SUBMISSION ON THE DRAFT PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE BILL[1]

INTRODUCTION

The AIDS and Rights Alliance for Southern Africa (ARASA) welcomes this opportunity to make written submissions on the draft Prevention of and Treatment for Substance Abuse Bill ("the draft Bill"). As an organisation that – amongst other things – seeks to promote an evidence-based approach to the health issues facing Southern Africa, we welcome the draft Bill and the many positive contributions we believe it will make in advancing a set of medically sound interventions regarding substance use.

We do, however, have certain concerns about the draft Bill. In particular, as is evident from the recommendations we make below, we submit that the draft Bill fails:

- To acknowledge that substance use is a chronic and relapsing medical condition;
- Sufficiently to recognize the links between substance use, HIV/AIDS and other infectious diseases; and
- To include key interventions to prevent and treat substance use and its associated harms.

SUMMARY OF OUR KEY CONCERNS

The chronic, relapsing nature of substance use; its links with HIV and hepatitis C (HCV); and the rise in heroin and injection drug use – as well as the abuse of other substances – in South Africa; require the establishment and wide availability of interventions that specifically address these concerns, particularly syringe exchange, substitution therapy and other harm reduction programmes. Below we explain why.

Substance use is a chronic, relapsing brain disease

Current research on addiction indicates that substance use is a disease of the human brain, with all addictive substances having specific physical effects on the brain itself. These effects, which keep drug users taking drugs,[2] last for long periods of time – even after the cessation of drug use.[3] Thus the biological nature of substance use, and the long-lasting changes in the brain that it causes, makes substance use for most people, a chronic, relapsing disorder, with total abstinence a relatively rare outcome. Interventions for addiction must therefore be approached more like other chronic illnesses, such as diabetes and heart disease, and less like acute conditions such as bacterial infections or broken bones.[4]

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[1] This submission is endorsed by the AIDS Law Project and the Treatment Action Campaign.

[2] Alan I. Leshner, Addiction Is a Brain Disease, and It Matters, Science **278**,5335, 45 (1997); G. F. Koob, Trends Pharmacol. Sci. 13, 177 (1992); G. F. Koob, et al., Semin. Neurosci. 6, 221 (1994)

[3] S. E. Hyman, Neuron 16, 901 (1996); E. J. Nestler, ibid., p. 897; W. P. Melega et al., Behav. Brain Res. 84, 259 (1997); J. Ortiz, et al., Synapse 21, 289 (1995); N. D. Volkow, et al., Am. J. Psychiatry 147, 719 (1990); E. J. Nestler et al., Mol. Psychiatry 1, 190 (1996); D. W. Self and E. J. Nestler, Annu. Rev. Neurosci. 18, 463 (1995).

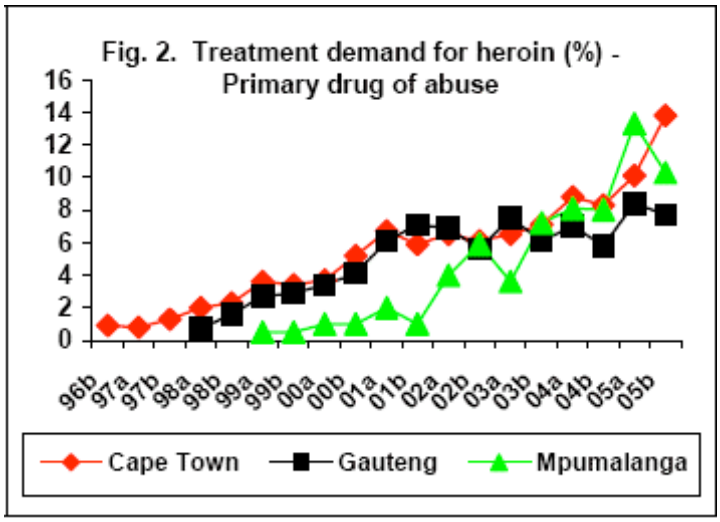
[4] C. P. O'Brien and A. T. McLellan, Lancet 347, 237 (1996)

Substance use is a vehicle for the transmission of HIV and HCV

In many settings, substance use is associated with specific other diseases, including HIV and hepatitis C. In particular, between 5 – 10% of all HIV infections globally can be attributed to injection drug use. By 2003, injection drug use had been reported in 136 countries, of which 93 also identified HIV infections among drug injectors.[5] Particularly noteworthy is that the emergence of HIV infection in injecting drug user (IDU) populations is often explosive, with the establishment of 30 – 40% prevalence in the first year.[6] In addition, viral hepatitis - particularly HCV – is extremely common amongst IDUs where up to 98% of the population can be infected despite a low prevalence of HIV.[7]

Heroin and injection drug use in South Africa is on the rise

The South African Community Epidemiology Network on Drug Use notes that "over time, there has been a large increase in treatment demand for heroin as a primary drug of abuse in Cape Town, Gauteng and Mpumalanga":



> "In Gauteng and Mpumalanga there was a decline in 2005b, but the upward trend continued in Cape Town (Fig. 2). In these sites between 11% and 16% of patients have heroin as a primary or secondary drug of abuse. Most heroin is smoked, but of patients with heroin as their

[5] WHO/UNODC/UNAIDS Position Paper on Substitution Maintenance Therapy for Opioid Dependence.
[6] Beyrer C. Emerging HIV epidemics Program and abstracts of the 3rd IAS Conference on HIV Pathogenesis and Treatment; July 24-27, 2005; Rio de Janeiro, Brazil. Abstract MoPI02.
[7] Roy K, Hay G, Andragetti R, Taylor A, Goldberg D, Wiessing L: Monitoring hepatitis C virus infection among injecting drug users in the European Union: a review of the literature. Epidemiology & Infection 2002, 129:577-585; European Monitoring Centre for Drugs and Drug Addiction: Annual Report on the State of the Drugs Problem in the European Union and Norway. [http://annualreport.emcdda.eu.int] Luxembourg, EMCDDA; 2003; Jager J, Limburg W, Kretzschmar M, Postma M, Wiessing L: Hepatitis C and Injecting Drug Use: impact, costs and policy options. Luxembourg, European Monitoring Centre for Drugs and Drug Addiction; 2004.

> primary drug of abuse in Cape Town, Gauteng, and Mpumalanga, 8%, 39% and 34% respectively report injection use."[8]

However, the Alcohol & Drug Abuse Research Unit of the South African Medical Research Council and the Global AIDS Program of the US Centers for Disease Control and Prevention note that while injection drug use in South Africa is primarily associated with heroin, IDUs are also injecting other drugs. In addition, they have reported needle sharing. Disturbingly, a small study showed that 20% of IDUs and 28% of drug users overall are already HIV-positive.[9]

Why are syringe exchange programmes necessary?

IDUs become infected and transmit HIV and HCV to others through sharing contaminated syringes and other drug injection equipment, as well as through high-risk sexual behaviours. Women who become infected with HIV through sharing needles or having sex with an infected IDU may also transmit the virus to their babies before or during birth or through breastfeeding. As is demonstrated in the studies referred to above, injection drug use and transmission of HIV infection among IDUs is already established in South Africa. Yet there are few services available for injection drug users in the country.

It is estimated that an individual IDU injects about 1 000 times a year.[10] This adds up to millions of injections, creating an enormous need for reliable sources of sterile syringes. Syringe exchange programs (SEPs) provide a way for those IDUs who continue to inject safely to dispose of used syringes and to obtain sterile syringes at no cost. Importantly, the effectiveness of SEPs in preventing HIV transmission among injecting drug users is well established.[11] According to a review of the evidence by the US National Institutes of Health:

> "an impressive body of evidence suggests powerful effects from needle exchange programs. … Studies show reduction in risk behaviour as high as 80%, with estimates of a 30% or greater reduction of HIV in IDUs."[12]

Additionally, scientific studies have shown that SEPs are associated with:

- stopping injecting/reduced injecting frequency;

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[8] Parry C, Plüddemann A, Bhana A, Harker N, Potgieter H, Gerber W, Johnson C, Alcohol and drug abuse trends: July – December 2005 (Phase 19). South African Community Epidemiology Network on Drug Use (SACENDU) Update (28 June 2006 --corrected 15 August 2006).

[9] Parry C, Dewing S, Petersen P, Carney T, Achrekar A, Kroeger K, Needle R. HIV Among IDUs, CSWs and MSM Drug Users in South Africa. Alcohol & Drug Abuse Research Unit (MRC) and the Global AIDS Program (CDC). Presentation at the Priorities in Aids Care and Treatment conference, Cape Town, 1 to 4 October 2006, available at http://www.phru.co.za/pact/pact2006_presentations.stm

[10] Lurie P, Jones TS, Foley J. A sterile syringe for every drug user injection: how many injections take place annually, and how might pharmacists contribute to syringe distribution? Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 1998;18(Suppl 1):S45-S51.

[11] Harm Reduction: Questions and Answers, [http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/qa_20041123]; Gibson DR, Flynn NM and Perales D (2001) Effectiveness of syringe exchange programs in reducing HIV risk behavior and HIV seroconversion among injecting drug users. AIDS 15(11), 1329-1341.

[12] National Institutes of Health. Consensus Development Statement. Interventions to prevent HIV risk behaviors, February 11-13, 1997:7-8.

- stopped/reduced reuse of needles and syringes and other injecting equipment;
- reduction/stopping crack use;
- increased needle disinfection;
- increased referrals for and participation in drug treatment; and
- increased condom use/reduction in unprotected sex.[13]

HIV and HCV co-infection is also common in settings where HIV prevention interventions – particularly SEPs – have not been established for IDU populations. Thus, HIV and HCV prevalence among regular IDUs in Australia is 1% and 50 – 60% respectively, meaning that HIV/HCV co-infection in Australia is relatively uncommon. In contrast, countries such as the United States – where harm reduction (including measures such as SEPs) coverage has been more limited – have considerably greater rates of HIV/HCV co-infection among IDU populations.[14]

Why are substitution therapy programmes necessary?

Substitution therapy, particularly with methadone or buprenorphine, is one of the most effective types of treatment for opiate dependence. Methadone and buprenorphine are synthetic opiates and are "substituted" for heroin for individuals suffering from addiction.[15] They act on the same receptors or connections in the brain that heroin does and in doing so have the ability to prevent the emergence of withdrawal symptoms and reduce cravings for heroin; reduce the effects of heroin; and allow the stabilization of brain functions that heroin disrupts.

Substitution maintenance therapy of opiate dependence is an important component of community-based approaches to drug addiction in that the treatment can be provided on an out-patient basis. This achieves high rates of retention in treatment, increasing the time and opportunity for individuals to tackle major health, psychological, family, housing, employment, financial and legal issues while in contact with treatment services.[16]

There is consistent evidence from numerous scientific studies that substitution maintenance treatment is associated with generally substantial reductions in illicit opiate use, criminal activity, deaths due to overdose, and behaviours with a high risk of HIV transmission.[17] In addition, patients in substitution treatment-based programs are more likely to stay in treatment than those in detoxification, placebo, or drug-free

[13] Coyle SL, Needle RH, Normand J (1999) Outreach-based HIV prevention for injecting drug users: a review of published outcome data. Public Health, 113 (Supplement I), 19-30.
[14] National Centre in HIV Epidemiology and Clinical Research. HIV/AIDS, Hepatitis C and Sexually Transmissible Infections in Australia Annual Surveillance Report. Sydney, NSW, National Centre. In: HIV Epidemiology and Clinical Research. The University of New South Wales. 2005.
[15] Both drugs are included for this medical indication as part of the World Health Organization's Model List of Essential Medicines. They are prescribed in pill or liquid form under medical supervision.
[16] Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: position paper, World Health Organization, United Nations Office on Drugs and Crime, UNAIDS
[17] Ibid

programs, and clinics based on substitution treatment have better outcomes than those that promote only abstinence.[18]

Yet the most effective treatments for opiate addiction are not widely available in South Africa. With the increase in heroin use in the country, there is a clear need for the establishment of specific interventions for opiate addiction.

Why are other harm reduction programmes necessary?

In addition to syringe exchange and substitution therapy programmes for injection drug and opiate users, individual substance users who are unwilling or unable to cease their substance use need education, training and information-sharing programmes on the dangers of substance abuse, including the link between substance abuse, HIV and viral hepatitis; HIV and viral hepatitis prevention education; and overdose prevention and treatment.

The need for training, information-sharing and educational programmes on the dangers of substance use, HIV and viral hepatitis (and how to prevent transmission of these two infections) is evident from the links between drug use and HIV and HCV described above. However, despite the availability of such programmes (including opiate substitution therapy), many heroin users will continue to use the drug.

In order to minimize the risk of heroin overdose and the risk of death from overdose, several jurisdictions in the United States and elsewhere in the world have developed overdose prevention programs that include education, instruction in mouth-to-mouth resuscitation and the provision of the medication naloxone for use by lay persons. There is clear evidence that these programs are feasible, safe and are associated with significant decreases in overdose deaths.[19]

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[18] Farrell M, Ward J, Mattick RP, Hall W, Stimson G, Des Jarlais D, Gossop M and Strang J (1994) Methadone maintenance treatment for opiate dependence: A review. British Medical Journal, 309, 997-1001; Ward J, Mattick RP and Hall W (1998) Methadone Maintenance Treatment and other Opioid Replacement Therapies. Amsterdam: Harwood; Gerstein DR and Harwood HJ (Eds.) (1990) Treating drug problems, Vol. 1: A study of the evolution, effectiveness, and financing of public and private drug treatment systems. Washington: National Academy Press; Advisory Council on the Misuse of Drugs (1993). AIDS and drug misuse update report. London: HMSO; Farrell M, Ward J, Mattick RP, Hall W, Stimson G, Des Jarlais D, Gossop M and Strang J (1994) Methadone maintenance treatment for opiate dependence: A review. British Medical Journal, 309, 997-1001; Marsch LA (1998) The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-analysis. Addiction 93(4), 515-532; Mattick RP, Breen C, Kimber J, and Davoli M (2003) Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Cochrane Review). In: The Cochrane Library, Issue 1. Oxford: Update Software; Mattick RP, Kimber J, Breen C, and Davoli M (2003) Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Cochrane Review). In: The Cochrane Library, Issue 1. Oxford: Update Software.

[19] Galea S, Worthington N, Markham Piper T, Nandi VV, Curtis M, Rosenthal D. Provision of naloxone to injection drug users as an overdose prevention strategy: Early evidence from a pilot study in New York City. Addict Behav. 2006;31:907–12. doi: 10.1016/j.addbeh.2005.07.020. Seal KH, Thawley R, Gee L, Bamburger J, Kral AH, Ciccarone D, Downing M, Edlin BR. Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: A pilot intervention study. J Urban Health. 2005;82:303–311. Sherman, SG. Tobin, K. Rucker, M. Latkin, CA. A description of the Baltimore city overdose prevention program: Staying Alive. Paper presented at the 15th International Harm Reduction Conference Belfast,Ireland. March 13, 2005. Sherman, SG.;Cheng, Y.; Kral, AH. Prevalence and correlates of opiate overdose among young injection drug users in Baltimore, Maryland. Manuscript under review. 2006.

Finally, other drugs of abuse are extremely common in South Africa, particularly alcohol, cannabis ("dagga"), Mandrax (methaqualone) and cocaine (see Table 1 below). Of particular note is the explosive growth of the use of methamphetamine (MA) in Cape Town, where "almost half (45%) of patients in Cape Town now have MA as a primary or secondary drug of abuse, with 48% reporting daily use (up 4 percentage points)."[20]

Table 1. Primary drug of abuse (%) for all patients and patients under 20 years – selected drugs (2005b)

	Age	CTn	Dbn*	E-Cape	Gtg	Mpum
# centres>		26	5	10	18	4
Alcohol	All	25	58	58	52	54
	<20	3	24	19	11	21
Cannabis	All	11	28	13	21	23
	<20	22	65	39	63	57
Methaq.	All	6	3	8	3	0.5
	<20	7	4	12	5	0
Cocaine	All	8	7	11	10	6
	<20	1	2	10	5	3
Heroin	All	14	1	5	8	10
	<20	13	1	11	7	10
Methamphetamine	All	35	0	2	0.2	0.5
	<20	53	0	10	0.2	1

*-now includes Pietermaritzburg

Like other substances of abuse, addiction to alcohol, cannabis, Mandrax, cocaine and MA is chronic and relapsing, thus requiring training and educational programmes that seek to minimize the harms associated with drug use for those who continue to use them. Importantly, people who abuse alcohol, MA, cocaine or other non-injected drugs are more likely than non-substance users to be – or to become – HIV positive. People with a history of non-injection substance abuse are also more likely to engage in high-risk sexual activities.[21] Thus HIV prevention programmes specifically targeted at drug users are critical, particularly in the context of South Africa's existing and enormous HIV epidemic.

Constitutional obligations to respond reasonably to substance use

South Africa's Constitution recognises a set of socio-economic rights, including the right of "everyone" to have access to health care services, as well as positive obligations on the state in respect of such rights.[22] Regarding the progressive

[20] Parry C, Plüddemann A, Bhana A, Harker N, Potgieter H, Gerber W, Johnson C, Alcohol and drug abuse trends: July – December 2005 (Phase 19). South African Community Epidemiology Network on Drug Use (SACENDU) Update (28 June 2006 --corrected 15 August 2006).

[21] Leigh BC, Stall R. Substance use and risky sexual behavior for exposure to HIV. American Psychologist. 1993;48:1035-1045.

[22] Sections 26, 27 and 29 provide for housing, water, food, social security and education rights respectively. Section 28 provides for children's rights (including basic nutrition, shelter, basic health care services and social services), with section 35 guaranteeing certain rights to prisoners, including various socio-economic entitlements such as adequate nutrition and medical care. These rights underpin the Constitution's foundational commitment to the creation of a society based on human

realisation of the health care right in particular, section 27(2) of the Constitution requires the state to take "reasonable legislative and other measures, within available resources". In the context of drug use, such measures would include the development, enactment and implementation of a legislative framework that recognises the right of drug users to scientifically-proven health care interventions such as SEPs, substitution therapy and other harm reduction programmes.

While drug users themselves have a constitutional right to the introduction of such programmes, the evidence shows why the broader public interest demands such an approach. Access to such services is thus not only constitutionally required to protect drug users from HIV infection, for example, but also to reduce the risk of HIV transmission to the sexual partners of drug users, who may or may not be drug users themselves. Simply put, public health is placed at risk when evidence-based HIV prevention programmes such as SEPs are not implemented.

DETAILED SUBMISSIONS

The following section details the specific changes to the draft Bill that we recommend. Underlined text represents proposed additions to the text of the current draft Bill. Bold text in square brackets indicates proposed deletions.

Chapter 5 of the draft Bill: Centre-based and out-patient services

Chapter 5 of the draft Bill proposes much needed oversight of public and private drug treatment and rehabilitation services and defines a range of interventions to be established by the Minister of Social Development. Importantly, it proposes greater protection of the public and improved transparency and accountability. We therefore strongly support chapter 5 of the draft Bill.

Establishment of halfway houses

In our view, however, chapter 5 could be strengthened by including the educational components of the harm reduction services described above, based on the evidence of the effectiveness of these interventions and the constitutional obligations to provide them. Thus we submit that the language of chapter 5 of the draft Bill should more clearly define the programmes for drug users who relapse and continue their substance use. In the result, we recommend that sub-section 14(3)(b) be redrafted as follows:

> The management of a halfway house must submit to the Minister programmes regarding-
>
> (a) the relapse prevention in respect of substance abuse;
> (b) information to the community and the service user on the dangers of substance abuse, including the links between substance abuse, HIV and viral hepatitis; HIV and viral

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dignity, equality and freedom, which are the primary goals and values of the Constitution. In this regard, see Forman L.The imperative to treat: the South African state's constitutional obligations to provide antiretroviral medicines. Health Law Rev. 2003;12(1):9-15.

hepatitis prevention education; and overdose prevention and response;

(c) the education of children, youth and families regarding the dangers of substance abuse; and

(d) skills development for service users and their re-integration into society.

Death of service user in treatment centre or halfway house

Section 19 of the draft Bill addresses the death of a service user in treatment centres or halfway houses. While this is to be welcomed, it needs to be extended to enable the monitoring of short-term follow-up of service users, specifically any deaths within two weeks after release from these institutions (based on the chronic and relapsing nature of addiction described above). We therefore propose the following additional subsections to section 19:

(4) If a service user dies within two weeks of leaving a treatment centre or halfway house, the manager of the treatment centre or halfway house must immediately after the death of the service user report such death to a member of the South African Police Service and to the Director–General.

(5) Any manager who fails to comply with subsection (4) is guilty of an offence.

(6) The member of the South African Police Service must ensure that the circumstances of the death of such service user is investigated and inform the Director-General on the outcome of the investigation and make recommendations for further action, if any.

Types of out-patient services

Our foremost concern with the draft Bill is the absence of language to provide for critical harm reduction and HIV prevention services for drug users. The need for these specific services was addressed at length above. Thus, our strongest recommendation in this submission is for the addition of the following subsections in section 21:

(d) substitution treatment programs, including opiate (methadone, buprenorphine and other such drugs as become available) and stimulant (methamphetamine) maintenance, with services rendered by registered health professionals and licensed health care facilities;

(e) evidence-based HIV prevention and education programs, including syringe distribution by non-governmental and faith-based organisations (including street outreach), pharmacies, registered health professionals, licensed health care facilities and any other facility deemed suitable by the Minister; and

(f) harm reduction education, training, information-sharing and campaigns for individual substance abusers who are unwilling or unable to cease their substance use.

Chapter 6 of the draft Bill: Aftercare and reintegration services

Chapter 6 provides for a set of interventions that recognize that drug treatment is only part of the continuum of services for drug users that must be available in their communities. However, it does not sufficiently recognize the chronic and relapsing nature of drug addiction.

Establishment of programmes for aftercare and reintegration services

We propose further strengthening this chapter by the addition of a new subsection 25(2)(g), which directly addresses the chronic and relapsing nature of drug addiction and its links to HIV transmission. In the result, we propose amending section 25 as follows:

(1) The Minister may establish aftercare and reintegration programmes which must focus on the successful reintegration of a service user to society, the workforce and family and community life.
(2) The programmes referred to in subsection (1) must include elements, which –
    (a) allow service users interaction with other service users, their families and communities;
    (b) promote the design of specific aftercare and relapse prevention programmes;
    (c) allow service users to share long term sobriety experiences;
    (d) promote group cohesion among service users;
    (e) enable service users to stay clean from substance abuse; **[and]**
    (f) are based on structured programmes, and;
    (g) promote the design of specific evidence-based HIV prevention programmes, with a particular focus on relapsing substance abusers.

Support groups

In order to provide additional services for drug users in relapse or in the pre-treatment process, while also serving those in recovery, we also propose that section 27 be expressly amended to read as follows:

(1) Support groups which focus on supporting the service user in his or her recovery process, whilst in relapse or in the pre-treatment process may be established –
    (a) in the form of organised aftercare structures for professional support services and skills development; or
    (b) by the service users and include people affected by substance abuse.
(2) The purpose of such support groups will be to –
    (a) provide a safe, **[substances of abuse-free]** group experience where service users can **[practice re-socialisation skills]** discuss their substance abuse;
    (b) facilitate access to mental health professionals and social workers **[recovered substance abusers who can serve as**

role models for service users who are still in the beginning or middle stages of the recovery process]; and

(c) encourage service users to contemplate personal health, well-being and sobriety **[broaden their support system of sober and recovering friends]**.

Chapter 7 of the draft Bill: Admission, transfer and referral procedure to treatment centres

Committal to treatment centre after conviction

The current draft of section 32(2)(a) reads as follows:

> Where a court has referred a person to a treatment centre under subsection (1) and such person is later found not to be fit for treatment in such treatment centre, such person may be dealt with in accordance with the provisions of section 276A(4) of the Criminal Procedure Act.

This section, however, fails to acknowledge the chronic and relapsing nature of addiction disease. We therefore propose that section 32(2)(a) be followed by the following proviso:

> Provided that relapse to substance abuse does not automatically constitute a violation of the sentencing terms.

In addition, we propose the addition of the following new subsection 2(c):

> Before making a determination in respect of any possible violation of sentencing terms, a court must be satisfied that a person described in subsection (a), particularly a person who relapses and resumes his or her drug use, has been assessed by a qualified health professional with experience in addiction medicine and has been ruled out for further treatment, including harm reduction and support services as described in sections 21 and 27 above.

Chapter 8 of the draft Bill: Behaviour management and disciplinary interventions

Method of dealing with absconders from treatment centre

Section 48 of the draft Bill does not sufficiently protect the rights of the service user from extra-judicial seizure against his or her will. The state only has a compelling interest in the arrest of service users who have absconded from a treatment centre and who are a danger to themselves or others. In all other circumstances, the service user's informed consent to treatment – and the withdrawal from treatment – must be respected.

In our view, therefore, any arrest should be made only by way of a warrant and only by members of the South African Police Service – not by way of extra-judicial powers conferred upon non-law enforcement professionals such as social workers or the

staff of treatment centres. To that end, we make the following proposed amendments to sections 48(2) and 48(3), which allow arrest only by law enforcement officers with warrants for such purposes:

(2) A service user who has absconded from a treatment centre and is considered a danger to themselves or any other person may only be arrested **[without warrant]** by any member of the South African Police Service, **[social worker or member of the staff of the treatment centre]** who has a warrant for such purposes, and must as soon as is reasonably possible be brought before a magistrate of the district in which he or she was arrested.

(3) Any person who obstructs or hinders a member of the South African Police Service**[, social worker or the staff of the treatment centre]** in the exercise of any power conferred upon him or her under subsection (2) is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 12 months or to both such fine and such imprisonment.

Chapter 10 of the draft Bill: Central drug authority and supporting structures

The guiding principles for the provision of services (outlined in section 6) provide as follows:

> All services rendered to persons affected by substance abuse must be provided in an environment that –
>
> (a) recognizes the social, cultural, economic, physical challenges, age and gender of such persons;
> (b) ensures access to information regarding substance abuse;
> (c) promotes the prevention of exploitation of such persons;
> (d) promotes the respect and dignity of persons affected by substance abuse; and
> (e) promotes participation of persons affected by substance abuse in decision making processes regarding themselves.

In order to fulfil the principles set out in sections 6(d) and 6(e), we propose additions to sections 51(2), 55(2) and 58(3) to provide for direct representation by drug users and others with histories of substance use. We propose that these subsections be supplemented as follows:

- By the insertion of a new section 51(2)(v) that reads as follows:

  not less than six members who have experiential histories of substance abuse.

- By the insertion of a new section 55(2)(h) – with the existing subsection (h) being renumbered (i) – that reads as follows:

  self-organized drug user groups, where these exist;

- By the addition of a new section 58(3)(f) – with the existing subsection (f) being renumbered (g) – that reads as follows:

  a representative of self organized drug user groups, where these exist;

Finally, we propose the following addition to section 54(j) to ensure that the health consequences of drug use are integrated into the responsibilities of the Central Drug Authority:

> must ensure the development of effective strategies on prevention, early intervention, reintegration and aftercare services, and in particular, must ensure the development of effective strategies regarding the prevention of HIV infection and other medical consequences related to substance abuse;

Cape Town
26 February 2007

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