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SUBMISSION ON THE PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE BILL [B 12—2008][1]

INTRODUCTION

In February 2007, the AIDS and Rights Alliance for Southern Africa (ARASA)[2] made a written submission to the Department of Social Development (DSD) on the draft Prevention of and Treatment for Substance Abuse Bill ("the draft Bill").[3] While some of our detailed submissions have indeed been taken into account by the DSD in its revision of the draft legislation, the Prevention of and Treatment for Substance Abuse Bill [B 12—2008] ("the tabled Bill") also 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.

The purpose of this submission is twofold. First, it briefly identifies the key substantive issues addressed in our previous submission that remain relevant. Second, it considers the recommendations made in the previous submission that have not been – but should still be – addressed by the tabled Bill. In so doing, this submission makes recommendations on proposed amendments to the text of specific provisions of the tabled Bill.

SUMMARY OF OUR PREVIOUS SUBMISSION

[1] As was the case with our previous submission, this submission is also endorsed by the AIDS Law Project (ALP) and the Treatment Action Campaign (TAC). In addition, it is also endorsed by Substance Misuse: Advocacy, Research & Training (SMART). More information on the ALP and TAC can be found online at http://www.alp.org.za and http://www.tac.org.za respectively. SMART is South Africa's leading independent centre of expertise on drugs. Its aim is to inform policy development and reduce drug-related risk. To achieve its aim, SMART provides quality drug information, promotes effective responses to drug taking, undertakes research at local, national and international levels, and advises on policy-making and encourage informed debate.

[2] More information on ARASA is available online at http://www.arasa.info.

[3] A copy of this previous submission is attached.

Our previous submission called for the establishment and wide availability of syringe exchange, substitution therapy and other harm reduction programmes. It did so on the basis that these interventions are needed to address the following 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.

In particular, our submission addressed the following issues:

- Substance use as a chronic, relapsing brain disease;
- Substance use as a vehicle for the transmission of HIV and HCV;
- The rise of heroin and injection drug use in South Africa;
- The need for syringe exchange, substitution therapy and other harm reduction programmes; and
- The state's constitutional obligations to respond reasonably to substance use.

In addition, the submission made recommendations regarding specific changes to the text of the draft Bill.

DETAILED RECOMMENDATIONS

We stand by our recommendations and submit that the substantive issues raised remain relevant. However, because the tabled Bill differs in some respects from the draft Bill, we believe that it is important to restate those recommendations that have yet to be addressed. In addition, the tabled Bill raises a number of new issues that require attention. This section of the submission therefore details the specific changes to the tabled Bill that we recommend.[4]

<u>Chapter 2 of the tabled Bill: Combating of substance abuse</u>

Chapter 2 outlines key features of the framework that the Minister of Social Development ("the Minister") may develop for programmes to combat substance abuse. In particular, the chapter addresses the development of minimum norms and standards for all services. We strongly support this aspect of the tabled Bill because it addresses the issue of quality service for service users and improved accountability by service providers. In doing so, however, we propose the following minor amendments to clauses 4(1)*(b)* and 4(1)*(e)*:

(b) relating to the protection of children in <u>in-patient</u> treatment centres[5] <u>and halfway houses;</u>
(c) for prevention programmes;
(d) for community-based services;
(e) for the establishment, management, monitoring and assessment of halfway houses and <u>in-patient</u> treatment centres;[6]

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[4] <u>Underlined text</u> represents proposed additions to the text of the tabled Bill. **[Bold text in square brackets]** indicates proposed deletions.

[5] The tabled Bill does not adequately define a treatment centre. We propose that it expressly be amended, in line with the international norm, to refer to centres housing four or more persons under one roof.

Of greater concern is that the chapter fails to address the chronic and relapsing medical nature of the condition and to include key interventions to prevent and treat its associated harms. We believe that this can easily be remedied by simple additions to clause 3(2), thus recommending that it be supplemented with the following subclauses:

> *(f)* programmes to promote the health and well-being of individual substance abusers who are unwilling and/or unable to cease their substance use; and
> *(g)* programmes to prevent the harms associated with substance use, particularly HIV infection and other medical consequences.

In addition, we also recommend that the language of clause 3(2)*(a)*(ii) – which is unnecessarily restrictive, somewhat clumsy and technically incorrect – be amended as follows:

> proactive measures targeting individuals, families and communities **[that are at risk]** to avoid **[the]** risky substance use **[of substances of abuse]** and to prevent persons already using substances from moving **[in]**to higher levels of use **[addiction]**

Finally, we recommend that clause 6 – which addresses guiding principles for the provision of services – be amended to address concerns relating to the incorrect and/or clumsy use of terminology:

> All services rendered to persons who **[are dependent and addicted to]** use substances **[of abuse]** and those who are affected by **[substance abuse]** them, must be provided in an environment that—

Chapter 3 of the tabled Bill: Prevention of substance abuse

Chapter 3 outlines the framework for prevention programmes but does not address the need to ensure that the response to substance use is primarily one based on evidence and science, grounded in firm principles of good public health practice. To the contrary, it appears to open the door to unscientific and moralistic approaches to prevention programmes that may in fact be counterproductive. We therefore recommend that clause 7(2)*(a)* – which speaks about "address[ing] the values, perceptions, expectations and beliefs that a community associates with substances of abuse" – be removed in its entirety.

Furthermore, we recommend that clause 8(1) be strengthened as follows:

> The purpose of prevention services and programmes is to prevent a person from using or continuing to use substances **[of abuse]** that may result in addiction and to reduce the personal medical, public health and social harms associated with such use.

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[6] The revised text for clause 4(1)(*e*) obviates the need for clause 4(1)(*f*), which should be deleted (as it does not add anything new).

In addition, we recommend that clause 8(2)*(g)* – whilst retaining a focus on children – be expanded and amended as follows:

> promoting the diversion of **[a child]** persons using substances **[of abuse]**, especially children, away from the **[child and youth care system]** criminal justice system and, where appropriate, the child and youth care system

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

Chapter 5 of the tabled 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. Importantly, it proposes greater protection of the public and improved transparency and accountability. We therefore strongly support chapter 5 of the tabled Bill. In so doing, however, we believe that it could be strengthened in respect of the following three areas: the establishment of halfway houses; types of out-patient services; and support groups.

In particular, we submit that chapter 5 could be strengthened by including all the educational components of the harm reduction services described in our original submission (not only those targeted at HIV prevention), 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 tabled Bill should more clearly define the programmes for drug users who relapse and continue their substance use. In the result, we recommend that clause 14(3)*(e)* be redrafted as follows:

> the dissemination of information to the community and service users about the dangers of substance abuse, including the links between substance abuse, HIV infection and **[AIDS]** viral hepatitis; the prevention of HIV infection and viral hepatitis; and overdose prevention and response.

Our foremost concern with the tabled 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 in our original submission. Thus our strongest recommendation in this submission is for the addition of the following additions to clause 22:

(f) substitution treatment programmes, 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;

(g) evidence-based HIV prevention and education programmes, 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

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

Further, in order to provide additional services for drug users in relapse or in the pre-treatment process, while also serving those in recovery in a non-threatening and appropriate manner, we also propose that clause 27 expressly be amended to read as follows:

(1) Service users may establish support groups that focus on integrated ongoing support **[to service users]** in their recovery process, whilst in relapse or in the pre-treatment process, and may –
   (a) be in the form of organised aftercare structures for professional support services and skills development; and
   (b) include people affected by substance abuse.
(2) The purpose of **[the establishment of]** such support groups is to—
   (a) provide a safe **[and 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 **[broaden their support system from persons referred to in paragraph (b)]** contemplate personal health, well-being and sobriety.

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

The current draft of clause 32(3)*(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, he or she may be dealt with in accordance with 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 clause 32(3)*(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 clause 32(3)*(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/or support services as described in sections 22 and 27 of this Act.

Chapter 8 of the tabled Bill: disciplinary intervention and appeal procedure

Section 48 of the tabled 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 clauses 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 himself or herself or any other person may only be arrested **[without warrant]** by a police official**[, social worker or member of 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 police official**[, social worker or the staff of the treatment centre]** in the exercise of any power contemplated in 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 a fine and such imprisonment.

Chapter 9 of the tabled Bill: Central drug authority and supporting structures

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

> All services rendered to persons who are dependent and addicted to substances of abuse and those who are affected by substance abuse, must be provided in an environment that—
>
> *(a)* recognises the social, cultural, economic and physical needs, as well as the age and gender requirements, of such persons;
>
> *(b)* ensures access to information regarding the prevention of 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 their needs and requirements.

In order to fulfil the principles set out in clauses 6*(d)* and 6*(e)* in particular, we propose additions to clauses 49(2), 53(2), 55(2) and 56(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 clause 49(2)*(u)* that reads as follows:

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

- By the insertion of a new clause 53(2)*(h)* – with the existing subclause *(h)* being renumbered *(i)* – that reads as follows:

  self-organized drug user groups, where these exist;

- By the insertion of a new clause 55(2)*(e)* that reads as follows:

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

- By the addition of a new clause 56(3)*(i)* – with the existing subclause *(i)* being renumbered *(j)* – that reads as follows:

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

Finally, we propose the following addition to clause 52*(i)* to ensure that the health consequences of drug use are integrated into the responsibilities of the Central Drug Authority (and by implication, its supporting structures):

> 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;

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