standard: Harm reduction
Standard statement: As a first priority, those at risk of using substances are assisted to remain within the family and/or community context.
Outcomes:

- Rights and legislation: The admission process is in line with current legislation and the patients'/clients' rights. Copies of legislation should be available and staff should be informed and educated on the contents.
- Non-discrimination: Admission is available to all suitable patients/clients irrespective of their race, ethnicity, gender, culture, ideology, political or religious beliefs, sexual orientation, language and HIV status. This is reflected in the centre's admission criteria.
- Accessibility: The centre is accessible and available in terms of entry dates and times and prioritizes admissions according to clinical indicators for treatment such as the risk urgency and stress to the patients/clients, their families and their communities.

Programme practice:

- Excluded applicants: The centre advises applicants excluded on the basis of the centre's admission criteria of other available and appropriate services. The centre has a referral list with names of other resources and services and contact details.
- Orientation documentation: Patients/Clients and their families and caregivers receive up-to-date, clear, documented orientation information on the centre.

LEVEL 3: STATUTORY PROCESS

Standard: Statutory
Standard statement: Statutory interventions are provided for substance-dependent persons.
Outcome: Substance-dependent persons are admitted to inpatient treatment centres according to statutory provisions.
Programme practice:

- The Prevention and Treatment of Drug Dependency Act makes provision for referrals, admission, treatment and release of patients/clients.
- Substance-dependent persons committed to inpatient treatment centres in terms of section 22 of the Act are accompanied by a court order.
- The transfer of substance-dependent children from institutions in terms of section 30 of the Act should be accompanied by a designation from the Minister of his/her delegate.
- Voluntary patients/clients admitted in terms of section 40 of the Act should be accompanied by a voluntary admissions form.
- All admissions of substance-dependent persons to inpatient treatment centres should be accompanied by a comprehensive psychosocial report and medical certificate.
- The Criminal Procedure Act (No. 51 of 1977) makes provision for the admission of patients/clients who may have committed substance abuse-related crimes, e.g. drinking and driving.

LEVEL 4: CONTINUUM OF CARE (TREATMENT)

Standard: Patient/Client assessment/treatment.

Standards statement: All patients/clients receive a comprehensive, accurate, timely assessment of their physical, psychiatric and psychosocial functioning and a regular review of such functioning.
Outcome: The subjection of all patients/clients to holistic assessment processes.[19]
Programme practice:

- Assessment of competencies: Assessments are undertaken by professional staff with the adequate mental health and social work skills and experience to undertake the prescribed components of the assessments. A medical or psychiatric diagnosis should not be made by an accredited addiction counsellor.
- Intake assessment: Intake assessment/screening is undertaken by a medical practitioner within 24 hours, or, in the case of patients/clients admitted with alcohol, benzodiazepine or opiate dependency, within 8 hours of admission. The assessment includes:
    - Personal details and brief personal history.
    - Mental state examination, including intoxication status and needs.
    - Physical examination and history of medical conditions, including tests to facilitate evaluation.
    - Brief history of substance abuse (and other mental health problems).
    - Provisional psychiatric history and diagnosis.
    - Assessment of risk potential (i.e. for suicide and other forms of self-harm) and specifications for detoxification (if offered).
- Comprehensive assessment: A comprehensive assessment is undertaken in a timely manner by qualified and experienced professionals.
- The assessment includes:
    - Psychiatric and physical assessment and diagnosis, with special reference to any co-morbid conditions.
    - assessment including an evaluation of the patient's/client's social situation (e.g. family, employment, housing and legal situation) and vocational and developmental needs (especially in the case of adolescents/children and the elderly).
    - Referral for a more in-depth psychological, social work, psychometric or physical evaluation, as appropriate.
    - Provisional treatment goals and prognosis.
- Psychiatric diagnosis: Identified patients/clients receive as part of the comprehensive assessment a psychiatric diagnosis, according to DSM-IV or ICD 10, made by an appropriately qualified and experienced professional staff member. All psychiatric diagnoses are provisional until they have been reviewed by the psychiatrist and the interdisciplinary team.
- Specialist and team review: The results of each patient's comprehensive assessment is reviewed by a case manager and the centre's multidisciplinary team.
- Documentation: The assessments are recorded in the patients'/clients' case records in a timely and accurate manner.
- Assessment panel: The results of the comprehensive assessment and the treatment plan are presented and discussed at case conferences. This occurs within the first ten days of admission.
- Patient/Client feedback: Patients/Clients receive feedback during the assessment process on the results of the process.

[19] Department of Social Development. 2007: 20 – 24.

- On review of progress: A formal review of the patients'/clients' treatment progress (including psychiatric status) is done weekly by the multidisciplinary team. The review is made available weekly by the case manager and monthly by the Multidisciplinary team.

LEVEL 5: INDIVIDUALIZED TREATMENT PLANNING (IDP)

Standards statement: All patients/clients have a documented, individualized treatment plan that encourages their participation, motivation and recovery.
Outcome: Treatment plan - All patient/clients have an individualized treatment plan/ programme.
Programme practice:

- Informed consent and information: Informed consent is sought from all patients/clients prior to the onset of any treatment. Patients/Clients are given the opportunity, as far as possible and appropriate, to make choices regarding their care and are provided with adequate information on the specific treatment (e.g. medication used) and risks, benefits and options of the treatment offered.
- Health promotion/prevention: The centre seeks to promote optimal patient/client health and well-being and to prevent the onset and negative impact of health and mental health/substance-related problems among patients/clients (and their families and caregivers). The following is included:
    - Information and practical support to maintain a healthy, alcohol and drug-free lifestyle (e.g. exercise, better nutrition, stress management).
    - Information and practical support to prevent the onset and spread of HIV/AIDS and other sexually transmitted and infectious diseases (e.g. voluntary testing, counselling and education regarding needle use and exchange).[20]
    - Access to reproductive health care and support of pregnant
    - patients/clients.
    - Access to nutritional support and supplements for chronic alcohol dependent
    - patients/clients.
- Individual treatment selection: Treatment is selected for all patients/clients according to the nature of their substance addiction/dependency and/or other psychiatric or psychological conditions (symptoms, severity and history), their personal preferences, strengths and characteristics, and their social needs and circumstances
- Care plan: Based on the comprehensive assessment, a written individual treatment plan or provisional development treatment plan is developed in partnership with the patients/clients and recorded. The plan contains the following:[21]
    - Clear and concise statement of the patients'/clients' current strengths and needs.
    - Clear and concise statements of the short- and long-term goals the patients/clients are attempting to achieve.
    - Type and frequency of therapeutic activities and treatment programme in which the patients/clients will be participating.

[20] Department of Social Development. 2007: 27.
[21] Department of Social Development. 2007: 27.

    - Staff responsible for the patients'/clients' treatment and their individual counsellor.
    - The patients'/clients' responsibilities and commitment to the rehabilitation process.
    - The plan is dated and signed by the individual counsellor and the
    - patient; a copy of the plan is given to the patient/client.
- Participation: As far as possible, patients/clients (and their families and caregivers, as appropriate) participate in the development and regular review of the treatment plan and referring agencies to ensure that family reconstruction services are rendered while the patients/clients are still in the treatment programme.[22]

LEVEL 6: PHARMACOTHERAPY AND MEDICAL CARE

Standard statement: Medication and other medical care are provided in a timely, accessible and expert manner in accordance with professional and statutory requirements and patient/client safety.
Outcome: Medical coverage- outine medical and mental health care is available through employed or contracted medical and mental health professionals.
Programme practice:

- Medical coverage: Emergency medical and mental health care is available to patients/clients 24 hours a day, 7 days a week (e.g. through telephonic consultation with a medical doctor (e.g. a psychiatrist) and/or access to emergency services).
- Clinical/Case record: A medication record, with appropriate signatures, is kept in the patients'/clients' case records in accordance with statutory regulations. This includes at least the:
    - name of the medication,
    - method of administration,
    - dose and frequency of administration,
    - name, date and signature of prescribing doctor,
    - name, date and signature of person administering or dispensing
    - drug.
- Medicine administration: Medication is administered only by a registered professional nurse or medical practitioner according to the documented instructions of the attending doctor/psychiatrist. Self-administration of prescribed medication is observed by or is done under the supervision of such registered staff members.
- Medicine-related monitoring: Patients/Clients are carefully monitored by professional staff to prevent and/or respond promptly to adverse effects of prescribed and non-prescribed medication.
- Medicine storage and disposal: Storage and disposal of medicines comply with current legislation (i.e. storage of schedule 5, 6 and 7 medicines). Medicine prescribed for one patient/client may not be administered to or allowed to be in the possession of another patient/client.[23] All medicines should be kept in locked storage and all controlled substances in a locked box in a locked cabinet. Medicines that require refrigeration should be kept in a refrigerator separate from food and other Items. All unused prescription drugs prescribed for residents should be destroyed by the person responsible for medicines, and such destruction should be witnessed and noted in the patients'/clients' case record.

[22] Department of Social Development. 2007: 28.
[23] Department of Social Development. 2007: 29.

- Emergency equipment: Emergency and first-aid equipment and medicines in good condition are available, and staff are skilled and equipped to use/administer them.
- Medicine records: Records for medicines are accurately maintained according to statutory requirements (e.g. requisition books, register of controlled substances and schedule 5, 6 and 7 substances).
- Prescriptions: All patients/clients receive an initial intake assessment (i.e. face-to-face examination) by a medical doctor or psychiatrist before any medicines are prescribed.
- Medical waste storage and disposal: The centre stores and disposes of medical waste (e.g. syringes and unused medicines) according to current statutory requirements.[24]

LEVEL 7: STRUCTURED TREATMENT PROGRAMMES AND DAILY ACTIVITIES

Standard statement: Patients/Clients participate in a structured treatment and rehabilitation programme that effectively and safely addresses treatment goals and is supported by appropriate activities and routines.
Outcome: A formal treatment and rehabilitation programme that addresses patients/clients' needs.
Programme practice:

- Programme models/philosophy: A formal treatment and rehabilitation programme is regularly reviewed and updated in accordance with internationally accepted standards.
- Programme content: The structured programme consists of group counselling/ therapies, opportunities for individual and family therapies/counselling, and organized group activities such as sport, health education (e.g. HIV/AIDS), recreation and creative activities.
- Programme duration: The duration of the treatment programme offered by the centre is a minimum of 40 hours a week, which includes therapeutic/counselling sessions.[25]

LEVL 8: RELEASE, READMISSION AND AFTERCARE

Standard statement: Patients/Clients can be provided with appropriate programmes and support to enable their effective transition from a treatment centre to their families and their integration into their communities.
Outcome: Patients/Clients who are fully prepared to participate in after care programmes in their communities.
Programme practice:

- Discharge assessment and review: All patients/clients are assessed and reviewed by the multidisciplinary team at an appropriate time in their treatment to determine their potential for release and to facilitate release planning.
- Release documentation: Relevant referral agents are timeously supplied with a confidential signed and dated release report to facilitate continuity of care for all patients/clients leaving the centre. A copy of this report is kept in the patients'/clients' case records. The summary includes:
  - Patients'/Clients' personal details.
  - A brief summary of their personal history and family/social background.

[24] Department of Social Development. 2007: 30.
[25] Department of Social Development. 2007: 33.

    - A brief summary of the treatment plan and progress/participation at the centre.
    - Reason for release (e.g. completed programme or non-compliance).
    - An outline of their aftercare needs and preferences (release plan).
- Aftercare: Prior to release, the centre ensures adequate referral and linking of the patients/clients to their original referral social workers, local community services and self-help groups.
- Release information: Release information is provided for all patient/client families and caregivers, as appropriate, on release or expulsion. This includes:
    - Details and precautions/guidance on any prescribed medicines at release are not provided. And where inadvisable, e.g. in the case of an addicted person, alternative arrangements must be made, e.g. making a family member responsible for collection of the medication.
    - Names and details of aftercare referrals/sources (e.g. local AA branch).
    - Names and details of emergency and contact sources for crisis intervention associated with relapse prevention.
    - Procedure for readmission to the centre, if sought. [26]
- Caregiver support and information: Families and caregivers are assisted in planning and anticipating the patients'/clients' release and return to their homes and communities from the onset of inpatient/client care. They are also informed, whenever possible, when patients/clients are to be released, expelled or if they have absconded.
- Relapse prevention: Prior to release, the patients/clients (and their families and caregivers, as appropriate) are provided with information, support and counselling to assist with relapse prevention.[27]

The Prevention and Treatment for Substance Abuse Act No. 70 of 2008

The Prevention and Treatment for Substance abuse Act No. 70 of 2008 and the National Drug Master Plan 2013-2017 seek to reduce demand, reduce harm and reduce the supply of illicit substances, (including education and raising awareness) and associated crimes through law enforcement, prevention of community-based substance abuse, early intervention, drug treatment (including rehabilitation and risk reduction) and research. [28] It also sets up the Central Drug authority.[29] They are supported by many other Acts, government departments, statutory bodies, non-governmental organisations, etc.[30]

The purpose of the Act is to provide for a comprehensive national response for the combating of Harmful Drug use and to provide for mechanisms aimed at demand and harm reduction in relation to Harmful Drug use through intervention, treatment and re-integration programmes

[26] Department of Social Development. 2007: 35.
[27] Department of Social Development. 2007: 36.
[28] Van Niekerk, J. 2011. Time to Decriminalise Drugs? *South African Medical Journal* 101(2): 80.
[29]OSS Africa. n.d. *Summary of the Prevention of and Treatment for Substance Abuse Bill*. Available: http://ossafrica.com/esst/index.php?title=Summary_of_the_Prevention_of_and_Treatment_for_Substance_Abuse_Bill
[30] Van Niekerk. 2011: 80.

as well as to provide for registration and establishment of treatment centres and half way houses.[31]

The Act puts a duty on the State to establish programmes for combating substance abuse. Prevention programmes should offer services that aim at preventing substance use and provide information, education and communication about the risks associated with substance abuse. These programmes include: prevention programmes, early intervention programmes, treatment programmes, and aftercare and reintegration programmes. Minimum norms and standards may be set by the Minister of Social Development, setting out acceptable standards for services aimed at combating substance abuse. The State may also provide financial awards to service providers that prioritise the needs and services for persons affected by substance abuse, as long as proper accounting measures are in place.[32]

The Act makes provision for the establishment of a substance abuse forum (PSAF) for each of the nine provinces. PSAFs are appointed by MECs from the ranks of stakeholders in education, community action, legislation, law enforcement, policymaking, research and treatment, the business community and any other body interested in addressing substance abuse.[33] The act requires that the mayor of each municipality, of which there are at present 238, must establish a Local Drug Action Committee (LDAC) consisting of interested persons and organisations dealing with the combating of substance abuse in the municipality in question as well as appoint these persons using suitable service providers.[34]

At the local level, provincial substance abuse forums work to combat drug abuse by fulfilling the following functions: They encourage networking and the flow of information. They strengthen member organisations and act as a spokesperson for them on a national scale. They put substance abuse on the public and political agenda. They assist local drug action committees. They compile and submit a Mini Drug Master Plan for each province and submit a yearly report on activities to the Central Drug Authority.[35]

On an even more local level, the Local Drug Action Committees must ensure that the National Drug Master Plan is carried out in each community. The Committees also draw up their own action plan in cooperation with provincial and local government and provide relevant information to the Central Drug Authority. [36]

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[31] Western Cape Government. n.d. *Prevention & Treatment of Drug Dependency Act*. Available: http://druginfo.westerncape.gov.za/prevention-treatment-drug-dependency-act

[32]OSS Africa. n.d. *Summary of the Prevention of and Treatment for Substance Abuse Bill*. Available: http://ossafrica.com/esst/index.php?title=Summary_of_the_Prevention_of_and_Treatment_for_Substance_Abuse_Bill

[33] National Drug Master Plan: 126

[34] National Drug Master Plan: 127

[35]OSS Africa. n.d. *Summary of the Prevention of and Treatment for Substance Abuse Bill*. Available: http://ossafrica.com/esst/index.php?title=Summary_of_the_Prevention_of_and_Treatment_for_Substance_Abuse_Bill

[36]OSS Africa. n.d. *Summary of the Prevention of and Treatment for Substance Abuse Bill*. Available: http://ossafrica.com/esst/index.php?title=Summary_of_the_Prevention_of_and_Treatment_for_Substance_Abuse_Bill

The Prevention of Organised Crime Act 121 of 1998

While South Africa's 1994 transition gave rise to organized crime, it did not at the same time give rise to state institutions immediately in a position to counter the phenomenon. From 1991 onwards, when the threat of organized criminal groups became apparent, police investigative methods changed from targeting customers, street level drug pushers and similar types of criminals to increasingly aiming at syndicate leaders and crime bosses, so called "targeting upwards". However, insufficient detective skills and a weak system of crime intelligence remained stumbling blocks for the South African Police Service. In 1996, the Proceeds of Crime Act was passed, but problems were encountered in its implementation. Proceeds of crime have only recently been the target of organized crime prosecutions. [37]

The Prevention of Organised Crime Act of 1998 was "super-fast-tracked" through Parliament in December 1998 and amended in 1999. It makes provision for new powers for police and prosecutors to seize criminal assets on the grounds of "a balance of probabilities" rather than "beyond a reasonable doubt". It outlaws certain criminal conspiracies and furthers countermeasures against money laundering. Shortly after being enacted, the law was successfully challenged in the court system, requiring the Government to revise it. During 2000, it was used more successfully.[38]

The Prevention of Organised Crime Act allows for asset forfeiture. If a building, vehicle, or other piece of property is used to deal or even consume drugs, it may be forfeit to the state. Even if a building cannot be seized under the Act, it may be possible to shut down sites where drugs are sold under municipal by-laws (fire or health codes, for example) or foreclose on them due to failure to pay rates and taxes.[39] Criminal forfeiture is limited to illicit proceeds, while civil forfeiture can be used against "facilitating" property. [40]The Act also introduces some changes to pre-existing laws, such as the Drugs and Drug Trafficking Act and the Proceeds of Crime Act.[41]

The Act defines and lists 34 offence types, ranging from murder to racketeering activities. For a pattern of racketeering activity to exist, two of the offence types must be committed within a ten-year period. Anyone who manages the operation enterprise and who knows or ought to have known than any person, while employed by or associated with the enterprise, participated in the conduct of the enterprise's affairs through a pattern of racketeering activity, is guilty of an offence. The aim is to convict crime bosses against whom there is no direct evidence of criminal activity, but where there is evidence that they associated through an organisation with people who engage in racketeering activity. Persons convicted of a pattern of racketeering activity face tough fines of one billion rand to life imprisonment. The Act also focuses on offences related to criminal gangs. Gang members are guilty of an offence if they wilfully aid any criminal activity committed for the benefit of, or in association with a criminal gang. Furthermore, any person who promotes or contributes towards a pattern of criminal gang activity, or incites, aids or encourages another person to commit or participate in a pattern of criminal gang activity, is guilty of an offence. Persons

[37] United Nations Office on Drugs and Crime. 2002: 73 – 87.
[38] United Nations Office on Drugs and Crime. 2002: 73 – 87.
[39] Leggett, T. 2004: 6.
[40] United Nations Office on Drugs and Crime. 2002: 73 – 87.
[41]OSS Africa. n.d. *Summary of the Prevention of Organised Crime Act ,no. 121 (With_Amendments*). Available: http://ossafrica.com/esst/index.php?title=Summary_of_the_Prevention_of_Organised_Crime_Act,_no._121_of_1998_(With_Amendments)

found guilty of such offences are liable to a fine and imprisonment ranging from three to eight years. Money generated through the forfeiture of assets is to be deposited in a Criminal Assets Recovery Account. Such monies will be used as financial assistance for law enforcement agencies involved in combating organised crime, drug dealing, criminal gang activity and crime in general. [42]

Medicines and Related Substances Control Act 101 of 1965

The Medicines Control Council (MCC) is a statutory body appointed by the Minister of Health in terms of the Medicines and Related Substances Control Act, to oversee the regulation of medicines. Its main purpose is to safeguard and protect the public by ensuring that all medicines that are sold and used in South Africa are safe, therapeutically effective and consistently meet acceptable standards of quality. The MCC applies standards laid down by the Act to govern the manufacture, distribution, sale and marketing of medicines. The prescribing and dispensing of medicines are controlled by establishing schedules for various medicines and substances.[43]

The Act supports the processes set out in the major UN Conventions on drug control and provides the definitional and conceptual basis for drug control policy in South Africa. [44]

- The Mental Health Act (18/1973)
- The Criminal Procedures Act (51/1977)
- The Financial Intelligence Centre Act (38/2001):[45] The Financial Intelligence Centre is responsible for passing on to the relevant law enforcement authorities, intelligence agencies and SARS any drug and crime-related information it receives from banks and other institutions. In turn, these authorities and agencies are expected to inform the FIC about enforcement targets and drug distribution typologies in South Africa so that the FIC can do its work effectively.[46]

The National Crime Prevention Strategy

In May 1995 Cabinet approved the National Crime Prevention Strategy (NCPS). This strategy draws together a range of government departments to develop a holistic approach to fight crime. Drug trafficking as organised crime was listed as one of seven priority areas. However, NCPS implementation has, on occasion, been characterised by a complex set of committees and has been plagued by the failure to set clear objectives of delivery. [47]

[42] Haefele. n.d: 110-111.
[43]National Drug Master Plan: 120.
[44] United Nations Office on Drugs and Crime. 2002: 45.
[45] United Nations Office on Drugs and Crime. 2002: 45.
[46] National Drug Master Plan 2006 - 2011:30.
[47] Haefele. n.d: 110-111.

The National Crime Prevention Strategy (NCPS) was launched in 1996 and it is a historically important document, being the first attempt to "establish a comprehensive policy framework which addresses all policy areas which impact on crime and to develop a common vision around crime prevention" and at the same time proposing a fundamental paradigm shift in the handling of crime.[48]

The NCPS began to introduce a new paradigm for dealing with crime in South Africa. Some of the key concepts that it introduced were:

- Crime cannot be reduced using only law enforcement and criminal justice responses. States must also introduce methods to prevent crime. This is clear from the international experience of rising crime rates over the past fifty years, despite parallel increases in expenditure on criminal justice.
- The criminal justice system cannot operate effectively unless there is better cooperation between the departments which constitute the system, and integration of the things they do as part of the system. The government cannot deal with crime on its own. The institutions of government, in all three tiers, must work with each other and with civil society to overcome crime. This is one of the key elements of the 'social crime prevention' approach. Crimes are different, and must be 'dis-aggregated' if effective prevention strategies are to be designed and implemented.
- Prevention efforts need to be focused on victims and potential victims of crime, and not merely on perpetrators, as traditional systems of criminal justice tend to be.
- Prevention efforts need to take cognizance of fear of crime, as well as of real crime patterns. The success of the NCPS would be in reducing fear, as well as in reducing crime.

Shortly before the end of the first Cabinet's term of office, a Review of the NCPS was commissioned. The Review drew on a range of official reports that had made comments on the NCPS since its launch in 1996, including the 1997 Auditor-General's Report on the NCPS and the 1998 Presidential Review Commission. The recommendations of the NCPS review were made to the new Ministers responsible for the NCPS, after the June 1999 election, and correlated easily with the new approach of the Mbeki Cabinet. The new government followed the recommendations of the 1998 NCPS Review in prioritizing the issues such as organised crime: A recognition, largely absent from the original NCPS, that much of South Africa's crime problem is organised. By tackling organised crime, government believes it will be able to impact on vehicle crime, drug trafficking, trade in illegal weapons and endangered species as well as money laundering and certain forms of commercial crime.[49]

[48] Van Aswegen, W. 2000. The South African National Crime Prevention Strategy: Overview and Contextual Analysis. *Social Work.* 36(2): 141.
[49]Rauch, J. 2001. *The 1996 National Crime Prevention Strategy*. Institute for Security Studies. Available: http://www.csvr.org.za/docs/urbansafety/1996nationalcrime.pdf

NATIONAL DRUG MASTER PLANS

A drug master plan is defined by the United Nations Drug Control Programme (UNDCP) as 'the single document adopted by government outlining all national concerns in drug control. 'It summarizes authoritatively national policies, defines priorities and apportions responsibilities for drug-control efforts'. It acts both as a director and a directory of a country's policies and programmes in the fight against substance abuse. [50]

The basis for the national drug control framework is the National Drug Master Plan, adopted by parliament in February 1999. The elaboration of such a plan was necessary as the Government's response to the drug problem – as stated in the Master Plan – had become "disjointed, fragmented and uncoordinated." A number of national plans and strategies to address different aspects of substance abuse were drafted during the 1980s and early 1990s. They did not, however, provide a comprehensive response to the deteriorating drug problem of South Africa, and they were not properly implemented. Thus in 1997, the Minister of Welfare and Population Development requested the Drug Advisory Board to develop a Master Plan for South Africa to rectify these problems "in accordance with international practice". Taking a balanced approach to reducing the supply and demand for drugs, the overall objectives of the first Master Plan was "to build a drug free society together and to make a contribution to solving the global problem of substance abuse." The Master Plan's six priority areas were: (a) to reduce drug-related crime, (b) protect youth, (c) support community health and welfare, (d) strengthen research and information dissemination, (e) encourage international involvement, and (f) improve communication on substance abuse with all groups in South Africa's highly diverse population.

One aspect of the Government's demand reduction policy included "harm reduction", which aimed to reduce the negative social and health consequences associated with drug use rather than to reduce or eliminate drug use per se. The Master Plan set forth a broad strategy for integrating the efforts of various government departments and civil society to prevent and reduce drug-related problems, substance abuse and illicit drug trafficking in South Africa. Recognizing the social costs of addiction, the document called for greater resources to be diverted to disadvantaged communities. It called for a workable strategy at the community level through Local Drug Action Committees (in all 382 magisterial districts) and Provincial Drug Forums comprising the various government agencies, the private sector, experts and community organizations. It stressed the importance of shifting the focus from supply to demand reduction and from the individual to the community. Further, the Master Plan aimed to ensure that "all educational material and other information [that] is disseminated was contextually correct, that was in a form and language appropriate to the culture, language, level of education and socio-economic background of its intended recipients". The link between drug use and the spread of HIV/AIDS was not emphasized anywhere in the Master Plan. There were only two minor references to the drugs-HIV/AIDS nexus in South Africa.[51]

NDMP 2006 – 2011

The National Drug Master Plan 2006 – 2011 was drafted in accordance with the stipulations of the Prevention and Treatment of Drug Dependency. It reflects the country's responses to

[50] Department of Social Development. 1999. *National Drug Master Plan*. Available: http://www.dsd.gov.za/cda/dmdocuments/nationaldrugmasterplan.PDF
[51] United Nations Office on Drugs and Crime. 2002: 44.

the substance abuse problem as set out by UN Conventions and other international bodies. The administrative unit of the Act is the Central Drug Authority (CDA) whose secretariat is located in the Department of Social Development. The NDMP enables cooperation between government departments and stakeholders in the field of drug prevention. The NDMP outlines the role that each department should play in fighting the scourge of drug abuse. It also acknowledges the significant contribution in this regard of various departments and agencies in the country. The success of the NDMP depends on the extent to which CDA participants succeed in crafting sector-based responses to the drug problem. The CDA then has to draw these responses into a single master plan for South Africa. For the purposes of the National Drug Master Plan, the term **"**drugs**"** refers to illicit drugs as defined in the Drugs and Drug-Trafficking Act (No. 140 of 1992) and to the commonly abused licit medicines. Although not specifically included in the definition, alcohol, tobacco and volatile solvents are also recognised as major contributors to health and social problems in South Africa. [52]

Goals of the NDMP 2006 - 2011

- To ensure the coordination of efforts to reduce the supply of and demand for drugs/substances of abuse;
- To strengthen efforts aimed at the elimination of drug trafficking and related crimes;
- To strengthen the legal and institutional framework for combating the illicit supply and abuse of substances;
- To promote the integration of substance abuse issues into the mainstream of socioeconomic development programmes;
- To ensure appropriate intervention strategies through awareness raising, education, prevention, early intervention and treatment programmes;
- To promote family and community-based intervention approaches in order to facilitate the social reintegration of abusers;
- To promote partnerships and the participation of all stakeholders at local and provincial level in the fight against illicit substances and abuse;
- To promote regional, national and international cooperation in the management of the illicit supply of drugs and substances of abuse.[53]

To achieve its aims, the NDMP identified nine priority areas namely: crime, youth, other vulnerable groups (such as children on and off the streets, workers, women, people with disabilities, the elderly, unemployed persons and persons affected by HIV/AIDS, road users especially drivers and pedestrians), community health, research and information dissemination, international involvement, communication (cross-cutting area), capacity building, occupational groups at risk[54]

NDMP 2013 – 2017

While much of South Africa's approach to drug abuse is progressive and enlightened, evidence-based facts and sober reflection suggest that our strategies require re-thinking.

[52] Department of Social Development . 2006. *National Drug Master Plan 2006-2011*: 4. Available: http://www.drugsandalcohol.ie/11811/1/South_Africa_2006-2011.pdf
[53] National Drug Master Plan 2006-2011: 13.
[54] National Drug Master Plan 2006-2011: 14.

The Vision of the latest National Drug Master Plan 2013-2017 is a drug-free society. Human history and international experience clearly demonstrate that this does not reflect reality. We should acknowledge this and develop better ways of dealing with human frailty. A more evidence-based, nuanced approach to the harms of drugs is required. For example, it makes no sense to legalise the use of alcohol and tobacco but not the less dangerous cannabis which also has beneficial effects. Using psychoactive substances may be a vice but should not be considered to be a crime, thus criminalising a large proportion of our citizens. Making drugs illicit cedes their control to the drug dealers. Escalating the drug war makes drugs more valuable and attracts more participants into the illicit drug economy. Improved state control of substances, as with alcohol and cigarettes, could provide taxes and significantly reduce the roles of drug dealers.[55]

The revised National Drug Master Plan 2013 – 2017 and the work done by the Inter-Ministerial Committee on Alcohol and Substance Abuse seek to address these challenges. The Inter-Ministerial Committee has worked on policies, laws and strategies that seek to reduce the supply and demand for alcohol and illicit drugs. Extensive work is also being done to improve treatment for addicts and other harm reduction modalities The National Drug Master Plan complements the work of the Inter- Ministerial Committee on Alcohol and Drug Abuse by guiding and monitoring the actions of the government departments to reduce the demand for and supply of drugs and the harm associated with their use and abuse.[56]

The National Drug Master Plan (NDMP) 2013 – 2017 was formulated by the Central Drug Authority in terms of the Prevention and Treatment of Drug Dependency Act (20 of 1992), as amended, as well as the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended, and approved by Parliament. The NDMP sets out the contribution and role of various government departments at national and provincial level in fighting the scourge of substance abuse. It also recognises the need for a significant contribution to be made by other stakeholders in the country. It is generally accepted that a single approach such as criminalising or decriminalising substances or abusers will not solve the problem. Instead, a number of strategies should be applied in an integrated way. The commonly recognised strategies applied in the NDMP 2013 – 2017 are: demand reduction, supply reduction and a localised version of harm reduction.

The key specific outcomes derived from a review of the NDMP 2006 – 2011 are described in the NDMP 2013 – 2017 in terms of the basic concepts of monitoring and evaluation. These outcomes are:

- Reduction of the bio-psycho-social and economic impact of substance abuse and related illnesses on the South African population.
- Ability of all people in South Africa to deal with problems related to substance abuse within communities.
- Recreational facilities and diversion programmes that prevent vulnerable populations from becoming substance abusers/dependents.
- Reduced availability of dependence-forming substances/drugs, including alcoholic beverages.[57]

[55] Van Niekerk. 2011: 80.
[56] National Drug Master Plan: 2.
[57] National Drug Master Plan: 4.

- Development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment.
- Harmonisation and enforcement of laws and policies to facilitate effective governance of the supply chain with regard to alcohol and other drugs.
- Creation of job opportunities in the field of combating substance abuse.

The CDA is the body authorised in terms of the Prevention and Treatment of Drug Dependency Act (20 of 1992), as amended, as well as the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended, to develop the National Drug Master Plan (NDMP) and to direct, guide and oversee its implementation, as well as to monitor and evaluate the success of the NDMP and to make such amendments to the[58] plan as are necessary for success. The NMDP is designed to bring together government departments and other stakeholders in the field of substance abuse to combat the use and abuse of and dependence on dependence-forming substances and related problems. It sets out the contribution and role of various government departments at national and provincial level in fighting the scourge of substance abuse. It also recognises the need for a significant contribution to be made by other stakeholders in the country. The success of the NDMP depends on the efforts of each stakeholder in crafting national and provincial department drug master plans (DMPs) in response to the problems defined in the NDMP.

The following strategies are recognised by the NDMP 2013 – 2017:

- **Demand reduction**, or reducing the need for substances through prevention that includes educating potential users, making the use of substances culturally undesirable (such as was done with tobacco) and imposing restrictions on the use of substances (for example by increasing the age at which alcohol may be used legally);
- **Supply reduction**, or reducing the quantity of the substance available on the market by, for example, destroying cannabis (dagga) crops in the field; and
- **Harm reduction**, or limiting or ameliorating the damage caused to individuals or communities who have already succumbed to the temptation of substance abuse. This can be achieved, for example, by treatment, aftercare and reintegration of substance abusers/dependents with society.[59]

THE CENTRAL DRUG AUTHORITY

The CDA was established as an advisory body in terms of the Prevention of and Treatment for Substance Abuse Act (Act No. 70 of 2008)[60] and co-ordinates and directs drug counteraction across South Africa on both the demand and supply side.[61] The CDA has to report to parliament annually. This is done via the Minister. The annual CDA report is

[58] National Drug Master Plan: 20.
[59] National Drug Master Plan: 29.
[60] Department of Social Development. n.d. *Central Drug Authority Ready to Implement National Drug Master Plan.* Available: http://www.dsd.gov.za/cda/
[61] Van Niekerk. 2011: 80.

compiled in terms of Section 2(11)(a) of the Prevention and Treatment of Drug Dependency Act.[62]

The CDA's mandate requires that it co-ordinates the efforts of all departments (at national and provincial level) to combat substance abuse; Facilitates the integration of the work of the different stakeholders (including the national and provincial departments concerned); and Reports to Parliament on the outcomes of the NDMP about the outputs achieved by the CDA's institutional support framework (i.e. the national and provincial departments, PSAFs and LDACs), as well as striving to achieve a society free of substance abuse.[63]

Designated members of the CDA must attend the monthly and quarterly meetings of the PSAFs to carry out the monitoring and evaluation as required, and also the meetings of the local drug action committees (LDACs) if necessary. Designated members of the PSAFs must attend the quarterly general meetings of the CDA and submit their reports for discussion at those meetings. Departmental representatives on the CDA must also attend these meetings and submit their departmental reports based on the QuASAR for discussion at those meetings.

In terms of legislation, the CDA must submit an annual report to the Minister of Social Development for onward transmission to Parliament by the end of September each year. The report is based on the CDA's monitoring and evaluation by means of departmental and provincial reports or research conducted by or on behalf of the CDA; other matters of relevance should also be included in the annual report. The CDA also reports verbally and in writing to the Minister of Social Development after each general meeting and on such other occasions as the need demands, in order to[64] carry out the mandate of advising on matters affecting substance abuse in South Africa.[65]

Membership of the CDA

Members of the CDA serve for five years. The body consists of 13 experts on substance abuse appointed by the private sector, and representatives of 18 national departments and three other national government entities (34 members in total). The stakeholders are the following:
Department of Arts and Culture
Department of Correctional Services
Department of Basic Education
Department of Higher Education and Training
Department of International Relations and Co-operation
Department of Health
Medicines Control Council
Department of Home Affairs
Department of Justice and Constitutional Development
Department of Labour
Department of Agriculture
National Treasury
Department of Cooperation and Traditional Affairs (Provincial and Local Govt)

[62] Department of Social Development. 2008. *Central Drug Authority Annual Report* : 9.
[63]National Drug Master Plan: 23.
[64] National Drug Master Plan: 6.
[65] National Drug Master Plan: 7.

National prosecuting Authority
Department of Sport and Recreation
National Youth Development Agency
Department of Social Development[66]
South African Police Service
South African Revenue Service
Department of Trade and Industry
Department of Transport

The 12 experts are drawn from:
Non-governmental organisations (NGOs)
Research councils and universities
Teachers' trade unions
Community-based organisations
Faith-based organisations
Alcohol treatment centres
Addiction Counsellors' Association
Representatives of the provincial substance abuse forums serve ex officio.[67]

The CDA is supported by a Secretariat who ensures that the day-to-day work of the CDA is carried out in line with the outcomes required by the NDMP. It also provides such administrative support as is required by the CDA and its supporting institutional framework.[68]

INTERNATIONAL INSTRUMENTS

South Africa is a signatory to the 1961 UN Single Convention on Narcotic Drugs, the 1972 Protocol (which amended the Single Convention), the 1971 Convention on Psychotropic Substances and the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The country is a signatory to the African Union and the Southern African Development Community (SADC) Drug Control Protocol. South Africa is also a signatory to the United Nations Convention on Transnational Organised Crime. The South African drug enforcement agencies cooperate and collaborate with similar agencies in the United Kingdom and the United States, notably the Defence Logistics Organisation (DLO), the Drug Enforcement Administration (DEA), the Central Intelligence Agency (CIA) and the Federal Bureau of Investigation (FBI). Regionally, these agencies cooperate and collaborate with similar agencies in SADC countries, specifically the South African Regional Police Chiefs Co-operation Organisation (SARPCCO). Nationally, the South African Police Service (SAPS) is involved in the following committees to combat drug trafficking: Joint Operation and Intelligence Committee (JOINTS), Provincial Joint Operational and Intelligence Committee (provincial JOINTS), Provincial Crime Combating Forum (PCCF), Station Crime Combating Forum
(SCCF). [69]

[66] National Drug Master Plan: 24.
[67] National Drug Master Plan: 25.
[68] National Drug Master Plan: 26.
[69] National Drug Master Plan 2006 - 2011: 12.

South Africa helps combat the global substance abuse problem, notably illicit trafficking in drugs, and also participates in global decision making on solving the drug problem. International forums such as the United Nations Commission on Narcotic Drugs, the United Nations Specialised Agencies, Interpol, the World Customs Organisation, the Southern African Regional Police Chiefs Cooperation Organisation and a number of foreign government agencies play a key role in this regard. South Africa also encourages bilateral cooperation in fighting the drug problem and has entered into four police-to-police cooperation agreements in the area of drugs specifically.[70]

South Africa became a member of the Commonwealth in June 1994 and accordingly is now part of the London Scheme on Extradition and the Harare Scheme on Mutual Assistance. This provides potential coverage of over 50 countries.[71] A worldwide system for control of drugs of abuse has developed over the last 80 years through the adoption of a series of international treaties. The independent and judicial control organ for the implementation of the United Nations drug conventions is the International Narcotics Control Board. The Board, in cooperation with WHO, monitors the supply of and demand for opioids for medical and scientific needs. [72]

Strengthening domestic narcotic laws and ratifying the Narcotics Convention go hand-in-hand. In fact, ratification of the Narcotics Convention requires each state to enact laws that meet the standards imposed by the Convention. These standards concern many of the same ideas expressed above. The Narcotics Convention requires party states to criminalize a comprehensive list of activities related to trafficking; to enact legislation to counter the financial side of the drug trade as well; and to establish confiscation and extradition provisions. Thus, if South Africa follows the requirements above, it will derive a two-fold benefit. First, tougher regulations will have an immediate impact on trafficking on its own soil; second, it will qualify as a member state of the Narcotics Convention.

First, Article 7 of the Convention allows member states to give and receive law enforcement assistance, cooperation, and training. South Africa maintains weak policing ability and should take advantage of the Convention's aid provisions. Second, party states are given access to the clearinghouse of information concerning trafficking compiled by the U.N. Secretary-General's office. South Africa can use this information to spot trends and better allocate its resources in a manner which maximizes their utility. Third, the battle against trafficking in South Africa would receive oversight by the International Narcotics Control Board. The Board is in a position to render advice to struggling countries, like South Africa, concerning such areas as national and international coordination and mutual assistance. If the Board determines that further intervention is appropriate, it can charge the U.N. Commission on Narcotic Drugs to employ other enforcement mechanisms. Until South Africa attains some level of success concerning its trafficking problem, it should take advantage of the available resources.[73]

[70] National Drug Master Plan 2006 – 2011: 18.
[71] United Nations Office on Drugs and Crime. 2002: 76.
[72] Beck, S. A systematic Evaluation of Opioid Availability and Use in the Republic of South Africa. *Journal of Pharmaceutical Care in Pain and Symptom Control.* 6(4): 9.
[73] Joseph, S. 1997. The Internationalization of the War on Drugs and its Potential for Successfully Addressing Drug Trafficking and Related Crimes in South Africa. *The George Washington Journal of International Law and Economics.* 31(2): 316 – 317.

South Africa participates actively in the UN Commission on Narcotics Drugs (CND). Close operational ties exist between the South African Police Service and the International Criminal Police Organization (Interpol). One very successful area of cooperation has been the use of the Interpol X400 system to circulate the identities of potential couriers employed by drug traffickers to alert the law enforcement agencies of other countries. South Africa hosts drug liaison officers (DLOs) from the United States (Drug Enforcement Administration, Customs Service, and Federal Bureau of Investigation), the United Kingdom (Customs and Excise), France (SCTIP) and Germany. Nearly all major industrialized countries provide technical assistance for the strengthening of the judicial and law enforcement capacities of the Government of South Africa. Within drug control, the bulk of the assistance to date has been directed towards law enforcement as compared with demand reduction. Since July 1998, South Africa has hosted the regional office for Southern Africa of the United Nations Office on Drugs and Crime Prevention in Pretoria.[74]

The SAPS also promotes international co-operation and acts as competent authority under the following United Nations conventions:
Convention on the Law of the Sea,1982;
Single Convention of Narcotic Drugs, 1961;
Convention of Psychotropic Substances, 1971; and
Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, includes provisions for the control of deliveries in terms of (Article 11) as well as precursors (Article 12) in order to control the import and export of precursors and investigate any illicit uses.[75]

THE SOUTH AFRICAN POLICE SERVICE

In terms of the Constitution and Police Service Act of 1995, the role of the SAPS is the prevention and investigation of crime, maintenance of public order and preservation of internal security.[76] Official SAPS policing priorities place measures against drug trafficking under the category of organized crime where it features in the targeting of criminal organizations (along with firearms and stolen vehicles). Commercial crimes and corruption also fall under the category of organized crime. The cabinet's inter-agency "Justice Cluster" has a role in attempting to coordinate drug law enforcement on a national basis. [77]

The SAPS budget includes five key departmental programmes, namely Administration, Visible Policing, Detective Services, Crime Intelligence, and Protection and Security Services. All five programmes provide for drug demand and supply reduction strategies. Some of the priorities, which cut across and impact on the programme structure, are: Employee assistance services, which provide for pro-active and reactive social work to members and their families; Visible policing, which ensures visible crime deterrence through pro-active and reactive policing of drug-related crimes, also in the rail environment, and includes support for demand reduction programmes of the social sector; Crime intelligence, which entails intelligence operations relating to criminal groups involved in drugs, and gathering, collating and analysing related intelligence information, as well as providing intelligence and information on precursor chemical movements nationally and

[74] United Nations Office on Drugs and Crime. 2002:52.
[75] National Drug Master Plan: 123.
[76] Haefele. n.d: 112.
[77] United Nations Office on Drugs and Crime. 2002: 46.

internationally; Administration and detective services(including the Directorate of Priority Crime Investigation (DPCI, or the Hawks), which provide for co-operation between the SAPS and foreign law enforcement agencies to address drug trafficking; Protection and security services, which provide for policing and security at ports of entry and on the border to minimise drug trafficking into and out of the country and ensure arrests and seizures at ports of entry; and Detective services, which investigate and gather evidence on serious and organised crime and address transnational and domestic narcotics trafficking through intelligence-driven operations, such as: Project-driven operations, e.g. under-cover operations, controlled deliveries, entrapment, surveillance, interception and monitoring; and Disruption operations, e.g. search and seizure at ports of entry, nightclubs, drug outlets, etc.[78]

At police stations across the country, community police forums (CPF) were formed, constituting a channel through which community priorities and grievances could be communicated to the police. While not elected structures, CPF have been successful in many areas in making the police account more fully for their actions to the public. Legitimate questions remain, however, about the limited powers of the CPF and the degree to which they are taken seriously both by the police and the communities they are meant to represent. Two other institutions established at the time are of some importance. The first is the Independent Complaints Directorate (ICD), charged with investigating complaints from the public of cases of police abuse and poor service delivery. Given the history of policing in South Africa, the ICD is an innovative and necessary institution. It would be fair to say, however, that the overall success of the ICD has been constrained by the large number of cases with which the institution has had to process as well as the related problem of limited funding. Given that police policy had largely been made by police officers themselves, a key component of the reform process was the introduction of a civilian secretariat, reporting directly to a cabinet minister, and charged with policy development and the monitoring of police performance.

The Safety and Security Secretariat played a key role in the early days of the new democracy in designing and monitoring the implementation of the new police agency. More lately however, as the police have assumed greater confidence and the fight against crime (as opposed to the redesign and transformation of policing) has assumed higher priority, so the influence of the Secretariat has waned. Nevertheless, the Secretariat remains a potentially important tool in measuring the effectiveness of the police and monitoring their efforts in the fight against crime.[79] The following new units were established: 24 Serious and Violent Crime units, 24 Organized Crime units.[80]

BORDER POLICING

The SAPS also established a border-policing unit responsible for points of entry and exit into and out of South Africa. The unit works closely with SARS, the SANDF, NIA, SASS (the foreign intelligence agency) and the Department of Foreign Affairs. However, only three policemen cover 100 km of the Mozambique/KwaZulu-Natal border, well-known for gun running and Mandrax smuggling.[81] Although the SAPS made some progress in combating drug trafficking, problem areas still exist. Car thieves, cattle rustlers or drug smugglers simply drive through the ageing 0, 9m high barbed wire fence into or out of South Africa.

[78] National Drug Master Plan: 122.
[79] United Nations Office on Drugs and Crime. 2002: 89.
[80] United Nations Office on Drugs and Crime. 2002: 81.
[81] Haefele. n.d: 112.

Not to mention corrupt officials at the border who, by accepting bribery money, allow smugglers to enter the country illegally. [82]

Under the 1992 Drugs and Drug Trafficking Act, the South African Police Service's Narcotics Bureau (SANAB) is given the lead on the enforcement side primarily in terms of detecting and investigating drug crimes. However, there is also an important profiling, interdiction and controlled delivery role for SAPS Border Police and SARS Customs. An attempt to coordinate law enforcement work at the country's borders by SAPS Border Police, SARS Customs and Home Affairs (Immigration) was attempted in the mid-1990s. This occurred under the auspices of the National Inter- Departmental Structure on Border Control (NIDS) which was disbanded in 2001. Border control coordination now takes place under a Border Control Coordinating Committee. Over the past two years (200-2002?), however, a series of restructuring initiatives has resulted in unclarity within police ranks regarding which entity is primarily responsible for drug law enforcement. At present, the Organized Crime "component" (which operates under the Detective Service Division) has been given responsibility for this mandate within the police service. As constituted, the Organized Crime component serves as the reporting entity for several units including the Specialized Investigating Units, one of which was SANAB. The Organized Crime component also has 24 "task teams" reporting to it from throughout the country, each of which in principle contains at least one officer with specialized narcotics expertise. Specialized investigation units were being phased out, and some staff being integrated into the Organized Crime component. With some 40 per cent of SANAB offices already being closed in that manner, the future of the remaining was uncertain.[83]

DIRECTORATE OF PRIORITY CRIME INVESTIGATION (DPCI)

The Directorate for Priority Crime Investigation has been established as an independent directorate within the South African Police Service in terms of Section 17C of the South African Police Service Act, 1995 as amended by the South African Police Service Amendment Act, 2008 (Act 57 of 2008).

The Directorate for Priority Crime Investigation is now responsible for the combating, investigation and prevention of national priority crimes such as serious organized crime, serious commercial crime and serious corruption in terms of Section 17B and 17D of the South African Police Service Act, 1995 as amended.

The South African Police Service Amendment Act,2012 (Act 10 of 2012) introduced the reporting procedures as provided in Section 34(1) of the Prevention and Combating of Corrupt Activities Act, 2004 which stipulates that reporting should be made to any police officer. In terms of the latest amendment, all such offences must now be reported to a member of the Directorate of Priority Crime Investigation.

The Hawks have declared the countering of drug trafficking as one of its key operational priorities. Focusing on high-level drug trafficking organisations, it takes responsibility for the following in its fight against the scourge: To prevent, combat and investigate drug trafficking organisations through integrated intelligence-led operations; To maintain a National

[82] Haefele. n.d: 112.
[83] United Nations Office on Drugs and Crime. 2002: 46.

Chemical Monitoring Programme to prevent the diversion of precursor chemicals and laboratory equipment used in illicit drug production; To ensure compliance with the relevant United Nations drug conventions; And To promote regional and international co-operation through sharing intelligence and conducting joint operations against transnational drug trafficking organisations.

THE SOUTH AFRICAN NATIONAL DEFENCE FORCE

The SAPS is not the only law enforcement agency to combat cross border drug trafficking. The SANDF has been assisting the SAPS since 1994 in the fight against crime. Although it is not its primary function, the SANDF stands as a full partner in this regard. The SANDF has been employed for service by the President since July 1994 to uphold law and order in co-operation with the SAPS. One area of deployment is the combating of drug trafficking across land borders. Although the responsibility for borderline control lies within the SAPS, the SANDF currently executes this task.[84]

The SANDF is becoming increasingly unable to sustain an adequate border-line-control program for the following reasons. First, the SANDF is not the budgeting authority for borderline control. The effect of budget cuts means that the SANDF will only be able to deploy a shrinking force level until such time as the operational deployments and funding achieve equilibrium. Secondly, the current employment of the SANDF does not furnish it with an adequate legal mandate for the proper execution of borderline control task as a primary function. By relieving the SAPS of this task, valuable SAPS manpower could be utilised at border posts and in the urban and rural areas to combat crime. The SANDF will be able to fully take on the responsibility for the South African borderline once the amendments to the Defence Act have been accepted by Parliament. These amendments are being finalised at present. The approval of the amendments will be in line with the SANDF's preferred role of safeguarding South Africa's borders.

Despite the announcement that the SANDF would eventually take full responsibility for controlling the country's borders, there is no department that could effectively execute the task of border security without the involvement of other government departments. For example, departments like Home Affairs is needed to process individual entering into the country, Foreign Affairs to liaise with other governments, Intelligence for information etc. Close co-operation between the SAPS, SANDF and the above-mentioned departments is of the utmost importance for success. Furthermore, to counter drug-trafficking and cross-border crime, regionally based liaison with similar agencies in neighbouring countries is of greatest importance. South African law enforcement institutions, despite their problems, are far better resourced and skilled than their regional counterparts. Recent operations in Zambia and Mozambique have thus had to be carried out almost entirely by the SAPS. Despite this, co-operation among regional intelligence and security agencies has improved dramatically.

For example, since 1995 there has been an ongoing debate between South Africa and the Southern African countries regarding freedom of movement for the Southern African Development Community (SADC). This debate is open to serious questioning. How capable are the SADC member countries to control the movement of people through external borders? The current influx of illegal immigrants from neighbouring countries into South

[84] Haefele. n.d: 112.

Africa serves as a prime example of the lack of control at borders. The main concern here is the increase in cross-border crime and more specifically, drug-related crime. The signing of the proposed "Protocol on the Free Movement of Persons in the SADC" would be like opening the borders for criminals. The concept of free movement is not seen as an option. The lead agency of the SAPS, SANAB, is losing the battle against drugs given a lack of resources. Much more attention needs to be given to border-control initiatives. The SANDF is currently tasked with border control although constitutionally it is the responsibility of the SAPS. Police officers continue to execute border control. Another weakness remains a poorly organised customs and revenue service for the control of imports and exports through ports of entry. [85]

[85] Haefele. n.d: 111-112.