HSRC
HUMAN SCIENCES
RESEARCH COUNCIL

Costing of the Prevention and Treatment of Substance Abuse Bill

Report submitted to: National Department of Social Development

submitted by:

Human Sciences Research Council (HSRC)

Private Bag X41

PRETORIA, 0001

Contact person:

Prof Arvin Bhana

Research Director

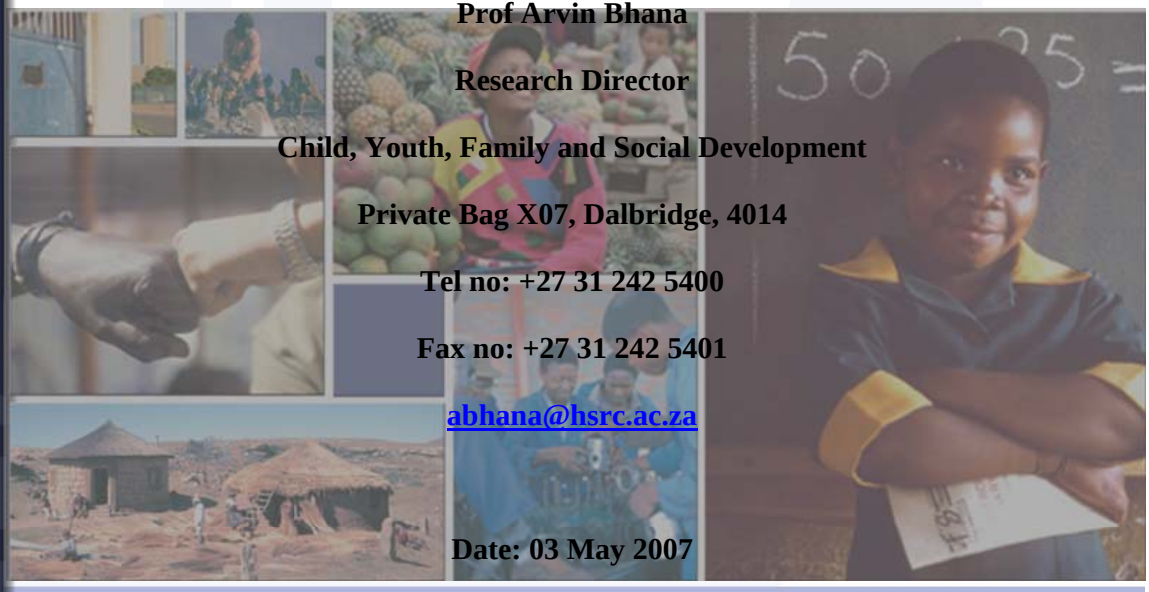
Child, Youth, Family and Social Development

Private Bag X07, Dalbridge, 4014

Tel no: +27 31 242 5400

Fax no: +27 31 242 5401

abhana@hsrc.ac.za



Date: 03 May 2007

Social science that makes a difference

TABLE OF CONTENTS

LIST OF TABLES

ACRONYMS AND ABBREVIATIONS

CBO	Community-based organisation
CDA	Central Drug Authority
DoSD	Department of Social Development
FAS	Foetal Alcohol Syndrome
LDAC	Local Drug Action Committee
M & E	Monitoring and Evaluation
NGO	Non-governmental organisation
NPO	Non-profit organisation
PSAF	Provincial Substance Abuse Forum
SACENDU	South African Community Epidemiology Network on Drug Use
SANCA	South African National Council on Alcoholism and Drug Dependence
ToR	Terms of Reference

1. Introduction

In May 2006, the National Department of Social Development sent out a request for proposals to Cost the Prevention and Treatment of Substance Abuse Bill (Tender number: SD 04/2006). Professor Arvin Bhana of the Child, Youth, Family and Social Development (CYFSD) Unit of the HSRC, a government-funded research entity, assembled a Research Team which submitted a proposal in response to this tender that was subsequently successful.

The objectives of the costing exercise, designed in collaboration with the Department, can be described as follows:

- To identify which resources will be used in either the introduction or expansion of certain selected activities under the Bill
- To estimate the costs associated with the use of the resources identified
- To investigate the changing profile of costs under a range of agreed upon scenarios
- To discuss the implications of these costs, especially in terms of the Department's planning or decision-making framework.

Project objectives are outlined more clearly in the project proposal, which also provides details on the steps that the Research Team felt were necessary for completion of their tasks under the project. Readers are also referred to this document for exact details of the composition of the Research Team.

In addition to costing the Bill, the Research Team also undertook to review the incidence and nature of substance abuse in South Africa and conduct a legal review of the government's obligations that will result from passage of the Bill as part of this project.

These results, as well as a brief description of the methodology employed to conduct each review, are included as sections of the costing report.

Essentially, the costing exercise entailed answering four key questions. These are listed in the order in which they were addressed by the Research Team as follows:

- *What services* have to be provided?
- At *what level* will these services be provided?
- *How* are services going to be provided?
- *How much* will they cost?

While some degree of overlap took place, as far as possible, each element was designed to be addressed by a particular component of the project. The four components of the project, listed in corresponding order to the questions above, are:

- Legal Review
- Review of Substance Abuse in South Africa
- Fieldwork
- Cost Modelling

The following sections describe how each component was undertaken and how the findings contained therein were used to answer each key question. Components are discussed in terms of methodologies employed, key findings and an analysis of findings in terms of their implications for service delivery or, in the latter instance, financial costs.

2. Legal Review

The project commenced with an analysis of legislation in the area of substance abuse. The purpose of the legal review was to assist in answering the first question: *what services* have to be provided? This entailed examining the legislative environment, including proposed legislation, current legislation as well as any other legislation that may circumscribe government's obligations in the area of substance abuse (e.g. the Constitution). The purpose of this analysis was to determine the extent of the government's obligations or commitments that will be created by the passage of this Bill. The legal analysis comprised three distinct activities:

- Identify obligations created for the state by the enactment of the Bill
- Identify the component of service delivery, or activity area, to which each obligation applies
- Identify the departments upon which obligations will fall
- Identify any possible exposure to litigation against the state not accounted for in the proposed Bill.

Due to the specific nature of each obligation identified, the legal review is presented separately as an Appendix (Appendix 1). In this review, each section of the legislation was analysed and the obligation created therein, if any, identified. Once identified, each obligation was classified as an existing, new or partly new and existing obligation. The classification of obligations into these categories was conducted after comparing them with those created under existing legislation, viz. the current Prevention and Treatment of Drug Dependency Act 20 of 1992 and its associated amendments. The purpose of this exercise was to identify the likely extent to which the Bill's provisions represented expansions of, and/or additions to, the state's service delivery mandate in the area of Substance Abuse. For reasons discovered during the fieldwork phase of the project, however, obtaining a neat distinction between these two dimensions (the expansion of existing obligations versus the addition of new ones) of service delivery proved difficult

in practice. Table 1 below summarises the obligations created under each section of the new Bill and their associated classification.

Table 1: Breakdown of legal obligations by type

Obligation #	Section	New/Existing Obligation
1	Section 2	New
2	Section 3	New
3	Section 4	New
4	Section 5	New
5	Section 6	New
6	Section 7	New
7	Section 8	New
8	Section 9	New
9	Section 10	New
10	Section 11	Existing
11	Section 12	New
12	Section 12 (2)	New
13	Section 13	New
14	Section 15	New
15	Section 18	New
16	Section 19	New
17	Section 20	New
18	Section 22	Existing
19	Section 24	New/Existing
20	Section 25	New/Existing
21	Section 26	New/Existing
22	Section 27	New
23	Section 28	New/Existing
24	Section 29	New/Existing

Obligation #	Section	New/Existing Obligation
25	Section 30	New
26	Section 31	New
27	Section 32	New
28	Section 33	New/Existing
29	Section 34	New
30	Section 35	New
31	Section 36	New
32	Section 37	New
33	Section 39	New
34	Section 40	New
35	Section 41	New/Existing
36	Section 42	New
37	Section 43	New/Existing
38	Section 47	Existing
39	Section 48	Existing
40	Section 50	New/Existing
41	Section 51	New/Existing
42	Section 52	Existing
43	Section 53	New/Existing
44	Section 54	New/Existing
45	Section 55	New
46	Section 56	Existing
47	Section 57	Existing
48	Section 58	Existing
49	Section 59	Existing
50	Section 60	Existing
51	Section 61	New
52	Section 65	Existing

Obligation #	Section	New/Existing Obligation
53	Section 66	New/Existing
54	Section 67	New
55	Section 68	New
56	Section 69	New
57	Section 70	New
58	Section 71	New
59	Section 72	Existing
60	Section 74	Existing

Total Number of Obligations	60
New Obligations	34
Existing Obligations	13
New/Existing Obligations	13

Regardless of its classification, each obligation was discussed, assessed in terms of other legislation and commented upon where appropriate. The legal analysis was completed by matching each obligation to a particular aspect of service delivery. To reiterate, the detailed analysis of each individual obligation is contained in Appendix 1.

3. Review of Substance Abuse in South Africa

Once the services that were to be provided under the Bill were identified, the next step was to determine to whom, or at *what level*, would these services need to be provided. In order to estimate this level of demand for services, a review of the prevalence of substance abuse in South Africa was conducted.

In addition to estimating overall prevalence levels, the objectives of the review of substance abuse were to:

- describe the substance abuse environment, in terms of the type, nature and incidence of substances abused, in South Africa,
- identify which groups were most vulnerable to substance abuse, where groups were determined along socio-economic, age, gender lines etc.
- identify the emerging substance abuse threats which face South Africa regionally, nationally and provincially.

Due to the increasingly globalised nature of the illegal drug trade, it was justifiably felt that identifying the global and regional threats, both potential threats and emerging threats, facing South Africa, in terms of substances abused and the effects of substances abused, would assist in the planning of substance abuse services in future. Insofar as possible, this perspective was adopted alongside a national and local perspective in the analysis of substance abuse in South Africa. Given these considerations, the following sections summarise the findings on the prevalence of substance abuse in South Africa.

3.1 The global context

Alcohol use is a growing phenomenon on a global scale, for the most part in developing countries (World Health Organisation, 2002). A global analysis of the average volume of alcohol consumed and patterns of drinking concluded that except in the Islamic regions of the world, ‘alcohol consumption is ubiquitous in the modern world’ (Rehm et al., 2003). In fact historical patterns of drinking indicate that the burden of disease attributable to alcohol use will increase in future (Rehm et al., 2003).

The World Drug Report of 2004 (United Nation Office on Drugs and Crime, 2006) paints a more optimistic picture for illicit drug use. It reports that despite the epidemic of drug use, its diffusion into the general population has been limited to only 5 percent and that in fact 95 percent of the general population does not use drugs (United Nation Office on

Drugs and Crime, 2006); this against the general epidemic of licit drug use of tobacco and alcohol reaching rates of almost 30 percent. This optimism is tempered by the finding that susceptible subgroups of the population such as youth have been seriously affected by illicit drug use (United Nation Office on Drugs and Crime, 2006). Furthermore, while the diffusion of the drug use epidemic has been contained, it has by no means been stopped (United Nation Office on Drugs and Crime, 2006).

3.2 The African context

While limited data is available on substance use in Africa, indications are that the use of both licit and illicit substances are on the increase especially in countries that are undergoing rapid socio-economic change (Parry, 1998). Data for 1996 to 2004 from the sentinel surveillance system in the Southern African Development Community (SADC) region indicates that the demand for treatment has increased and that the range of substances for which treatment is being sought is also increasing (Parry & Pluddemann, 2005). Alcohol and cannabis remain the primary substances of abuse, accounting for over a third of treatment demand (Parry et al., 2005). Other drugs such as heroin, cocaine, methaqualone, amphetamine type stimulants and Khat are limited to certain geographic regions (Parry et al., 2005). For example, while heroin use is high and increasing in the south and east of the region (South Africa, Mozambique, Tanzania and Mauritius), treatment demand for cocaine is confined to the coastal countries (Mozambique, Namibia and South Africa) (Parry et al., 2005).

Modes of drug usage are also changing in Africa. Contrary to previous views that injection drug use (IDU) was rare in Africa, indications are that IDU is growing on the continent, albeit from a low base, due to increasing presence of traffic routes, ineffective supply control and increased availability of heroin and cocaine (Dewing, Pluddemann, Myers & Parry, 2006). Given the ensuing HIV epidemic in Africa, findings that high risk behaviours (needle sharing and unprotected sex) are common practice among IDU population groups in Africa (Dewing et al., 2006) is a cause for concern.

3.2.1 Reasons for the increase in substance use in Africa

The rise of substance use on the African continent and other developing country contexts tends to correlate with the overall social and economic problems experienced including poverty, unemployment and underemployment, homelessness, migration, fragmented families, crime, poor mental and physical health, technological changes, educational deficits and vested interests in marketing substances (Nkowane et al., 2004; Uchtenhagen, 2004; World Health Organisation, 2002). The vicious cycle created between social disintegration and substance abuse perpetuates the problem (Uchtenhagen, 2004). Public awareness of the health and social effects of substance use, coupled with lobbying and legislative control, has stabilized the extent of use in the US and Western Europe. To compensate for the dwindling revenue from these markets, the tobacco and alcohol industry turned to developing countries where lack of legislative control means that these substances can be aggressively marketed. Furthermore, the growing contribution of organised crime operating on a transnational level to increase the supply of illicit drugs for substantial profit cannot be underestimated (Uchtenhagen, 2004).

Globalisation has also played a role in proliferating the liberalisation and penetration of tobacco, alcohol and drug use into relative untapped markets (Yach & Bettcher, 2000). The pervasiveness of globalisation allows people in remote parts of the world to consume a Western culture that is tolerant of and in many respects promotes the use of substances (United Nations, 2005). As a result, for young people especially, substance use is perceived as normative and its use has grown beyond marginalised groups to become a recreational tool. Globalisation both drives and reinforces this lifestyle by making drugs more readily available and accessible and by meeting an increasing demand for drugs.

3.3 The South African context

Almost fifteen years of research on substance use in South Africa allows us to make a few seminal conclusions:

- Substance use is increasing on the whole in the country.

- A broad range of substances are being used (Parry et al., 2002).
- While some patterns of drug use are unique to South Africa (for example the mix of cannabis and methaqualone know as white pipe), albeit at a declining level, since 1994, a range of substances that are available on the international market, are being used. These include cocaine/crack, heroin and a range of club drugs (Parry et al., 2002).
- Alcohol remains the primary substance of abuse followed by cannabis; although some geographic variations are starting to emerge (for example methamphetamine has taken over as the primary substance for treatment demand in the Western Cape).
- Except for alcohol, smoking remains the primary mode of drug use.
- Despite the stark race and gender differences in substance use in South Africa, gender gaps are closing particularly for the White and Coloured population groups. This pattern is particularly evident amongst the younger age cohorts.

3.3.1 National data on alcohol use

In the absence of reliable national statistics on illicit drug use in the country – in part due to the illegal nature of its use - statistics on alcohol use provide a window into the extent of substance abuse in the country. For all intents and purposes, alcohol use has become pervasive in South Africa. While adult per capita alcohol consumption is comparatively low in South Africa (10.3 -12.4 litres per adult in SA compared to >13 litres per adult in other regions), consumption per drinker is ranked amongst the highest in the world (Rehm et al., 2003). In other words, while a significant proportion of the population does not drink, those who do consume alcohol do so at hazardous levels.

According to the first national Demographic and Health Survey of 1998 (Department of Health, 1998), 8.3 million or 28 percent of the South African population 15 years and older were current drinkers. A more recent study, the South African National HIV Survey

(Shisana et al., 2005), also reported that about a third of adult South Africans 15 years and older consumed alcohol (28%). Similarly a third of high school students reported consuming alcohol in the past month (32%) (Reddy et al., 2003). Alcohol consumption rates are more than double among men (45%) than among women (17%). Table 1 demonstrates the stark race and gender differences for alcohol consumption with higher rates reported by White men and women and Coloured men, while lower rates were reported by African and Asian women.

Table 2: Percentage of adults 15 years and older in South Africa who consume alcohol

Population group	Male	Female
African	41	12
Coloured	45	24
White	71	51
Indian	37	9
Total	45	17

Source: SADHS, 1998

As indicated earlier, in accordance with the World Health Organisation ratings, South Africa falls into the group of countries with the most hazardous patterns of drinking (Rehm et al., 2003). While rates of risky drinking (5 or more drinks per day for men and 3 or more drinks per day for women) were below 10 percent during weekdays (men 7%, women 7%), almost a third of men and women (32%) drank to risky levels over weekends (Department of Health, 1998). The similarity in rates of risky drinking between men and women can in part be explained by the lower standard of risky drinking applied to women (Department of Health, 1998). Similar to the adult population, high levels of past month binge drinking were also reported by high school students on a national level, with one out of every four students (23%) drinking five or more drinks on one or more days (Reddy et al., 2003)

Both national surveys (Department of Health, 1998; Shisana et al., 2005) also estimated levels of alcohol dependence in the country although different scales were used, limiting the comparability between studies. Using the CAGE Questionnaire (4 item scale, felt should cut down on drinking, annoyed or criticized for drinking, felt guilty about drinking, or drink first thing in the morning), the SADHS (1998) classified just under a third of men (28%) and a tenth of women (10%) as alcohol dependent.

Higher rates of dependency were reported by the middle age group (35-44 and 45-54), Coloured (34%) and African (29%) men, and those with primary or lower levels of education. It must be noted that while higher rates of alcohol consumption were reported by both White men (71%) and women (51%), this group reported low rates of alcohol dependence (White men 10%, White women 6%). Alcohol dependence did not differ by locality (urban vs. rural). Provincially, Northern Cape, Mpumalanga, Free State and Eastern Cape reported rates of alcohol dependence above 30 percent.

The South African National HIV Survey (Shisana et al., 2005) used a somewhat different measure - the 10 item AUDIT scale (accounts for both the frequency and duration of drinking) - to assess the level of harmful or risky drinking in the population. Using this measure, seven percent of the population was classified as high-risk drinkers. Rates were higher among males (14%) than among females (2%). Similar to the SADHS (Department of Health, 1998), high-risk drinking was elevated among the Coloured population group (18%) and middle age group (9%). The study also reported that three provinces - Western Cape (16%), North West (13%) and Northern Cape (12%) – had rates of alcohol dependence above 10 percent. Alcohol dependence rates using the AUDIT measure (Shisana et al., 2005) were substantially lower than the estimates using the CAGE measure (Department of Health, 1998) as the former estimates past year use while the latter estimates lifetime use.

3.3.2 National data on drug use

As indicated earlier, prevalence rates of drug use tend to be underestimates due to the illegal nature of its use. Studies of drug use in South Africa tend to be small scale, limited by geographic area, population group or to high risk groups. The HSRC Survey (Shisana et al., 2005) provided national estimates of drug use albeit at a very low level. Cannabis (commonly known as dagga) was the most frequently reported substance used (2.1%), followed by cocaine and sedatives (0.3%), amphetamines (0.2%), and inhalants, hallucinogens and opiates (0.1% respectively). A small percentage of participants (5%) reported lifetime injection drug use with 0.1% reporting shared needle use.

3.4 South African Community Epidemiology Network on Drug Use (SACENDU)

South Africa makes use of multiple data sources to build the picture of substance use in the country. SACENDU is a surveillance system that tracks patients accessing treatment at facilities across the country. Since 1996, almost 80 percent of treatment facilities in the country feed data into the system on a six monthly basis. SACENDU has become an integral part and a reliable source of the substance use tracking system, providing an indication of the extent of abuse in the country.

3.4.1 Profile of patients seeking treatment

South Africa has a youthful population with 40 percent of the population between 14 and 35 years of age. The average age of patients seeking treatment in South Africa is between 27-35 years although age differences based on drugs of abuse are evident. Patients whose primary substance of abuse is alcohol tend to be older, while those abusing cannabis, heroin or methamphetamine tend to be younger. The proportion of patients younger than 20 years of age seeking treatment has increased over time and remains high across the SACENDU sites. Rates range between 13 percent in East London to a third in Cape Town (Plüddemann et al., 2006). As increasing numbers of young people start to abuse

substances, specialist treatment facilities for youth, currently not available in the country, will be required.

The profile of patients seeking treatment in South Africa is not reflective of the country's demographic profile. There is an under-representation of African patients seeking treatment, probably related to limited availability of treatment facilities, inaccessibility due to transport costs, in affordability of treatment, language and cultural barriers and stigma associated with seeking treatment (Myers & Parry, 2005). Women are also severely under-represented in treatment facilities, with on average 80 percent of patients seeking treatment being male. The high levels of risky drinking reported by women in the SADHS (1998) coupled with the high levels of foetal alcohol syndrome reported provide some indication that the under-representation of women in treatment facilities are as a result of gender-related barriers to accessing treatment rather than low levels of substance abuse amongst women (Myers, Parry, & Pluddermann, 2004).

Between a third and a half of patients in treatment facilities were in full time employment, probably reflective of the high costs associated with accessing treatment in South Africa. Accordingly, the majority of patients (42% - 71%) fund treatment services either through the support of family or friends or by themselves. There are currently only five state-funded facilities in the country although a range of private and non-profit organisation is subsidized to provide treatment. The majority of patients seeking treatment (84%) have some form of secondary school education (Plüddemann et al., 2006).

3.4.2 Alcohol

Almost 10 years of surveillance (July 1996-December 2005) demonstrates that alcohol remains the primary substance for which treatment is sought. Although recent trends indicate a drop in the demand for treatment for alcohol-related problems – replaced by other illicit drugs - treatment demand still remains high. Treatment demand for alcohol

ranges from 72 percent of admissions in East London, to 58 percent of admissions in Durban, and 25 percent of admissions in Cape Town (Plüddemann et al., 2006). Methamphetamine has taken over as the primary substance of abuse in the Western Cape. As reported in the SADHS (1998) and the HSRC surveys (Shisana et al., 2005), patients admitted for alcohol dependence tend to be middle aged (35-40 years) and predominantly male.

3.4.3 Cannabis

Findings from SACENDU indicate an increasing demand for treatment for substances other than alcohol (Myers et al., 2004). Cannabis remains the most widely and most frequently consumed illegal drug across the world (United Nations, 2005) and is the main illicit drug of concern in sub-Saharan Africa (United Nations, 2004). According to SACENDU findings, cannabis is the second most common primary substance of abuse amongst patients seeking treatment in South Africa, ranging from 28 percent in Durban to 11 percent in East London. Although, young people do not perceive cannabis as a dangerous drug (Nkowane et al., 2004), it remains the primary drug of treatment demand in this group (Parry, Myers, & Pluddemann, 2004).

Rates of demand for treatment for methaqualone use (Mandrax) or in combination with cannabis (white pipe) have decreased significantly over time ranging from nine percent in Port Elizabeth to less than one percent in Mpumalanga (Plüddemann et al., 2006).

3.4.4 Other illicit drugs

A range of illicit drugs are used in South Africa and they demonstrate some geographic specificity. Poly-drug use is also substantial with between a third and half of patients in Gauteng and Cape Town reporting multiple drug use (Plüddemann et al., 2006).

SACENDU data for 2005 (Plüddemann et al., 2006) indicates that the proportion of patients whose primary substance of abuse was *cocaine powder or crack* remained stable or decreased with exceptions in Port Elizabeth and Mpumalanga where rates increased. Rates of abuse ranged from six percent in Mpumalanga and East London to 15 percent in Port Elizabeth.

Although rates of *heroin* use in Africa remain low at less than one percent (United Nation Office on Drugs and Crime, 2006), UN reports point to increased use in countries situated along the primary drug trafficking routes, including South Africa. Trends from SACENDU data indicate that heroin use is increasing and that the profile of users, who were predominantly White and male, may be shifting to younger cohorts.

Heroin use tends to be limited to certain geographic areas. Rates in Cape Town have increased steadily from one percent in 1996 to a high of 14 percent by 2005. Mpumalanga (10%) and Gauteng (8%) also report substantial proportions of patients seeking treatment for heroin as a primary substance of abuse (Plüddemann et al., 2006). While overall rates of injection use decreased, a substantial proportion of patients in Gauteng (39%) and Mpumalanga (35%) still reported injection use in 2005 (Plüddemann et al., 2006). Anecdotal evidence across the country indicates increases in the use of heroin mixed with cannabis, particularly by young people, under various names: ‘Sugars’ in Durban, ‘Naope’ in Pretoria, ‘Unga’ in Cape Town, ‘Pinch’ in Mpumalanga.

A small percentage of patients (1-5%) reported *over-the-counter or prescription medicine* as their primary substance of abuse (Plüddemann et al., 2006). These include benzodiazepines, analgesics, codeine products, and sedatives. SACENDU findings in Cape Town (Myers, Siegfried, & Parry, 2003) showed that between 1998 and 2000, eight percent of patients at treatment centres abused over-the-counter or prescription drugs. Most patients sought treatment for drugs such as Benzodiazepines (46%) and analgesics (45%). These patients were predominantly middle-aged and female.

Low levels of *ecstasy* (1%) and *LSD* (< 1%) use were reported as the primary substance of abuse (Plüddemann et al., 2006). However, a steep increase in *methamphetamine use* – commonly known as tik - has been noted in Cape Town. Rates have increased from 0.1 percent in 1997 to 35 percent in 2005 (Plüddemann et al., 2006). According to the SACENDU data (Plüddemann et al., 2006), 'this represents the largest and fastest increase in the number of patients presenting with a particular drug (problem) in' SACENDU's history. In fact, treatment demand for methamphetamine use has overtaken alcohol as the primary substance of abuse at treatment centres in the Western Cape. Methamphetamine is used primarily by young people below the age of 20. The drug heightens libido and its use has been connected with risky sexual behaviour– a worrisome trend in SA given the high rates of HIV in the country (Morris & Parry, 2006).

3.5 The health, social and economic burden of substance use

3.5.1 The global context

Substance use has a significant impact on the mortality profile at global and local levels. It places an increasing yet preventable burden on the health, social welfare and the criminal justice systems. In 2002, the World Health Organisation rated alcohol consumption as one of the ten leading risk factors for the global burden of disease. Worldwide, alcohol use causes 1.8 million deaths each year equivalent to 4 percent of the global disease burden (World Health Organisation, 2002). In addition, alcohol has been estimated to cause 20-30 percent of oesophageal cancer, liver disease, epilepsy, motor vehicle accidents, and homicide and other intentional injuries (World Health Organisation, 2002). Although the burden of alcohol use is now primarily felt in developed countries, this pattern is shifting, with the greatest disease burden expected to manifest in developing countries (World Health Organisation, 2002). The World Bank estimates that between 70-80 percent of alcohol-related deaths will occur in developing countries (Murray & Lopez, 1996).

The illicit nature of drug use means that its use is often hidden, hence it becomes harder to estimate its prevalence and its health and social consequences (World Health Organisation, 2002). Currently, about 0.4 percent (0.2 million) of deaths at the global level are attributed to illicit drug use. These figures tend to be higher in low mortality industrialized countries accounting for 2-4 percent of the disease burden among men (World Health Organisation, 2002).

3.5.2 The South African context

In 2000, 30 percent of deaths in South Africa were attributed to HIV/AIDS, 21 percent to other communicable, maternal, perinatal and nutritional diseases, 37 percent to non-communicable diseases and 12 percent to injuries (Bradshaw et al., 2003). Cardiovascular disease (17%) and malignant neoplasms (8%), for which causal relationships with alcohol use (World Health Organisation, 2002) is known, were among the leading causes of death (Bradshaw et al., 2003).

Alcohol consumption has been causally related to over 60 types of diseases and injury (World Health Organisation, 2002). The increasing use of recreational drugs such as methamphetamine and ecstacy has toxic effects on the sympathetic and central nervous system. The structural brain changes resulting from its use are associated with long-term impairment in cognitive processing, memory and emotion. Table 2 outlines some of the health risks associated with alcohol and illicit drug use.

Table 3: Selected major risks to health: addictive substances

Risk factor	Measured adverse outcomes of exposure
Alcohol	Stroke, ischaemic heart diseases, hypertensive disease, diabetes mellitus, liver cancer, cancer of mouth and oropharynx, breast cancer, oesophagus cancer, other neoplasms, liver cirrhosis, epilepsy, alcohol use disorder, falls, motor accidents, drowning, homicide, other intentional injuries, self-inflicted injuries, poisonings
Illicit drugs	HIV/AIDS, overdose, drug use disorder, suicide, trauma

Source: World Health Report, 2002

In addition to the health effects, substance use is linked to a host of negative outcomes:

The *economic costs* of drug use are at minimum two-fold, namely lost productivity due to morbidity and premature mortality and the cost of treatment. These accrue not only through treatment of alcohol abuse itself, but also through its association with transport-related injuries and death, trauma, violence and crime, and foetal alcohol syndrome, among others. Extrapolations to the South African context based on findings from developed countries indicate that the annual economic costs associated with alcohol abuse are one percent of the country's GDP or about R8.7 billion per year (Parry, Myers, & Thiede, 2003).

South Africa has a substantial burden of *mortality* attributable to intentional (7%) and unintentional injuries (5%) (Bradshaw et al., 2003) and substance use is a leading contributing factor. According to the National Injury Mortality Surveillance System of 2004 (Matzopoulos, Seedat, & Cassim, 2005), fifty percent of the fatally injured cases for which blood alcohol concentrations were obtained, had levels equal or above 0.05g/100ml. The average blood alcohol concentration for those who tested positive was 0.17g/100ml.

Substance use also contributes towards *non-fatal injuries*. Sentinel surveillance of trauma and substance abuse in three cities indicated that at least a third of cases tested positive for alcohol. Between 16.5 percent and 67 percent of patients tested had breath-alcohol concentrations greater or equal to 0.05g/100ml. In addition, patients who were injured as a result of violence were more likely to test positive for alcohol than patients who were injured in road traffic accidents or other unintentional injuries (Pluddermann, Parry, Donson, & Sukhai, 2004).

South Africa is struggling under the burgeoning weight of *crime* and substance use is linked to this burden. Parry (2006) indicated that there is a wealth of information pointing towards the strong association between alcohol, crime and injury. A three-metro arrestee study of drugs and crime in 2000 indicated that almost half of arrestees (45.3%) tested positive for at least one of six drugs (Parry et al., 2004). Cannabis was the most common drug used by arrestees followed by methaqualone. Legget and colleagues (2002) also demonstrated the role that drugs play in recidivism with over half of arrestees testing positive for drug use reporting an arrest history.

Foetal Alcohol Syndrome (FAS) is regarded as one of the leading cause of preventable birth defects and developmental disabilities (Viljoen, Graig, Hymbaugh, Boyle, & Blount, 2003). FAS in the Western Cape represents some of the highest figures in the world with 46 per 1000 grade 1 students displaying the consequences of FAS compared to 0.3 to 1.5 per 1000 live births in the US (Viljoen et al., 2003). Figures reported in Gauteng (26 per 1000 children) indicate that FAS is not only limited to the wine producing regions of the country and is in fact a problem across South Africa (Viljoen et al., 2003).

Given the dual burden of HIV and substance use in the country, several studies have focused on the ways in which alcohol and drug use serve as precursors for risky sex and subsequently HIV in South Africa (Kalichman et al., 2006; Taylor, Dlamini, Kagoro,

Jinabhai, & de Vries, 2003; Morojele et al., 2006; Morejele, Brook, & Kachieng'a, 2006; Wechsberg, Luseno, Lam, Parry, & Morojele, 2006). Substance use seems to increase sexual arousal, decrease inhibitions and tenseness and disempowers females to resist sex (Morejele et al., 2006). King et al. (2004) showed that females who consumed alcohol were more likely to become victims of sexual violence. In fact, the use of recreational drugs such as ecstasy and methamphetamine has been associated with high-risk sexual behaviour, increasing the likelihood of HIV transmission and other sexually transmitted infections.

Injection drug users have a high risk of acquiring and transmitting human immunodeficiency virus and hepatitis C through the sharing of needles. There are indication in Africa (Parry & Pluddemann, 2002) and in South Africa that this mode of drug usage, although currently low, appears to be increasing (Pluddemann et al., 2005).

Foetal Alcohol Syndrome (FAS) is regarded as one of the leading cause of preventable birth defects and developmental disabilities (Viljoen, Graig, Hymbaugh, Boyle, & Blount, 2003). FAS in the Western Cape represents some of the highest figures in the world with 46 per 1000 grade 1 students displaying the consequences of FAS compared to 0.3 to 1.5 per 1000 live births in the US (Viljoen et al., 2003). Figures reported in Gauteng (26 per 1000 children) indicate that FAS is not only limited to the wine producing regions of the country and is in fact a problem across South Africa (Viljoen et al., 2003).

4. Fieldwork

The purpose of the fieldwork was to determine *how* the services that have to be provided (identified in the legal review) to the groups identified in the substance abuse review will be provided. Fieldwork consisted of conducting interviews with key personnel currently involved in the public provision of Substance Abuse services. Personnel were located at both national and provincial level. In addition, fieldwork also entailed the collection and

analysis of secondary data (e.g. budgets, data on utilisation levels etc.) from these respondents for later analysis. In cases where the Bill called for new activities upon which no historical data was available, the Research Team engaged with policy-level planning staff to obtain information on how these activities were likely to be implemented or rolled out.

Initially, a meeting with senior staff in the Unit within the DoSD that commissioned the research was held in order to determine the scope of the work to be conducted and establish the framework within which the project would take place. At this meeting, these staff also identified key DoSD personnel involved in service delivery at national level and within each province. The close collaboration between these staff and the Research Team was maintained throughout the duration of this project.

The first area where national level staff members' input was sought was in constructing a profile of Substance Abuse services nationally. This input was used to supplement the state obligations identified in the Bill to obtain a broad overview of the envisaged framework (in terms of service delivery components, implementation levels, responsibilities etc.) of public Substance Abuse services in South Africa. This blueprint for service delivery has been attached as Appendix 2. It serves as a rough guide to the overall implementation framework of public services and highlights the linkages between the individual components of service delivery that were examined more closely in the fieldwork and cost modelling stages of the project. Staff at national level were instrumental in facilitating subsequent interviews with provincial staff and ensuring the cooperation of DoSD staff with respect to access to departmental information. In addition, they would regularly engage with the Research Team on the validity of assumptions and approaches to service delivery that were used by the team to inform the costing analysis. This collaboration took the form of periodic meetings as well as telephonic correspondence.

Based on the information provided by national level DoSD staff, key staff members who were involved in the provision of substance abuse services in each province were contacted with requests for interviews. Initially, staff members were drawn primarily from the ranks of Provincial Substance Abuse Coordinators. As more information was gathered, however, other categories of staff were identified and approached for interviews. During each Key Informant Interview, researchers administered a semi-structured interview schedule developed for the purpose of this project to respondents. Interview schedules varied between categories of staff and are available to be shared with the department upon request. Interviews were conducted either face-to-face or telephonically. Regardless of method used, all provinces were consulted in order to obtain their input into the costing report. Site visits were conducted in five provinces. These were, in order of site visit:

- KwaZulu-Natal,
- Gauteng,
- Orange Free State,
- Northern Cape and
- Western Cape.

The selection of provinces for site visits was based upon consideration of a number of provincial characteristics. These included provincial prevalence rates, levels of substance abuse services infrastructure per province, population density and rural/urban split. The aim of this exercise was to draw a sample of provinces that were representative of the range of contexts for the delivery of substance abuse services in South Africa. Further information on the method used to extract a sample of provinces is contained in Appendix 3.

As a follow-up to each interview, researchers drew up a list of information requirements and requested that respondents make these available to them, as agreed initially. This

information, together with the data gathered during interviews, was used to inform the construction of scenarios in the cost modelling component of the project. Whilst facilitated by senior departmental staff, it is drawn to the attention of the client that there were frequently difficulties associated with this follow-up aspect of interviews.

While interviewees in each province were drawn mainly from the ranks of DoSD staff, efforts were made to contact persons who were identified as rendering Substance Abuse services who were not employed in the DoSD. These personnel were drawn from staff in other government departments as well as NGO's. A full list of public servants, listed by designation and implementation level, contacted for interviews is attached as Appendix 4.

5. Cost Modelling

Using the results of the fieldwork, substance abuse and policy review, a spreadsheet cost model was developed wherein data on services and projected levels of service utilisation was integrated in order to generate a financial cost of service provision for the services set out under the proposed legislation, the Prevention and Treatment of Substance Abuse Bill. In keeping within the terms of reference, all cost estimates have been calculated for a three year period and take inflation into account. As mentioned, estimates make provision for three scenarios which correspond to varying levels of service provision, from conservative to more aggressive models of service provision. The specific assumptions that have been used to construct each scenario are explained in greater detail in the applicable sections of the costing results.

Costs have been broken down along a number of dimensions, viz:

- Implementation level (national, provincial or local),
- Line department (e.g. health, social development)
- Nature of activity (prevention versus treatment)

- Input (e.g. salaries, buildings)
- Nature of costs (short-term versus long-term)

The actual model used to estimate costs, as well as a brief explanation of the information contained in the relevant sections of the model, has been provided as an accompaniment to this report.

5.1 Cost Estimates

The following sections outline the results of the costing process. As far as possible the results that follow are estimated using an activity-based costing approach. This works by first estimating the resources required to provide one unit of a service and then estimating how many units are required.

Activity-based costing is the preferred approach as it highlights the link between cost and demand/coverage, which are the key policy decisions. While this method was used wherever possible its applicability was limited by the nature of the substance abuse field.

Ideally, what would have been done would have been to estimate the unit costs of every service outlined in the Bill and then to estimate the demand for such services. This was not possible in a number of instances for three reasons. Firstly, the Bill is not specific on the nature of services. It specifies, for example, community-based treatment but does not outline what it entails. Where there is agreement on what a service entails this does not present a substantial barrier, but where there is not, it does.

Secondly, estimating demand for services in an area such as substance abuse is particularly difficult. As has been discussed in earlier sections of this report, statistics on the scale of the substance abuse problem are troublesome to collect and often highly affected by biases. Further, estimating what proportion of people with a problem will

seek services or be forced to access them is complicated by lack of data, particularly when it comes to estimating demand for new services that have previously not been available.

Thirdly, not all services discussed in the Bill are demand-driven in the normal sense. Prevention, for example, is needed but not demanded in the way that inpatient care is. Determining the appropriate level of prevention required to realise the intentions of the Bill is essentially a matter of interpretation. A different but related point is the establishment of structures that are also not demand driven.

Given the above considerations, the activity-based approach was used where possible, but other methods had to be used to supplement the approach. Methods used to address particular problems are discussed in the relevant sections below.

In general, to address the issue of lack of agreement on what services are and what the appropriate level of delivery for them will be, a scenarios approach to costing was employed. The costs of three scenarios were estimated to highlight the importance of assumptions and interpretation in the determination of cost estimates. The first scenario costs a conservative interpretation of the Bill's implementation; the second tries as far as possible to cost the planned implementation as described by respondents covered in the fieldwork which is described in Section 4 of this report; the final scenario provides estimates of aggressive implementation based on a liberal reading of the Bill's intentions.

The terms of reference for this work required that the cost estimates be for the first three years of implementation. This has been done with a slight variation that we hope will generate more useful results. The costs over the first three years will be greatly affected by the speed of implementation and will not reflect the long-term running costs. Given the usefulness for policy making of having an estimate of long-term running costs, the scenarios were all estimated on the basis of full implementation by year three. Such rapid

scale up of services may not be the intention of the state, but the first and third year estimates provide a range within which years of more gradual roll-out would be expected to fall.

To reach full implementation there will be a need for some capital investments. Estimates of the cost of these capital investments have been made for each scenario and are included. As these investments distort the running costs, they can be separated out to avoid misunderstanding. In particular, the results for year three include no major capital investments and reflect only the ongoing costs of full implementation.

The costing exercise was undertaken using 2006 prices and for the most part the costs presented are in 2006 Rand. This was done to allow for easy comparison across the years. The terms of reference required inflation to be considered; this has been done and all results are available with inflation adjustments. Some of these are presented below, particularly for key cost drivers. The estimates are based on implementation starting in the 2006/7 financial year and an average inflation rate of 5%. From here on references to 2006 Rand refer to constant prices with 2006 as the base year. References to nominal Rand refer to costs which have been inflated to their expected nominal amount as determined by the assumed inflation rate and the years since 2006. Nominal amounts are raised 5% from the first year.

As has been mentioned, the Bill that is the subject of this costing is a replacement for an existing Act. It is important therefore to consider the cost estimates alongside what is currently being spent. This does, however, need to be done with some caution. The current costs reflect the current level of implementation not the full cost of the existing Act. The old Act and the new Bill have many essential elements in common (see Legal Review) and, if the current Act were brought up to full implementation based on similar interpretations as this Bill, the cost of the Act would certainly be far larger than what is currently being spent. While it is difficult to predict, given the problems mentioned above

in estimating demand, the Bill's push away from inpatient care towards outpatient and community-based care could possibly lead to long-term costs of full implementation being lower for the new Bill than the costs of fully implementing the existing Act. So, while the costs of current implementation are far lower than the costs associated with the Bill, it should be emphasised that this is a result more of lack of implementation of the current Act rather than of new services in the Bill.

While comparing the costs of the Bill to existing services it is also worth keeping in mind the costs relative to other programmes and services. The bulk of the costs associated with the Bill will be carried by the Department of Social Development. The following table outlines, by Province, medium term estimates of social development expenditure, as provided by Treasury.

Table 4: Provincial social development expenditure – Medium-term estimates (millions of Rand)

Province	2006/7	2007/8	2008/9
Eastern Cape	763	957	1 235
Free State	418	443	469
Gauteng	982	1 143	1 391
KwaZulu-Natal	895	939	998
Limpopo	432	466	696
Mpumalanga	430	471	606
North West	428	595	689
Northern Cape	215	263	312
Western Cape	727	867	1 035
Total	5 289	6 145	7 430

Source: National treasury Provincial Database, as reported in The Provincial Budget and Expenditure Review: 2002/03-2008/09.

These estimates can be usefully compared to the estimate of the cost of continuing with existing and currently planned services associated with the treatment and prevention of substance abuse.

Table 5: Expenditure on the Prevention and Treatment of Substance Abuse (Millions)

	2006/7	**2007/8**	**2008/9**
Medium term estimate for all Provinces	108	120	139

Source: National treasury Provincial Database, as reported in The Provincial Budget and Expenditure Review: 2002/03-2008/09.

Overall, it is clear that the costs associated with this area, while significant, are small relative to the Department's size. This, however, is largely true of all programmes, given the overwhelming importance of grants in shaping the Department's expenditure patterns. The above comparison may suggest that costs are relatively small and therefore services would not be greatly constrained by resource requirements. This, however, would be incorrect on two accounts: firstly, as a specialised service it would not be expected to attract enormous costs and secondly, the constraints are not always financial. As with many services provided by Social Development, implementation is often undertaken by social workers. Social workers are, however, in short supply. The following table highlights the situation across provinces.

Table 6: Social worker numbers by province

Province	Social workers			Individuals per social worker	
	Government	NPO	Total	Standard/ norm	Current
Eastern Cape	510	245	755	3 000	9 324
Free State	148	165	313	3 000	9 435
Gauteng	532	564	1 096	5 000	8 228
KwaZulu-Natal	429	536	965	4 500	10 001
Limpopo	361	92	453	3 000	12 439
Mpumalanga	208	48	256	3 000	12 578
North West	238	60	298	3 000	12 932
Northern Cape	108	98	206	3 000	4 380
Western Cape	284	437	721	4 500	6 443
Total	2 818	2 245	5 063		

Source: Findings Report on the Financial Awards to Service Providers, 2005, as reported in The Provincial Budget and Expenditure Review: 2002/03-2008/09.

In the costing results that follow, the areas of service delivery where significant demands will be placed on social workers are highlighted.

The following sections now detail the cost estimates for the three scenarios. The first section highlights total costs and compares these to current expenditures. The sections that follow then examine the costs by component of the Bill. It was originally intended to compare these component costs to costs of current provision, but inconsistent and insufficient responses from some provincial departments made this impossible.

Each section details the major decisions and assumptions on which the costs are based. A host of other decisions, assumptions and data were, of course, needed to generate the results. It would be cumbersome to repeat them all here. The Department has been provided with the costing model from which these results are drawn, which records the bulk of assumptions and data. Some calculations are conducted outside of this model and entered in, but these were in regard to major issues and are discussed below.

5.1.2 Major assumptions and scenarios formulation

While a number of the assumptions and methods used in the costing have already been mentioned it is worth reiterating them as it provides clarity on the formulation of the scenarios. To this end, before detailing the scenarios, the costing principals and assumptions will be summarised.

As mentioned, the costing exercise was undertaken for three scenarios. The scenarios approach was used to reflect uncertainties in the Act with regard to the context in which it would be implemented. The following section outlines each of the scenarios and the data and assumptions on which they are based making it clear what is and what is not covered.

a) Three year time period

The terms of reference for the costing study requested a three year costing. When considering implementing a Bill it is important to consider what the Bill, if enacted, would cost when fully implemented. Given the planning and capital investments required by the Bill, it is unlikely that full implementation would be reached within three years; an estimate closer to ten would be more realistic. The costs in the first three years will be dominated by the speed of implementation and as such are highly uncertain. In order to provide as useful an input into the policymaking process as possible, the costs of full implementation were estimated. To keep within the ToR these were presented as year three costs although it is noted throughout that it is possible but unlikely that the costs

will rise so quickly. The results are presented as **year one, year two** and **year three** but they may be better read as **initial, transitory** and **fully implemented**.

b) Capital costs

In order to reach an estimate of the costs of a fully implemented Bill, the capital costs were recognised in the first two years of each scenario. Across scenarios, year three represents running costs only with only replacement capital costs included. As mentioned above, this was done so as to provide as useful as possible information within the ToR. It is, however, worth noting that it is not as unrealistic as it may at first appear as the Department of Social Development has already begun the process of planning for many of the capital expenditures envisaged. It is important to note that **costs in year three include no major capital costs and considers recurrent costs only**.

c) Demand-driven estimates of service provision

Best practice in costing exercises such as this is to conduct activity based costing and link the results to demand. Where there is uncertainty in the demand then scenarios can be run. The nature of substance abuse as well as the services envisaged in the Bill made such an approach difficult. That said, wherever the service could be linked to demand, and were appropriate to the scale of the problem, they were.

Data on drug and alcohol abuse are problematic, as has been discussed in Section 3.3. People do not wish to report use and are far less likely to report abuse. What is more, not all those who abuse substances and are in need of services will ever seek them and only a limited number will be forced to access them. Further, the introduction of new services and prevention efforts may well alter the level and composition of demand. Modelling demand in the way one would model the potential number of recipients of a grant or patients requiring treatment for example was, therefore, largely impossible.

In addition to the problems associated with estimating demand there were also a number of services which were not demand-based in the traditional sense. The most obvious of these is prevention services. If data were available on how effective different prevention efforts were and if the Bill or the Department had a target in terms of prevention then appropriate spending to reach that target could be estimated. As there is neither the data nor the target, appropriate prevention spending had to be estimated using an alternative method. This method is discussed shortly. Also not demand-driven are aspects of the Bill such as the establishment of forums like the CDA, PSAFs and LDACs. While this is not such a problem for structures such as the CDA and PSAFs where the appropriate number is obvious, it is for LDACs. LDACs, as with a number of other services and structures envisaged under the Bill, are based on need rather than demand. Every area which has substance abuse or the potential for it has some need for an LDAC. Whether that need is sufficient to warrant investment in the establishment and operation of an LDAC is a value judgement, one which has not been made in the Bill making estimation difficult.

To continue with as much of a demand-based model and to link services as far as possible to the scale and distribution of the problem, a number of approaches were adopted. These approaches were based on the assumption that treatment seeking behaviour would be similar across the country. This allowed data on demand for services in provinces where implementers felt service levels were sufficient to be used to predict what level of service provision would be adequate were service levels were not. This was done by linking service provision to the scale of the problem in different settings. The scale of the problem was approximated by alcohol use and abuse for reasons outlined earlier. This may be somewhat problematic as drug patterns may well differ although there does appear to be, from the limited data, some correlation between the incidence of drug and alcohol abuse. Nevertheless, the fact that alcohol abuse remains the most common reason for seeking treatment provides some reassurance of its usefulness in estimating service provision needs.

Where new services were envisaged and no data on demand were available, appropriate levels were determined based on discussions with implementers regarding need. The estimated costs of these categories of services vary the most across the scenarios given this uncertainty.

Where services were not demand-driven or based on value judgements regarding coverage, a combination of two assumptions were used: reflect planned policy and promote equity. The implementation of certain aspects of the Bill are already being planned and as these plans reflect the values of the Department it was felt appropriate to use them in the costing when value judgements were needed. It would have been ideal to have conducted wider consultation with civil society and more broadly within government, particularly across Departments, but the timeframe and resources available, however, did not allow for this.

d) Departmental distribution

The Bill would require action from a range of Departments although service delivery would mainly be concentrated in the Department of Social Development. For the most part the demands on other Departments are small and would require, relative to the total, very few resources. There are however some notable exceptions regarding who will be responsible for different aspects of treatment. The Department of Health and the Department of Social Development could both be argued to be responsible and the division of resources between Departments is almost entirely determined by the policy decision of which Department is responsible for which aspects of treatment. The Bill is not clear on this and neither is past practice. As it is beyond the scope of the costing exercise to comment on this policy decision, the concentration has been on the total cost and not the distribution across Departments although the implication of policy decisions for that distribution is discussed.

e) Scenarios

Based on the above base assumptions and principles the following scenarios were developed. Where there is clarity within the Bill or clear agreement on what is required the scenarios do not vary a great deal. Where there is uncertainty the variation is far greater.

The following table highlights the coverage of the costing and the major differences between the scenarios for each of the components. Details of these differences, the further assumptions made and cost implications are provided in the subsequent sections.

Table 7: Scenarios summary

Component of Service Delivery	**Scenario differences**
Central Drug Authority	Full meeting as outlined in the Bill are standard across scenarios but expansion from the existing size is assumed to be more rapid in Scenario 2 (S2) and Scenario 3 (S3). Number of subcommittees unclear in the Bill. Range of possibilities established, lowest included in Scenario 1 (S1) and highest in S3. Secretariat expanded to support larger CDA in all scenarios in accordance with current plans. Formed into a Directorate in S3 as there was some wish for this but not agreement so included only in S3. Biennial summit based on current Departmental plans.
National Administration	Staffing and budgetary needs linked to other aspects of the scenarios. Needs required to manage other aspects of the scenarios estimated based on discussions with current national administration, current expansion policies

	and examination of current budgets.
National Prevention efforts	Non demand-driven service requiring policy direction. Based on discussions with the national Department, a policy shift towards large scale media campaigns was highlighted. Scenarios differ in terms of interpretation of large. S1: Basic large media campaign S2: Large media campaign with market segmentation S3: As above plus follow up media support Includes transfers to national NGOs. National Department reported an intention to increase support for structures and prevention efforts. The appropriate increase is subjective and the uncertainty is reflected in the scenarios. S1: 0% S2: 30% of base by year 3 S3: 50% of base by year 3
Provincial Administration	A small directorate was included in all three scenarios. Given its more aggressive nature, S3 included one administrator and two regional coordinators more in each province than S1 and S2.
Provincial Substance Abuse Forums	There are a variety of views on what form these may take. To account for this the scenarios differed. S1: 20 sponsored participants in smaller provinces, 30 in larger. S2: 30 in smaller, 40 in larger S3: 40 in smaller, 50 in larger
Local Drug Action Committees	The Bill does not define the structure or required coverage of LDACs. The coverage was kept constant across scenarios as there already are Department plans for this. The uncertainty regarding the nature of LDACs was reflected in the scenarios. S1 and S2: 30 people in full committee, subcommittees of 5 meeting 12 times a year.

	S3: 30 people in full committee, subcommittees of 10 meeting 18 times a year.
Treatment Centres	No variations were considered across the scenarios. The Bill is clear in seeing a shift away from an inpatient focus. For this reason only the costs of bringing all provinces up to a similar standard, considering the scale of the problem and size of the population, were considered.
Halfway Houses	Halfway houses are included in the Bill only to regulate non state provided institutions of this nature. No direct service costs were considered in any of the scenarios.
Aftercare	The Bill does not prescribe the nature of aftercare to be provided. Respondents at national and provincial level expressed different understandings of what form it would take. To reflect this uncertainty, the scenarios were based on alternative models of provision. Demand for the services in all three scenarios was based on estimates of treatment seeking patterns, in better resourced provinces, adjusted for population size and scale of the problem. S1: Group-based aftercare S2: Group-based plus individual site based support S3: Group-based plus individual support including home visits
Prevention	Based on the costing principle of equity mentioned above, the costs of prevention were estimated to bring all provinces in line with the current highest spending province. Adjustments were made for population size and the scale of the problem in each province. Current spending even in the highest spending province could be increased if it were deemed appropriate. To reflect the impact of this value judgement the scenarios varied. S1: Equity in real spending in year one, thereafter remains constant in real terms in years 2 and 3. S2: Equity in year 1, real increases of 10% per annum thereafter. S3: Equity in year 1, real increases of 20% per annum thereafter.
Community-based	The Bill suggests a push towards outpatient and community based care

services and outpatient care	although neither is clearly defined. There was no agreement or current plans on what form these services would take and little data on what demand for them would be. This high level of uncertainty is reflected in the scenarios. The scenarios were based on combined services with outpatient facilities focussing on urban areas and community-based services linking to these from rural areas. For outpatient care: S1: Large outpatient facility in all large urban areas S2: Above plus medium facility in medium sized urban areas S3: Above plus small facility in small urban areas. For community-based services: S1: Small scale projects in 20% of municipalities linked closely to outpatient centres. S2: Larger projects in 20% of municipalities linked less closely to outpatient centres. S3: As above but expanded coverage to 50% of municipalities.

The above table summarises the differences considered across scenarios. The scenarios concentrate on where there are potential differences in the interpretation of the Bill. Another layer could be added by varying the demand assumptions. To some extent these are included with variations in coverage, but these relate more closely to judgements of appropriateness rather than predictions of demand. Given the uncertainty in the data on prevalence and the absence of quality data on uptake, particularly for new services and in a changing environment, the generation of scenarios based on varying demand would introduce enormous uncertainty into the estimates. As a decision support tool it was deemed more appropriate to use point estimates of demand and focus on interpretational issues.

The following sections detail the costs of each scenario and provide further details on the differences across them and the motivations for these variations. The scenarios were, as

noted, based on discussions with implementers at national and provincial levels. It is, however, appreciated that the need of the costing process to be clear in the assumptions may well prompt debate which, combined with the continued discussions of the Bill itself, may well require scenarios to be changed. In anticipation of this the costing model has been provided to the Department so that the cost implications of changes can be examined.

5.2 Total Costs

It is estimated that, once the services are up and running and capital investments have been made, the Bill will cost between R258 and R375 million per annum in current 2006 prices and between R298 and R434 million in nominal terms for the financial year 2009/10. In the earlier years of implementation, as capital investments are made, the cost will probably exceed this range. The following table presents the results for the three scenarios for the three years. Scenario 1 refers to the conservative interpretation and scenario 3 to the most liberal; scenario 2 reflects, as far as possible, what is planned. As the cost results presented in constant 2006 Rand are unaffected by the implementation date they are presented under headings of years 1, 2 and 3. The nominal estimates are linked to the dates and it is therefore appropriate to attach the assumed years to the headings.

It should again be noted that the three year period does not realistically represent the implementation schedule. The time period was stipulated in the terms of reference and, in order to generate a useful output, year three was modelled to reflect full implementation. The results for years 1 and 3 should be read as providing a range within which costs are expected to fall as services are rolled out. The length of time until the costs in year three are reached will largely be determined by the aggressiveness with which rollout is pursued. It should also be noted that the first two years include capital investments necessary to allow for full implementation in year three.

Table 8: Total cost by scenario, with and without inflation

Millions of 2006 Rands			
	Year 1	**Year 2**	**Year 3**
Scenario 1	280.4	282.4	257.7
Scenario 2	**305**	**310.6**	**290.2**
Scenario 3	346.8	374.7	374.6
Millions of nominal Rands			
	2007/8	**2008/9**	**2009/10**
Scenario 1	294.4	311.4	298.3
Scenario 2	**320.2**	**342.5**	**335.9**
Scenario 3	354.2	413.1	433.7

As mentioned, these costs include the capital outlays necessary to improve and build facilities. The importance of these costs is apparent from the following table, which examines the cost by category of expenditure.

Table 9: Percentage of total cost by cost category

Cost Category	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Land and buildings	29.52	27.13	23.86	17.65	16.07	13.33	0.00	0.00	0.00
Capital assets excluding buildings	0.20	0.25	0.33	0.01	0.03	0.07	0.03	0.00	0.00

Compensation of employees	6.60	8.78	8.30	9.13	9.85	10.20	11.13	10.75	10.47
Communication	0.40	0.42	0.41	0.42	0.46	0.48	0.50	0.50	0.46
Consultants and contractors	15.39	17.51	18.36	14.87	16.85	16.73	16.54	18.28	16.94
Travel and subsistence	1.45	1.55	1.61	1.19	1.39	1.52	1.62	1.82	1.85
Transfers to state provider	17.23	15.84	14.36	26.35	23.99	20.91	35.48	31.59	26.11
Transfers to non-state providers	28.61	27.93	32.20	29.77	30.75	36.16	33.99	36.37	43.57
Running costs	0.61	0.59	0.56	0.62	0.62	0.61	0.72	0.68	0.60
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

The above highlights the importance of capital costs, across all scenarios, in the early years. The results for year three relate to the cost breakdown for the Bill once it is running at full service provision. The table also shows the high proportion of costs associated with transfers to state and non-state providers; this relates to service provision and will be discussed in the appropriate sections. The high costs associated with consultants and contractors stem from the media campaigns envisaged in the scenarios.

The provincial breakdown of costs reflects the differences in provincial size, in the incidence of substance abuse, in current levels of service provision, and in need for capital investments.

Table 10: Total cost by province

Millions of 2006 Rands									
Province	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	15.5	17.0	23.1	40.6	42.5	52.1	24.3	**27.1**	39.5
Free State	33.9	35.3	37.5	16.7	18.2	22.4	17.5	**19.2**	25.4
Gauteng	34.1	35.8	37.4	35.4	37.7	41.6	36.3	**39.3**	45.0
KwaZulu-Natal	27.5	29.2	33.7	29.4	31.9	40.3	31.3	**35.0**	47.2
Limpopo	13.8	15.3	19.9	38.7	40.6	47.1	21.8	**24.0**	33.0
Mpumalanga	14.4	15.9	19.9	15.8	17.6	23.2	16.6	**18.5**	25.6
North West	35.1	36.6	40.0	17.2	18.8	24.3	18.1	**20.0**	27.4
Northern Cape	33.6	35.1	38.3	16.0	17.8	23.6	16.9	**18.8**	26.5
Western Cape	24.4	26.1	27.6	25.9	28.2	32.0	27.0	**29.8**	36.0
Balance of total to National	48.1	58.7	69.4	46.7	57.3	68.1	47.8	**58.4**	69.0
Total	280.4	305.0	346.8	282.4	310.6	374.7	257.7	**290.2**	374.6
Millions of Nominal Rands									
Province	**2007/8**			**2008/9**			**2009/10**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	16.3	17.9	24.3	44.7	46.9	57.4	28.1	**31.4**	45.7
Free State	35.6	37.1	39.3	18.4	20.1	24.7	20.3	**22.3**	29.4

Gauteng	35.8	37.6	39.3	39.0	41.5	45.9	42.1	**45.5**	52.1
KwaZulu-Natal	28.8	30.6	35.3	32.4	35.2	44.4	36.2	**40.6**	54.6
Limpopo	14.5	16.1	20.9	42.7	44.8	51.9	25.3	**27.7**	38.2
Mpumalanga	15.1	16.7	20.9	17.5	19.4	25.6	19.2	**21.4**	29.7
North West	36.9	38.5	42.0	19.0	20.8	26.8	21.0	**23.2**	31.7
Northern Cape	35.3	36.8	40.2	17.6	19.6	26.0	19.5	**21.7**	30.7
Western Cape	25.6	27.4	29.0	28.5	31.1	35.3	31.2	**34.5**	41.7
Balance of the total to National	50.5	61.7	72.9	51.5	63.2	75.1	55.4	**67.6**	79.9
Total	294.4	320.3	364.2	311.4	342.5	413.1	298.3	**335.9**	433.7

The costs for individual provinces are prone to large fluctuations as a result of capital investments. The best comparison of running costs is provided in year 3; for the planned scenario, scenario 2 is the best reference.

The provincial cost estimates can be compared to the costs of current levels of service provision. The following table provides estimates for the financial year 2005/6. Some caution should be exercised when making the comparison, as the above estimates include some items relating to provincial administration that do exist but are not included in the estimates below.

Table 11: Current service costs (millions of nominal Rand)

Province	2005/6
Eastern Cape	3.7
Free State	3.3
Gauteng	32.5
KwaZulu-Natal	18.0
Limpopo	3.9
Mpumalanga	5.6
North West	1.5
Northern Cape	0.5
Western Cape	22.6
Total	91.6

Source: National Treasury Provincial Database, as reported in The Provincial Budget and Expenditure Review: 2002/03-2008/09.

The comparison shows that costs will increase across all provinces, particularly those with currently very low levels of service. The North-West and the Northern Cape, for example, will require very large increases in spending from a small base. Other provinces that already have significant levels of services, such as the Western Cape and Gauteng, will require budget increases but not on the same scale. As has been mentioned, it should be kept in mind that not all of these required increases result from new services provided for in the Bill; bringing to scale services that are already provided for in the existing legislation is also a factor.

The above provides an overview of the results. To interpret them more fully the following subsections detail the assumptions and cost drivers that shape the totals. For ease of understanding, service delivery was broken down into a number of components, or activity areas, and costs estimated for each component. This allows for the cost implications of specific decisions to be highlighted. The components examined were:

- the Central Drug Authority (CDA)
- National Administration
- National Prevention efforts,
- Provincial Substance Abuse Forums
- Social development provincial administration
- Local Drug Action Committees (LDACs)
- Treatment
- Community-based services and outpatient care
- Aftercare
- Halfway Houses
- Prevention
- Other departments' provincial costs.

5.2.1 The Central Drug Authority

The costs associated with the CDA are determined largely by the size of the CDA, the staffing of its secretariat and the scale of the biennial conference. There is reasonable agreement on the appropriate size of the CDA; the only variation across the scenarios, with regard to size, was the speed at which this size was reached. The costs are based on a CDA of 40 people having a full meeting 4 times a year plus a number of sub committees; the number and size of subcommittees varies across scenarios.

The appropriate staffing of the secretariat is not as clear. It was felt that, to be able to cope with the enlarged role for the CDA, the current secretariat would need to be expanded. There was, however, a feeling that to function really effectively, rather than just to cope, the secretariat should be developed into a directorate. The budget for the secretariat staffing and office costs, after the absolutely necessary expansion, would be close to R1 million; as a directorate it would be in the region of R1.5 million. The staffing and office costs are larger than the meeting costs, which would reach R230 000 – R260 000 depending on the number of sub-committees.

The CDA is also responsible for convening a biennial summit on substance abuse. It is estimated that this would cost in the region of R1.4 million every second year. The size and nature of the event is already agreed and so does not vary across scenarios. The event costs are based on a 400-person event lasting three days. The costs associated with the event are included in the first and third years of the projection. The total costs of the CDA for each scenario over the three years are estimated as follows.

Table 12: CDA costs by sub-component, year and scenario (thousands of 2006 Rand)

Component	Year 1			Year 2			Year 3		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Full meeting	107.6	142.8	142.8	142.8	142.8	142.8	142.8	**142.8**	142.8
Executive and sub com meetings	66.9	87.6	119.8	66.9	87.6	119.8	66.9	**87.6**	119.8
Secretariat	986.9	997.3	1015.3	972.9	983.3	1 589.3	972.9	**983.3**	1 558.3
Biennial summit	1 431.2	1 431.2	1 431.2	0.0	0.0	0.0	1 401.2	**1 401.2**	1 401.2
Total	2 592.6	2 658.9	2 709.1	1 182.6	1 213.7	1 851.9	2 583.8	**2 614.9**	3 222.1

It is estimated that, once up and running, the CDA will cost R1.2 million a year under the planned scenario and an extra R1.4 million in summit years. The costs of the CDA are fairly small in relation to the total cost of the Bill. Moreover, the CDA already exists and a summit is already planned. There are fairly good data available on the current costs of the CDA that suggest that the planned expansion will cost in the region of R500 000 more than the existing budget.

While there is general agreement on the nature of the CDA, and so little variation across the scenarios, the potential variability associated with decisions, should disputes arise, is highlighted in the following table.

Table 13: Sensitivity of CDA cost estimates to assumptions (2006 Rand)

Cost	Estimate
Per additional CDA member	3 520
Per additional full meeting	26 900
Increase in ave. sub com size of one	7 840
One additional sub com meeting	3 360
Additional conference day	234 000
Additional person attending conference	2 800

The table provides estimates of what it would cost to increase the membership of the CDA by one person, to hold an additional full meeting each year, to add one member to each sub-committee, or to hold an additional sub committee meeting. With regard to the conference, estimates are provided for adding an extra day or person to the event.

5.2.2 National Department of Social Development Administration – excluding the CDA

In order to implement the Bill in a meaningful manner, an expansion in the current staffing of the National Department, much of which is already planned, will be required. Based on existing plans to expand and discussions with the current administration of needs associated with the scenarios as outlined to them it was estimated that, for the first two scenarios, two additional senior staff with administrative support will be required. For the more aggressive third scenario, a further two additional staff would be appropriate, given the faster rollout associated with the more liberal interpretation.

Many of the tasks of the national administration, such as the development of norms and standards, are already being undertaken. The costs associated with the development of norms and standards are based on the development of one a year. This involves a full consultation process, including a national workshop and two consultative workshops per province.

As with the CDA, much of the activities are ongoing; the increases in the costs associated with the Bill are, therefore, not very great: again in the region of R500 000 on current budgets for the planned scenario. This, however, excludes one important aspect. The Bill implies the need for research in this field and to realise the intentions of the Bill it would be appropriate to add in a research budget for the National Department to facilitate this process in conjunction with the CDA. Research, like prevention, costs as much as one is willing to spend and depends on the research agenda. National surveys cost millions, whereas desk reviews may be a few hundred thousand. The Department is currently considering a national prevalence study, a socio-economic impact of substance use study and a study of the impact of treatment interventions. A budget of between R1.5 million and R2 million is allocated each year across the three scenarios as an indication of possible costs.

Table 14: National Administration costs by cost category, year and scenario (thousands of 2006 Rand)

Cost Category	Year 1			Year 2			Year 3		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Capital assets	11.0	22.0	33.0	6.0	11.0	40.0	0.0	**0.0**	0.0
Compensation	1 590.0	1 685.0	1 895.0	1 800.0	1 895.0	2 730.0	1 800.0	**1 895.0**	2 730.0
Communication	48.0	54.0	60.0	54.0	60.0	162.0	54.0	**60.0**	72.0
Consultants and contractors	1 602.5	1 852.5	2 102.5	1 584.5	1 834.5	2 084.5	1 584.5	**1 834.5**	2 084.5
Travel and subsistence	246.0	268.0	316.4	246.0	268.0	316.4	246.0	**268.0**	316.4
Transfers to state providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Transfers to non-state providers	200.0	200.0	200.0	200.0	200.0	200.0	200.0	**200.0**	200.0
Running costs	36.0	42.0	48.0	42.0	48.0	132.0	42.0	**48.0**	60.0
Total	3 733.5	4 123.5	4 654.9	3 932.5	4 316.5	5 664.9	3 926.5	**4 305.5**	5 462.9

As would be expected, a large proportion of the costs of national administration is associated with compensation to employees. There is, however, not a great deal of debate here as the staffing needed is a result of decisions made elsewhere. The one point that could be discussed relates to the formation of a specialised monitoring and evaluation (M & E) unit for substance abuse. This was mentioned as a possibility, but it is included only in scenario 3. M & E is mentioned in the Bill as an important aspect, but the staffing required is largely covered in the provincial and national structures suggested; a specialised unit would be an extra. The other major cost component, besides

compensation, is consultants and contractors. This refers to research spending and outside support to the unit's processes.

5.2.3 National Prevention

The costing of national prevention efforts included the development of programmes to be implemented by Provinces as well as national media campaigns and national events. The cost of developing and introducing a new programme, together with training, was included every three years. Some of the costs associated with development of a new intervention have, in the past, been met by outside donors. This is also the case with some of the development costs associated with norms and standards. In this costing these costs are included as part of the Department's requirement.

This section also included the costs associated with transfers to SANCA national and other national NGOs involved in the response. These are not all for prevention and should perhaps be considered separately.

Prevention at both the national and provincial levels is a difficult aspect of the Bill to cost. The Bill expressly discusses prevention, but it does not prescribe how much or of what type: a new programme could be introduced every year or every second year; media campaigns could be conducted aggressively or at a low level. The following assumptions of the appropriate level of prevention efforts are based on responses, mainly from the national department, often based on feedback they had received from parliamentarians.

It was argued by implementers that a three-year cycle for new programmes was appropriate and this is included in all scenarios. The costs associated with training for a new intervention are based on the current training model. The training involves one national training workshop followed by two regional workshops in the first year of implementation. Respondents noted that many of those initially trained in this manner move to other areas and as such follow-up training is required. To account for this, the

costs of two additional regional workshops were included in year two. It should be noted that all the costs associated with training are included in the estimates for Social Development although those trained may well be from other departments, notably Education. The cyclical nature of the implementation of new programmes results in rising and falling costs for this aspect of the costing.

The need for media support was agreed. It was felt strongly by respondents that this is an area that has been neglected in terms of formulating a response. It was argued that to really make the presence of the response felt, an aggressive media campaign should be undertaken. Respondents argued that this needed to go beyond TV and radio and to include billboards, taxi branding and similar mass marketing approaches. To this end, scenario one includes a budget of R40 million for a large-scale national campaign. Scenario two includes a budget of R50 million, which would allow for market segmentation and the varying of messages across the country rather than the single message associated with scenario one. Finally, a budget of R60 million was included in scenario three, which would allow for market segmentation and follow-up media support such as involving personalities, conducting interviews and holding events. These costs are large and would be associated with a shift in approach from current prevention efforts.

SANCA is supported by the National Department. It is assumed that this will at least continue and possibly increase. It was, however, also felt that support to National NGOs in general needs to be improved; an increase of current subsidies of 30% by year three for scenario 2 and 50% for scenario 3 is, therefore, included in the estimates. Support to these structures and to their prevention efforts are not demand driven and it is not possible to stipulate what the appropriate amount implied by the bill is. The need reported by the National Department for support to be increased and broadened to other organisations was modelled as they seemed the most appropriate to make such a judgment.

The total cost for the three scenarios, including NGO transfers, is presented in the table below.

Table 15: Total cost by scenario of National Prevention (millions of 2006 Rand)

	Year 1	Year 2	Year 3
Scenario 1	41.9	41.5	41.5
Scenario 2	**52.1**	**51.7**	**51.7**
Scenario 3	62.2	60.6	60.6

The costs in the first year are slightly higher because of the inclusion of the development and training costs associated with the introduction of a new programme.

The national level costs associated with the CDA and administration is only about 3% of the total estimated costs. While some of the decisions outlined above will influence costs, they are relatively minor compared to those associated with national prevention, now that it includes a large-scale media intervention, and those that need to be made at the provincial level, particularly with regard to service delivery and, most of all, to treatment.

5.2.4 Provincial substance abuse forums

The establishment and maintenance of provincial substance abuse forums in every province is envisaged in the Bill. These already exist in some provinces in different forms and to varying degrees.

There is some dispute about the appropriate size and make-up of these forums. Some suggest larger bodies, while others prefer smaller bodies that meet more frequently. The conservative scenario costs a smaller (30 people for larger provinces) meeting fewer

times (4) compared to the more adventurous version for larger provinces of 50 people meeting 8 times a year, with more subcommittees. Others still see very large forums being formed, but these would not cover as much or as many of the participants' costs and would, therefore, require similar budgets to those presented. Some administrative support is required for these forums to function and this is included in all scenarios. The total costs are as follows.

Table 16: Total cost by scenario of all PSAF (millions of 2006 Rand)

	Year 1	**Year 2**	**Year 3**
Scenario 1	2.8	2.8	2.8
Scenario 2	**3.1**	**3.0**	**3.0**
Scenario 3	3.2	3.1	3.1

The costs of the provincial substance abuse forums are largely driven by the administrative support necessary to organise them and the costs associated with meetings. The following table outlines the cost by category.

Table 17: Provincial PSAF costs by cost category, year and scenario (thousands of 2006 Rand)

Cost Category	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Capital assets	63.0	126.0	126.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Compensation	855.0	855.0	855.0	855.0	855.0	855.0	855.0	**855.0**	855.0
Communication	108.0	216.0	216.0	108.0	216.0	216.0	108.0	**216.0**	216.0

Consultants and contractors	367.6	389.2	410.8	367.6	389.2	410.8	367.6	**389.2**	410.8
Travel and subsistence	481.8	546.6	611.4	481.8	546.6	611.4	481.8	**546.6**	611.4
Transfers to state providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Transfers to non-state providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Running costs	954.0	1 008.0	1 008.0	954.0	1 008.0	1 008.0	954.0	**1 008.0**	1 008.0
Total	2 829.4	3 140.8	3 227.2	2 766.4	3 014.8	3 101.2	2 766.4	**3 014.8**	3 101.2

The high proportion of compensation results from the employment of administrative support. The running costs result from office costs associated with the administration and the publication of forum materials, such as annual reports. The remaining costs are associated with meetings, covering travel, subsistence and venue costs.

The costs to each province vary according to the size of the province's population. The larger provinces (KwaZulu-Natal, the Free State, the Eastern Cape, the Western Cape and Gauteng) were grouped together with costs in year three ranging from R310 000 – 350 000 in scenarios 1 and 3 respectively. The remaining provinces' costs ranged from R300 000 – R340 000.

5.2.5 Provincial Administration

The administrative structures considered at the provincial level are fairly large in scale, as it was felt by respondents that effective implementation would require a fairly substantial increase in staffing. The costs associated with the formation and maintaining of a small directorate to deal with the rollout of services were estimated for each province. This was

deemed to be absolutely necessary and is, therefore, included in all scenarios. For the first two scenarios the directorate consisted of a director with two coordinators and an administrator; an extra administrator was included for the third scenario.

It was considered necessary to have some dedicated staff away from the provincial centre, but the number will be determined by the aggressiveness of service expansion. The aggressive scenario includes more staff (4 as opposed to 2) at the regional level to cope with the greater demands associated with the services included.

While the administrative structures did consider the aggressiveness of the scenarios they were otherwise not activity-based. The variability in staffing requirements associated with the different scale of provision necessary in the different provinces is dealt with for each service. The administrative structure is, therefore, not affected by differences across provinces and is kept standard.

Table 18: Provincial administration costs by cost category, year and scenario

(thousands of 2006 Rand)

Cost Category	Year 1			Year 2			Year 3		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Capital assets	126.0	189.0	396.0	0.0	63.0	189.0	63.0	**0.0**	0.0
Compensation	6 975.0	13 005.0	13 860.0	13 005.0	15 345.0	19 980.0	15 345.0	**15 345.0**	19 980.0
Communication	162.0	162.0	216.0	162.0	216.0	378.0	216.0	**216.0**	378.0
Consultants and contractors	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Travel and sub	1 506.6	1 506.6	1 506.6	1 506.6	1 506.6	1 506.6	1 506.6	**1 506.6**	1 506.6

Transfers to state providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Transfers to non-state providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Running costs	162.0	162.0	216.0	162.0	216.0	378.0	216.0	**216.0**	378.0
Total	8 931.6	15 024.6	16 194.6	14 835.6	17 346.6	22 431.6	17 346.6	**17 283.6**	22 242.6

The costs are primarily for staff compensation and travel, as would be expected in an administrative and coordinating structure. The capital costs relate to setting up offices. The costs presented in the above table relate to the Department of Social Development. Such structures will be needed in other departments but on a much smaller scale. The cost of providing these is estimated to add in the region of R7 million per year, but these costs will be discussed separately.

The above costs are far more substantial than those discussed for national structures and the staffing decisions here, particularly have far greater impact. The more aggressive scenario requires more regional staff, increasing the costs by R4.8 million - more than the entire cost of the CDA.

As mentioned, the provincial administration costs were not linked to services and so were held constant across all the provinces. The above costs are equally distributed across the provinces. At full implementation they are expected to range between R1.9 – R2.5 million depending on the scenario.

5.2.6 Local Drug Action Committees (LDACs)

There are currently a number of LDACs across the country and the Department is already planning to expand coverage. They currently follow different patterns of operation that influence costs.

The total costs of running LDACs are determined by two factors: the activity level of the committee and the number of committees established. All three scenarios were based on a similar-sized LDAC of 30 people, but the aggressive scenario incorporated more frequent full meetings and more active and larger subcommittees. The first two scenarios were based on an average subcommittee size of 5 meeting 12 times a year (one executive subcommittee and one additional joint meeting every second month), while the third scenario was based on an average size of 10 meeting 18 times a year (an executive and two additional) that increased the average cost per LDAC from R37 600 to R69 000.

The number of LDACs established was based on the number of municipalities covered, assuming that LDACs will follow municipal boundaries, with cost adjustments for larger municipalities. The Department's existing goals in this regard were reflected in all scenarios. The coverage considered was 20% in the first year, increasing to 50%, and then to 80%. The resulting number of LDACs per province is presented in the following table.

Table 19: LDACs per province

Province	Year 3
Eastern Cape	30
Free State	16
Gauteng	12

KwaZulu-Natal	40
Limpopo	20
Mpumalanga	19
North West	16
Northern Cape	22
Western Cape	19
Total	194

For very large municipalities it was assumed that they would either have two or one large one. The number of LDACs for provinces such as Gauteng is therefore inflated to account for the average size of municipalities. As a result of this adjustment the total in the above table is a greater number than would be reflected if it were simply 80% of the municipalities. The costs resulting from this level of coverage are presented for each province in the following table.

Table 20: Total cost by scenario of all LDACs (millions of 2006 Rand)

Province	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	263.2	263.2	483.0	714.4	714.4	1 311.0	1 128.0	**1 128.0**	2 070.0
Free State	150.4	150.4	276.0	376.0	376.0	690.0	601.6	**601.6**	1 104.0
Gauteng	150.4	150.4	276.0	300.8	300.8	552.0	451.2	**451.2**	828.0
KwaZulu-Natal	376.0	376.0	690.0	940.0	940.0	1 725.0	1 504.0	**1 504.0**	2 760.0

Limpopo	188.0	188.0	345.0	488.8	488.8	897.0	752.0	**752.0**	1 380.0
Mpumalanga	150.4	150.4	276.0	338.4	338.4	621.0	526.4	**526.4**	966.0
North West	150.4	150.4	276.0	376.0	376.0	690.0	601.6	**601.6**	1 104.0
Northern Cape	188.0	188.0	345.0	526.4	526.4	966.0	827.2	**827.2**	1 518.0
Western Cape	188.0	188.0	345.0	451.2	451.2	828.0	714.4	**714.4**	1 311.0
Total	1 804.8	1 804.8	3 312.0	4 512.0	4 512.0	8 280.0	7 106.4	**7 106.4**	13 041.0

As would be expected, the provinces with more municipalities and larger populations have the greatest costs. KwaZulu-Natal, which is large, both population-wise and physically, would require the most LDACs to reach the coverage modelled. Scenarios 1 and 2 are based on the same assumptions and so have the same costs. The higher cost associated with scenario 3 is a direct result of the assumption of more active LDACs.

5.3 Provincial service delivery

The costs of service delivery at the provincial level were examined by component. It is, however, worth noting some issues relating to interaction between the components before examining the costs of each. It would be a far easier process to cost if it were possible to assume that the current level of treatment provided met the demand for treatment. It would then be possible to examine how dividing the demand for treatment across different services affects costs. For example, if such an assumption were true the introduction of greater outpatient services and community-based care would proportionately reduce the demand for inpatient care. Similarly, an improved aftercare programme that reduced relapse would reduce the demand for treatment.

The situation is, however, not that simple. There will be those who, once alternative treatments are available, will no longer demand inpatient care. There are, however, those

who will want care now that alternatives exist. Community-based care and prevention campaigns may well increase awareness of the problem and increase the numbers seeking treatment in the short term, while decreasing the numbers in the long term.

Bearing in mind the above problems associated with predicting demand patterns and considering the Bill's push towards community-based services, the following was modelled for costing purposes:

- Inpatient facilities to be improved in provinces that have low availability but not in those with high levels, except to accommodate youth. This is in the belief that alternative services will reduce demand to some extent and negate any need to expand beyond the service level currently enjoyed by better-resourced Provinces.
- Aftercare to be provided to deal with the demand associated with a level of inpatient treatment comparable to well-resourced provinces.
- Outpatient and community-based care to be expanded, more or less aggressively depending on the scenario.
- Prevention efforts to be similarly resourced across the country and possibly expanded.

The above assumptions are based on an interpretation of the Bill as seeing inpatient treatment as a last resort and prioritising outpatient and community-based approaches. The costs associated with this reading of the Bill and the current situation result in the following costs for each component.

5.3.1 Treatment centres

The costs associated with treatment centres include state inpatient facilities and subsidies to non-state facilities including existing outpatient care. Expanded outpatient care is examined in a later section. Ideally, the existing subsidies would have been divided between inpatient and outpatient services and dealt with in the appropriate sections. The insufficiency of the data on this issue received from provinces made this impossible.

From the limited data that are available it is clear that the bulk of subsidies are for inpatient treatment, so including them here does not lead to a high level of distortion and obviously has no impact on total cost.

This component and the policy decisions relating to it are a major influence on total costs. In the first two years of the costing, this component, due largely to capital investments, accounts for approximately half of the total. In year three, which considers only running costs, the percentage falls but is still high at close to 40%.

Before discussing the costs it should be noted that the previous Act also commits the state to supporting treatment. Arguably, the costs associated with improving inpatient treatment to an equitable standard across provinces should not be considered a direct result of the Bill but rather a redressing of past imbalances in service provision.

A rather bold step, supported by almost all respondents, was taken in the costing exercise: it was decided to interpret the intention of the Bill as being to bring about some equity in service availability, while not focusing on inpatient care as the preferred model but rather favouring outpatient and community-based options. This decision led to the inclusion of the costs of building and maintaining an inpatient treatment centre in every province that currently does not have a state facility, while maintaining existing state facilities.

Existing state facilities tend to be large. While the decision was to cost the provision of equity, the building of large centres seemed to be against the general trend of the Bill away from this model of care. For this reason, the building of medium-sized facilities providing 65 beds for long-stay programmes was considered in the costing. Where this would still leave a shortfall in the availability of beds in some provinces, current subsidy budgets were adjusted to bring about a minimum level of availability similar to well-resourced provinces after adjusting for province size and the scale of the problem.

The following table outlines the surveyed capacity of provinces in terms of inpatient beds. The beds included here are from all facilities, public and private, surveyed by the Department to gather data to respond to a parliamentary question. The figures include private facilities, subsidised facilities and state facilities. Some facilities may have been missed but it still provides an indication of the availability of services and their distribution across the country.

The after-capital-investment column reflects the capacity as it would be if a 65 bed facility were established for each province that does not currently have any state treatment facilities. Provinces marked in bold are those that currently have no state facilities.

Table 21: Inpatient capacity by province

Province	Capacity	After capital investment
Eastern Cape	**256**	**321**
Free State	**42**	**107**
Gauteng	845	845
KwaZulu-Natal	672	672
Limpopo	**50**	**115**
Mpumalanga	**143**	**143**
North West	**32**	**97**
Northern Cape*	**285(85)**	**350(150)**
Western Cape	543	543

*Figures in parenthesis exclude one large private centre that is utilised mainly by clients from outside the province.

A number of the better-resourced provinces felt that they had sufficient capacity, although they were still having some problems with the location of services. For these provinces the ratio of beds to people possibly requiring treatment (estimated using the prevalence data) was calculated. This was compared to the ratio of capacity to people requiring treatment in the other provinces, after adjusting for the increase in capacity associated with the building of a centre. This process identified two provinces (North West and Free State) that would still fall short compared to the better-resourced provinces. For these two additional subsidies were budgeted for to increase available capacity.

State facilities are expensive to run and the building of more increases the ongoing costs of treatment. It could be argued that a cheaper option to bring about some equity would be to increase subsidies to non-state providers. Non-state providers are cheaper because of a combination of the subsidies being insufficient, lower level staff being used or lower pay and poorer staff-to-client ratios (even if they are within norms and standards). If the decision is for equity it would be inappropriate to support a lower standard of care; if it were increased then it would cost the same. Some respondents stressed that clients do not like state facilities and NGO-run institutions run at a higher capacity. It may be worthwhile for provinces to consider contracting out the running of facilities, but for the reasons mentioned this would not influence cost.

The costs of building the new state facilities are based on Departmental estimates already submitted to Treasury. The staffing levels proposed similarly are those suggested by the department for long-stay treatment centres. The following table outlines the staffing requirements for a centre.

Table 22: Treatment centre staffing: Inpatient long-stay facility

Staff Category	Number
Manager	1
Social workers	3
CPN	3
Occupational Therapist	1
Occupational therapist assistant	2
Supervisor laundry officer	1
Laundry aid	3
Driver	2
Admin officer	1
Admin clerk	1
Typist	1
Chief care officer	1
Care officer	15
Unit cost (R millions per annum) including non-staff costs	7.2

In addition to building centres, some further capital investments are considered. These include the development and running of a centre for youth. It is a requirement that youth be treated in separate facilities. Where these are currently not available, a budget for their establishment and maintenance is included. What it will cost to set up a youth facility has, in the past, been determined by what was already available and to what extent alterations were required. Some provinces have, however, had to set up facilities from

almost nothing. The cost of doing this, estimated at R1.4 million, was included for all provinces that do not currently have youth facilities. Thereafter, an increase in subsidies of R1million was budgeted for running the facility, based on two-thirds occupancy.

The cost of treatment is, therefore, shaped by the maintenance of current facilities, increases in subsidies in two provinces, new centres in all provinces without state facilities and the establishment of youth facilities in provinces that currently do not have any. The costs associated with these factors are presented in the following table.

Table 23: Treatment centre costs (inpatient only) by cost category, year and scenario (thousands of 2006 Rand)

Cost Category	Year 1			Year 2			Year 3		
	S1	S2	S3	S1	S2	S3	S1	S2	S3
Land and buildings	82 761.2	82 761.2	82 761.2	49 840.8	49 840.8	49 840.8	0.0	**0.0**	0.0
Other Capital	7.0	7.0	7.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Compensation	95.0	95.0	95.0	95.0	95.0	95.0	95.0	**95.0**	95.0
Communication	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Consultants and contractors	1.9	1.9	1.9	1.9	1.9	1.9	1.9	**1.9**	1.9
Travel and subsistence	9.0	9.0	9.0	9.0	9.0	9.0	9.0	**9.0**	9.0
Transfers to state providers	46500.0	46 500.0	46 500.0	69 900.0	69 900.0	69 900.0	84 300.0	**84 300.0**	84 300.0
Transfers to non-state providers	23100.0	23 100.0	23 100.0	23 100.0	23 100.0	23 100.0	23 100.0	**23 100.0**	23 100.0

Running costs	18.0	18.0	18.0	18.0	18.0	18.0	18.0	**18.0**	18.0
Total	152 492	152 492	152 492	142 965	142 965	142 965	107 524	**107 524**	107 524

The above table shows the heavy investment necessary to develop the treatment centres in the first two years, including improvements to existing facilities to accommodate young clients separately as is required by the Bill. Realistically this might take a few more years but, for the sake of generating an estimate that showed the full running costs by year three, the building costs were included in the first two years.

The compensation, travel and other capital refer mainly to the costs associated with setting up and running an appeals committee for treatment centre clients. The transfers to state providers deal with the costs associated with running state inpatient facilities. The transfers to non-state providers refer to treatment subsidies for inpatient care. Running costs refer to the costs of covering the basic bills of the centres.

It is important to note that over half of the transfers to state providers envisaged for year three are already occurring in year one, as these are to existing facilities.

The above table shows that the costs of treatment centres do not vary across scenarios. This is because only the provision of equity was estimated. Different scenarios could then have estimated the cost implications of expanding inpatient facilities, at different rates, to levels above those in the well-resourced provinces. This, however, would have been contrary to the tone of the Bill, which suggests that inpatient approaches will not be seen as the core of the response as they have been in the past. It should also be remembered that in time it would be hoped that these inpatient facilities, particularly the very large existing facilities, could even be scaled back. This may be possible if expanded outpatient and community-based services, not to forget prevention, reduce the need for inpatient care.

The above costs are divided across the provinces as follows:

Table 24: Treatment centre costs by province (millions of Rand)

Millions of 2006 Rands									
Province	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	5.9	5.9	5.9	29.4	29.4	29.4	11.7	**11.7**	11.7
Free State	27.2	27.2	27.2	9.0	9.0	9.0	9.0	**9.0**	9.0
Gauteng	19.5	19.5	19.5	19.5	19.5	19.5	19.5	**19.5**	19.5
KwaZulu-Natal	16.0	16.0	16.0	15.5	15.5	15.5	15.5	**15.5**	15.5
Limpopo	5.9	5.9	5.9	29.4	29.4	29.4	11.7	**11.7**	11.7
Mpumalanga	8.0	8.0	8.0	8.4	8.4	8.4	8.4	**8.4**	8.4
North West	28.3	28.3	28.3	9.2	9.2	9.2	9.2	**9.2**	9.2
Northern Cape	27.8	27.8	27.8	8.7	8.7	8.7	8.7	**8.7**	8.7
Western Cape	13.7	13.7	13.7	13.7	13.7	13.7	13.7	**13.7**	13.7
National DoSD	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**0.1**	0.1
Total	152.5	152.5	152.5	143.0	143.0	143.0	107.5	**107.5**	107.5
Millions of Nominal Rands									
	2007/8			**2008/9**			**2009/10**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	6.2	6.2	6.2	32.4	32.4	32.4	13.5	**13.5**	13.5

Free State	28.6	28.6	28.6	9.9	9.9	9.9	10.4	**10.4**	10.4
Gauteng	20.5	20.5	20.5	21.5	21.5	21.5	22.6	**22.6**	22.6
KwaZulu-Natal	16.8	16.8	16.8	17.1	17.1	17.1	17.9	**17.9**	17.9
Limpopo	6.2	6.2	6.2	32.4	32.4	32.4	13.5	**13.5**	13.5
Mpumalanga	8.4	8.4	8.4	9.3	9.3	9.3	9.7	**9.7**	9.7
North West	29.7	29.7	29.7	10.1	10.1	10.1	10.7	**10.7**	10.7
Northern Cape	29.2	29.2	29.2	9.6	9.6	9.6	10.1	**10.1**	10.1
Western Cape	14.4	14.4	14.4	15.1	15.1	15.1	15.9	**15.9**	15.9
National DoSD	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**0.1**	0.1
Total	160.1	160.1	160.1	157.6	157.6	157.6	124.5	**124.5**	124.5

Major year-on-year fluctuations for individual provinces are a result of the costs of building new facilities. The costs attached to the National Department are those relating to the appeals committee.

There is also a need to consider the distribution of these costs across Departments. If the Department of Health is deemed responsible for medical services at state facilities the costs of these can be allocated to them. This will be discussed in more detail shortly.

Finally, with regard to centres, the Bill also mentions halfway houses. After considerable discussion with policy-level staff, it was agreed that these were included for definitional purposes and the State's role would be in registering and monitoring, not in providing, them. Given this decision, no direct costs relating to halfway houses were estimated.

5.3.2 Aftercare

There are a number of alternative approaches to providing aftercare that result in different costs. Three models of aftercare were examined and the costs associated with their provision estimated. The first, forming part of scenario one, is group-based aftercare where clients come in for group sessions twice a month for the first two months; then once a month for the next 10 months; and then gradually less frequently for the next 12 months. The second approach, included in scenario two, involves a combination of group care, as outlined above, and individual sessions once a month. The final approach addresses the Bill's mention of aftercare, including a fuller consideration of family and community circumstances, by considering a provision for home visits every second month with the individual coming in on alternate months with supportive group care. In both scenarios involving individual sessions the sessions are assumed to last 45-60 minutes. Individual sessions are assumed to continue for the first year. In all three scenarios the group sessions are assumed to continue for 24 months.

Aftercare is assumed to make use of social workers. Given the constraints associated with availability, it is useful to consider the number of social workers required for each of the approaches. The following table does this, based on the assumption that 30% of all inpatient clients, from state or private facilities, will demand aftercare when they complete their stay. The figure is low as it is assumed that few patients from private centres will want to access the service. The number of patients in inpatient care is based on incidence of demand for inpatient care relative to the level of substance abuse in well-resourced settings. Well-resourced settings were considered as this is where inpatient care has been fairly readily available, as opposed to the more poorly-resourced provinces where demand may have been low because of lack of access.

Table 25: Social workers required for aftercare

Province	Group only	Group and individual	Group and individual including home visits
Eastern Cape	2	2	4
Free State	2	2	3
Gauteng	6	8	12
KwaZulu-Natal	4	5	7
Limpopo	1	1	2
Mpumalanga	1	2	2
North West	3	3	4
Northern Cape	2	2	4
Western Cape	5	7	10
Total	26	32	48

The resources required to phase in each of the above approaches were estimated, resulting in the following output:

Table 26: Provincial breakdown and total cost for aftercare (thousands of 2006 Rand)

Province	Year 1			Year 2			Year 3		
	S1	S2	S3	S1	S2	S3	S1	S2	S3
Eastern Cape	383.6	702.3	738.3	372.6	684.3	1 076.3	372.6	**684.3**	1 072.3
Free State	383.6	582.3	768.3	372.6	571.3	898.3	372.6	**571.3**	896.3

Gauteng	383.6	844.3	1 076.3	642.2	1 304.3	1 766.3	907.8	**1 618.3**	2 470.3
KwaZulu-Natal	383.6	618.3	916.3	916.2	1 085.3	1 430.3	940.2	**1 105.3**	1 588.3
Limpopo	256.0	542.3	738.3	247.0	526.3	720.3	247.0	**526.3**	720.3
Mpumalanga	248.8	524.3	738.3	250.6	686.3	720.3	250.6	**684.3**	720.3
North West	248.8	542.3	738.3	374.6	686.3	1 076.3	519.4	**844.3**	1 072.3
Northern Cape	248.8	524.3	738.3	374.6	686.3	1 076.3	372.6	**684.3**	1 072.3
Western Cape	378.6	862.3	1 094.3	512.4	1 162.3	1 606.3	775.0	**1 478.3**	2 134.3
Total	2 915.4	5 742.7	7 546.7	4 062.8	7 392.7	1 0370.7	4 757.8	**8 196.7**	11 746.7

The differences in costs across the provinces result from the differing scale of the problem and the different size of the population. Both of these factors mean that there will be a different level of demand for aftercare services and therefore a different level of need for social workers to provide it. The costs, however, will not be determined only by social worker salaries, but also by home visits where travel is an important factor, as can be seen in the following table.

Table 27: Aftercare costs by scenario and cost category (thousands of 2006 Rand)

Cost Category	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Capital assets	86.0	144.0	172.0	21.0	20.0	34.0	16.0	**10.0**	14.0
Compensation	2 395.0	4 555.0	5 485.0	3 425.0	5 765.0	7 325.0	3 975.0	**6 315.0**	8 205.0
Communication	138.0	192.0	246.0	186.0	258.0	348.0	234.0	**300.0**	390.0

Consultants and contractor	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Travel and subsistence	158.4	659.7	1397.7	244.8	1 091.7	2 315.7	298.8	**1 271.7**	2 747.7
Transfers to state providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Transfers to non-state providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Running costs	138.0	192.0	246.0	186.0	258.0	348.0	234.0	**300.0**	390.0
Total	2 915	5 743	7 547	4 063	7 393	10 371	4 758	**8 197**	11 747

The table shows that the costs associated with the provision of aftercare will be largely staff-related, although with some significant travel costs. Capital costs and running costs are office-related.

All three options described, and for which the costs were estimated, could be considered as aftercare. This is a typical example of how the interpretation of the Bill determines costs.

5.3.3 Outpatient and Community-based Care

Outpatient and community-based care are very similar and difficult to distinguish, so were considered together. As both concern treatment, the model of provision examined must consider the decisions made regarding inpatient facilities.

Outpatient care and community-based care are very similar in a number of respects, as they both involve the care of clients while they live at home. There is not a great deal of clarity as to what form outpatient and community-based care will take and how they will

be combined. The situation is further complicated, as was the case with inpatient care, by the lack of data on demand for expanded services and potential demand for new services.

To conduct the costing, a concrete outline was necessary, and has been presented to the department for consideration. It was agreed with the department that this should be presented as an example and it should be acknowledged that provinces might well opt to implement it in a different way. What this provides is an indication of what scale of cost is associated with this area. Based on consideration of the situation and consultation during the fieldwork, the following model was considered:

- Placement of large outpatient facilities in large urban areas (1 million plus) in all scenarios
- Placement of medium outpatient facilities in all medium-sized urban areas (500 000 - 1 million) in all scenarios
- Placement of small outpatient facilities in all small urban areas (250 000 – 500 000) in scenario 3 only
- Adjustments made for very rural provinces to include centres in smaller urban areas that act as catchments areas
- Community-based care that links in with the outpatient network:
    - Scenario 1: Provide small-scale community-based projects, in 20% of municipalities, that link up with outpatient centres for medical support when necessary and cover mainly rural areas
    - Scenario 2: Provide larger community-based projects, in 20% of municipalities that have some in-house health services and link less frequently to outpatient centres
    - Scenario 3: As for scenario 2 but expanded to 50% of municipalities.

In the above model, the care is provided from outpatient centres; wider support and referral is provided by community-based projects. The costs of both the outpatient centres and the community-based care are considered in this section.

Ideally, one would want to estimate the demand for a combination of outpatient and community-based care. There is, however, insufficient data to do so; the above is therefore seen as a starting point that would have to be monitored and, if successful but insufficient, expanded. This would obviously increase costs, but it would also reduce the need for more expensive inpatient treatment. If the model worked, provinces could encourage subsidised NGOs that are providing inpatient treatment to move towards outpatient and community-based care.

The scenarios envisage the establishment of different-sized facilities. The structure of the facilities is based on currently-provided models of outpatient care, these models typically being NGO run. The state may well opt for an alternative structure but it was felt appropriate to base the models on existing structures. The staffing and full cost of the facilities is presented in the following table. As mentioned a number of times, the costs are based on state costs even though the costs in this case are recorded as subsidies to non-state service providers.

Table 28: Outpatient centres' staffing level and total costs

Staff Category	Large	Medium	Small
Director	1	1	0
Administrative personnel	3	2	1
Profession nurse	1	1	1
Managers	3	1	1
Social workers	4	2	1
Prevention information officer	1	1	0

Medical doctor	0.2	0.1	0.1
Support staff	1	1	1
Unit cost (R millions per annum) including non-staff costs	1.7	1.1	0.6

As was described above, these centres are to be located in urban areas with the size of the urban area determining the size of the centre. The costs of the different scenarios vary depending on the number of centres established. The following table presents the number and size of centres by province and scenario**.** Population data for this exercise were taken from Census 2001 (Stats SA, 2003).

Table 29: Outpatient centres by size, province and scenario

Province	**Scenario**	**No. of Outpatient facilities**		
		Large	**Medium**	**Small**
Eastern Cape	S1/S2	1	1	-
	S3	1	1	6
Free State	S1/S2	-	1	-
	S3	-	1	2
Gauteng	S1/S2	2	2	-
	S3	2	2	1
KwaZulu-Natal	S1/S2	1	1	-
	S3	1	1	2

Limpopo	S1/S2	-	2	-
	S3	-	2	5
Mpumalanga	S1/S2	-	1	-
	S3	-	1	5
North West	S1/S2	-	1	-
	S3	-	1	4
Northern Cape	S1/S2	-	1	-
	S3	-	1	2
Western Cape	S1/S2	2	-	-
	S3	2	-	-
Total	S1/S2	6	10	-
	S3	6	10	22

The model of community-based care was briefly mentioned above. It was decided to cost a model of community-based services linked to outpatient care, where an NGO-run project provides services and links up with outpatient facilities where necessary. As there was no real agreement on what form such efforts would take, a budget for each community-based project that covered a number of the small options suggested was included for scenario one and a budget that covers some of the more substantial options was included for scenarios two and three. The figures used were R250 000 and R500 000 per community respectively, the main difference between the two being the latter's potential to offer some basic medical services.

There could, of course, be much debate about what constitutes a community and, more importantly, about how many should be covered by such services. For the purposes of

this initial costing, it was assumed that a community could be selected from within a municipality with the involvement of the LDAC. The question then becomes how many municipalities to target.

The first two scenarios consider a goal of 20% of municipalities by year three, while scenario three costs a goal of 50%. Ideally, it would have been better to try to determine which municipalities needed such a programme, but substance abuse occurs across the country, so the decision is essentially one of policy.

The costs of the above scenarios are presented in the following table. Given the scale of the costs the nominal figures are also presented.

Table 30: Total cost by scenario of outpatient and community-based care

Millions of 2006 Rands									
Province	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	3.3	3.8	9.5	3.8	4.8	12.5	4.6	**6.3**	16.0
Free State	1.6	2.1	3.8	1.8	2.6	5.3	2.1	**3.1**	7.3
Gauteng	6.1	6.6	7.7	6.4	7.1	9.2	6.6	**7.6**	10.2
KwaZulu-Natal	3.6	4.3	8.0	4.3	5.8	12.0	5.3	**7.8**	16.5
Limpopo	2.7	3.2	7.2	3.2	4.2	9.2	3.4	**4.7**	11.7
Mpumalanga	1.6	2.1	5.6	1.8	2.6	7.1	2.1	**3.1**	8.6
North West	1.6	2.1	5.0	1.8	2.6	6.5	2.1	**3.1**	8.5
Northern Cape	1.6	2.1	4.8	2.1	3.1	7.3	2.3	**3.6**	9.3

Western Cape	4.0	4.5	5.5	4.5	5.5	7.5	4.7	**6.0**	9.5
Total	25.9	30.7	57.1	29.7	38.2	76.6	33.2	**45.2**	97.6
Millions of nominal Rands									
Province	**2007/8**			**2008/9**			**2009/10**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	3.5	4.0	9.9	4.2	5.3	13.7	5.3	**7.3**	18.5
Free State	1.7	2.2	4.0	2.0	2.8	5.8	2.4	**3.6**	8.4
Gauteng	6.4	7.0	8.1	7.0	7.9	10.2	7.7	**8.8**	11.8
KwaZulu-Natal	3.7	4.5	8.4	4.8	6.4	13.3	6.2	**9.0**	19.1
Limpopo	2.8	3.3	7.5	3.5	4.6	10.1	3.9	**5.4**	13.5
Mpumalanga	1.7	2.2	5.9	2.0	2.8	7.8	2.4	**3.6**	10.0
North West	1.7	2.2	5.3	2.0	2.8	7.2	2.4	**3.6**	9.8
Northern Cape	1.7	2.2	5.0	2.3	3.4	8.0	2.7	**4.1**	10.8
Western Cape	4.2	4.7	5.8	4.9	6.0	8.2	5.5	**6.9**	11.0
Total	27.2	32.2	59.9	32.7	42.1	84.4	38.4	**52.3**	113.0

The variations across the provinces are almost entirely determined by population size. The differences between the scenarios are large compared to the other sections. This is because of the high degree of uncertainty associated with demand for outpatient services and community-based care and what form the latter will take.

5.3.4 Prevention

Prevention is difficult to cost as more could always be spent. As has been mentioned, the decision was taken to bring every province's spending into line with that of the well-resourced provinces as a starting point. This was, however, not as simple as it sounds and required a number of policy decisions.

There needs to be an adjustment for the size of the province, as it would be inappropriate simply to say that all provinces should spend the same. This could be achieved by allocating each province the same per capita spending. This, however, would fail to consider the differential distribution of the problem of substance abuse. Provinces with a greater problem should arguably get more for prevention. Further, there is no consideration of scale and of how it is not twice as expensive to double the size of a prevention campaign.

To account for these factors the following calculation was undertaken:

- A basic amount of R1 million was allocated to each province to account for economies of scale. This is a basic assumption as very little data on returns to scale are available.
- The total prevention spending for the best-resourced province, less the one million basic amount, was taken as a base.
- The base figure was divided by the population size in the best-resourced province and this per capita rate was used to generate a population-adjusted budget for each province. This was done by multiplying this ratio by the population of each province.
- The base figure was then divided by the number of people considered at risk in the best resourced province, using national survey data. This per capita at risk figure was then applied to the other eight provinces to generate a risk-adjusted budget for each province. This was done by multiplying the new ratio by an estimate from the same survey of the number of people at risk.

- The average of the above two was taken and added to the R1 million base. For the best resourced province this calculation results in the current budget. For all other provinces it involves an increase.

This calculation effectively takes all the considerations mentioned into account and, based on this, it was estimated that to bring all provinces' prevention efforts into line with the current best case would result in a cost of R30 million per year. Again, this would not be all new expenditure as all provinces are currently spending something.

It was felt by respondents that simply bringing all provinces in line might not be enough and that it might be necessary to expand efforts. Scenario one is based on bringing costs in line and maintaining their real value. Scenario two incorporates a 10% per annum real increase and scenario three a 20% real increase.

The prevention spending estimates across provinces are presented in the following table. The first half indicates real values and the second nominal.

Table 31: Prevention spending at the provincial level, by scenario

Millions of 2006 Rands									
Province	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	3.5	3.5	3.5	3.5	3.9	4.2	3.5	**4.2**	5.0
Free State	2.4	2.4	2.4	2.4	2.6	2.9	2.4	**2.9**	3.5
Gauteng	5.8	5.8	5.8	5.8	6.4	7.0	5.8	**7.0**	8.4
KwaZulu-Natal	5.0	5.0	5.0	5.0	5.5	6.0	5.0	**6.1**	7.2

Limpopo	2.7	2.7	2.7	2.7	3.0	3.2	2.7	**3.3**	3.9
Mpumalanga	2.3	2.3	2.3	2.3	2.5	2.8	2.3	**2.8**	3.3
North West	2.7	2.7	2.7	2.7	3.0	3.2	2.7	**3.3**	3.9
Northern Cape	1.6	1.6	1.6	1.6	1.8	1.9	1.6	**1.9**	2.3
Western Cape	4.0	4.0	4.0	4.0	4.4	4.8	4.0	**4.8**	5.8
Total	30.0	30.0	30.0	30.0	33.0	36.0	30.0	**36.3**	43.2
Millions of nominal Rands									
Province	**2007/8**			**2008/9**			**2009/10**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
Eastern Cape	3.7	3.7	3.7	3.9	4.2	4.6	4.1	**4.9**	5.8
Free State	2.5	2.5	2.5	2.6	2.9	3.2	2.8	**3.4**	4.0
Gauteng	6.1	6.1	6.1	6.4	7.0	7.7	6.7	**8.1**	9.7
KwaZulu-Natal	5.3	5.3	5.3	5.5	6.1	6.6	5.8	**7.0**	8.3
Limpopo	2.8	2.8	2.8	3.0	3.3	3.6	3.1	**3.8**	4.5
Mpumalanga	2.4	2.4	2.4	2.5	2.8	3.0	2.7	**3.2**	3.8
North West	2.8	2.8	2.8	3.0	3.3	3.6	3.1	**3.8**	4.5
Northern Cape	1.7	1.7	1.7	1.8	1.9	2.1	1.9	**2.2**	2.7
Western Cape	4.2	4.2	4.2	4.4	4.9	5.3	4.6	**5.6**	6.7
Total	31.5	31.5	31.5	33.1	36.4	39.7	34.7	**42.0**	50.0

Gauteng ends up with the largest budget as it is both large and has a high incidence of substance abuse. It may be argued that the method used was inappropriate and that all provinces should rather have the same per capita spending with no adjustment for level of risk. This would favour those provinces with lower recorded risk.

5.4 Other departments

The costs outlined above relate to structures and services that are likely to be largely run from within the Department of Social Development. There are, however, instances where some of these costs should be allocated to other departments. For example, the costs associated with other departments being represented on the CDA are allocated to them, similarly the costs of sending their staff for training. These allocations will not affect the total cost, which is the emphasis of this work, but rather their distribution.

There are also instances where there are structures specific to departments and the provincial structures necessary have already been mentioned. The following subsections discuss these issues with regard to key departments.

a) Health

The distribution of costs between the Departments of Social Development and Health is a complex issue and essentially a policy choice. There is a clear requirement that the Department of Health take on an accreditation and monitoring and evaluation role with regard to treatment facilities. The cost of the personnel and support for them have been included in the above estimates and amount to R3.5 million across the provinces or R390 000 per province. This is based on one dedicated staff member as a coordinator with administrative support and offices in each province. Arguably, smaller provinces would not need a dedicated member of staff, but respondents repeatedly noted the need for full-time staff for things to happen.

The more difficult area with regard to Health is the appropriate distribution of treatment costs. The Department of Health currently runs a number of detoxification facilities in hospitals around the country. It has been argued by some that, in addition to these, they should be responsible for at least detoxification facilities and medical services in treatment centres. It may, therefore, be appropriate to distribute some of the inpatient care costs estimated above to Health, but as mentioned this will not change the total and is essentially a policy decision. As an indication, however, it would involve an allocation of R1.65 million per annum if the Department of Health takes responsibility for the employment of any new nursing staff at treatment centres, which might be argued to be the absolute minimum role.

b) Education

The Department of Education has a role in terms of the implementation of programmes in schools. The training costs were estimated along with other training in the National Prevention section above. The Department would also require provincial support to facilitate and monitor the implementation of interventions. Following the same reasoning as described above, one person plus administrative support was budgeted for the department for each province - again at a cost of R3.5 million nationally or R390 000 per province.

c) Justice and Safety and Security

The Bill does impose some responsibilities on Justice and Safety and Security. These responsibilities are largely part of the existing Act and where there are differences they tend to be towards reduced involvement. The costs associated with these Departments are likely to be very small compared to the Bill as a whole. One possibility would be to distribute some of the resources from aftercare to follow-up of patients receiving treatment as a result of court decisions. Given the size of the costs and the fact that most will remain constant, the implications for this department were not considered further.

6. Summary of costing results

The above discussion details the results of the costing exercise. It is intended to show the importance of interpretation in determining the costs in the hope that this will inform discussion on the issues.

As a final summary, the costs by component are presented in the following table. The table clearly shows the domination of services in determining costs; in particular, the costs associated with treatment. Although the costs associated with prevention, when provincial and national costs are combined, are significant.

Inpatient treatment still represents the highest cost for a single component. Many of these costs are already being incurred. In real terms, in the region of R40 million of scenario three's inpatient costs are associated with expanded services, the balance of R68 million being a result of continuing existing state and subsidised services. If the outpatient and community-based care are successful, this R68 million could well be reduced by pushing subsidies towards community-based projects and away from inpatient care.

The primary cost drivers for the above process can be summarised as follows:

- Decisions relating to National Media Campaigns
- Bringing equity in access to inpatient treatment facilities
- Bringing equity in prevention spending
- Speed and scale of outpatient and community-based care rollout.

The views taken on the above cost drivers will be the main determinants of cost and dwarf the importance of other decisions and assumptions.

Table 32: Total costs by component, year and scenario

Millions of 2006 Rands									
Component	**Year 1**			**Year 2**			**Year 3**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
CDA	2.6	2.7	2.7	1.2	1.2	1.9	2.6	**2.6**	3.2
National administration	3.7	4.1	4.7	3.9	4.3	5.6	3.9	**4.3**	5.5
National prevention efforts	41.9	52.1	62.2	41.5	51.7	60.6	41.5	**51.7**	60.6
Provincial administration	8.9	15.0	16.2	14.8	17.3	22.4	17.3	**17.3**	22.2
Provincial substance abuse forum	2.8	3.1	3.2	2.8	3.0	3.1	2.8	**3.0**	3.1
LDACs	1.8	1.8	3.3	4.5	4.5	8.3	7.1	**7.1**	13.0
Treatment centres	152.5	152.5	152.5	143.0	143.0	143.0	107.5	**107.5**	107.5
Halfway houses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0

Aftercare	2.9	5.7	7.5	4.1	7.4	10.4	4.8	**8.2**	11.7
Prevention	30.0	30.0	30.0	30.0	33.0	36.0	30.0	**36.3**	43.2
Community based services and outpatient	25.9	30.7	57.1	29.7	38.2	76.6	33.2	**45.2**	97.6
Other department structures	7.2	7.2	7.4	7.0	7.0	7.0	7.0	**7.0**	7.0
Total cost	280.4	305.0	346.8	282.4	310.6	374.7	257.7	**290.2**	374.6
Millions of nominal Rands									
Component	**2007/8**			**2008/9**			**2009/10**		
	S1	**S2**	**S3**	**S1**	**S2**	**S3**	**S1**	**S2**	**S3**
CDA	2.7	2.8	2.8	1.3	1.3	2.0	3.0	**3.0**	3.7
National administration	3.9	4.3	4.9	4.3	4.8	6.2	4.5	**5.0**	6.3
National prevention	44.0	54.7	65.3	45.8	57.0	66.8	48.0	**59.8**	70.1

efforts									
Provincial administration	9.4	15.8	17.0	16.4	19.1	24.7	20.1	**20.0**	25.7
Provincial substance abuse forum	3.0	3.3	3.4	3.0	3.3	3.4	3.2	**3.5**	3.6
LDACs	1.9	1.9	3.5	5.0	5.0	9.1	8.2	**8.2**	15.1
Treatment centres	160.1	160.1	160.1	157.6	157.6	157.6	124.5	**124.5**	124.5
Halfway houses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0
Aftercare	3.1	6.0	7.9	4.5	8.2	11.4	5.5	**9.5**	13.6
Prevention	31.5	31.5	31.5	33.1	36.4	39.7	34.7	**42.0**	50.0
Community based services and out patient	27.2	32.2	59.9	32.7	42.1	84.4	38.4	**52.3**	113.0
Other department structures	7.6	7.6	7.7	7.7	7.7	7.7	8.1	**8.1**	8.1
Total cost	294.4	320.3	364.2	311.4	342.5	413.1	298.3	**335.9**	433.7

7. References

Bradshaw, D., Groenewald, P., Laubscher, R., Nannan, N., Nojilana, B., Norman, R. et al. (2003). *Initial estimates from the South African National Burden of Disease Study, 2000* (Rep. No. MRC Policy Brief No. 1). Tygerberg: Medical Research Council.

Department of Health (1998). *South African Demographic and Health Survey 1998* Pretoria: Department of Health.

Dewing, S., Pluddemann, A., Myers, B., & Parry, C. D. H. (2006). Review of injection drug use in six African countries: Egypt, Kenya, Mauritius, Nigeria, South Africa and Tanzania. *Drugs: Education, Prevention and Policy, 13,* 121-137.

Kalichman, S., Simbayi, L. C., Kagee, A., Toefy, Y., Jooste, S., Cain, D. et al. (2006). Associations of poverty, substance use, and HIV transmission risk behaviors in three South African communities. *Social Science and Medicine, 62,* 1641-1649.

King, G., Flisher, A. J., Noubary, F., Reece, L., Marais, A., & Lombard, C. (2004). Substance abuse and behavioral correlates of sexual assault among South African adolescents. *Child Abuse and Neglect, 28,* 683-696.

Leggett, T., Louw, A., & Parry, C. (2002). Implications for Drugs Policy. In T.Leggett (Ed.), *Drugs and Crime in South Africa: A Study in Three Cities* (ISS Monograph No. 69 ed., pp. 43-47). Pretoria: Institute for Security Studies.

Matzopoulos, R., Seedat, M., & Cassim, M. (2005). *A Profile of Fatal Injuries in South Africa: 6th Annual Report of the National Injury Motality Surveillance System 2004* Parow: Medical Research Council.

Morejele, N., Brook, J. S., & Kachieng'a, M. A. (2006). Perceptions of sexual risk and substance abuse among adolescents in South Africa: A qualitative investigation. *AIDS Care, 18,* 215-219.

Morojele, N., Kacheng'a, M., Mokoko, E., Nkoko, M. A., Parry, C., Nkowane, A. M. et al. (2006). Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science & Medicine, 62,* 217-227.

Morris, K. & Parry, C. (2006). South African methamphetamine boom could fule further HIV [Newsdesk]. *The Lancet Infectious Diseases, 6,* 471.

Murray, C. J. L. & Lopez, A. D. (1996). Quantifying the Burden of Disease Attributable to Ten Major Risk Factors. In C.J.L.Murray & A.D.Lopez (Eds.), *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020* (pp. 295-324). Cambridge: Harvard University Press.

Myers, B. & Parry, C. D. H. (2005). Access to substance abuse treatment services for black South Africans: Findings from audits of specialist treatment facilities in Cape Town and Gauteng. *South African Psychiatry Review, 8,* 15-19.

Myers, B., Parry, C. D. H., & Pluddermann, A. (2004). Indicators of substance abuse treatment demand in Cape Town, South Africa (1997-2001). *Curationis,* 27-31.

Myers, B., Siegfried, N., & Parry, C. (2003). Over-the-counter and perscription medicine misuse in Cape Town - Findings from specialist treatment centres. *South African Medical Journal, 93,* 367-370.

Nkowane, M. A., Rocha-Silva, L., Saxena, S., Mbatia, J., Ndubani, P., & Weir-Smith, G. (2004). Psychoactive substance use among young people: Findings of a multi-center study in three African countries. *Contemporary Drug Problems, 31,* 329-356.

Parry, C. (1998). *Substance Abuse in South Africa: Country Report Focusing on Young Persons* Tygerberg: Medical Research Council.

Parry, C., Myers, B., & Pluddemann, A. (2004). Drug policy for methamphetamine use urgently needed. *South African Medical Journal, 94,* 901-902.

Parry, C. & Pluddemann, A. (2002). *Southern African Development Community Epidemiology Network on Drug Use (SENDU): July - December 2002* Cape Town: MRC.

Parry, C. D. H., Bhana, A., Pluddermann, A., Myers, B., Siegfried, N., Morojele, N. et al. (2002). The South African Community Epidemiology Network on Drug Use (SACENDU): Description, findings (1997-99) and policy implications. *Addiction, 97,* 969-976.

Parry, C. D. H. & Dewing, S. (2006). A public health approach to addressing alcohol-related crime in South Africa. *African Journal of Drug & Alcohol Studies, 5,* 41-56.

Parry, C. D. H., Myers, B., & Thiede, M. (2003). The case for an increased tax on alcohol in South Africa. *The South African Journal of Economics, 71,* 265-281.

Parry, C. D. H. & Pluddemann, A. (2005). *Southern African Development Community Epidemiology Network on Drug Use (SENDU): January - June 2004* Cape Town, South Africa: Medical Research Council South Africa.

Parry, C. D. H., Plüddemann, A., & Myers, B. (2005). Heroin treatment demand in South Africa: trends from two large metropolitan sites (January 1997-December 2003). *Drug and Alcohol Review, 24,* 1-5.

Pluddemann, A., Parry, C., Bhana, A., Harker, N., Potgieter, H., Gerber, W. et al. (2005). Monitoring alcohol and drug abuse trends in South Africa (July 1996 - December 2004). *SACENDU Research Brief, 8,* 1-11.

Plüddemann, A., Parry, C., Cerf, P., Bhana, A., Harker, N., Potgieter, H. et al. (2006). Monitoring alcohol and drug abuse trends in South Africa (July 1996-December 2005). *SACENDU Research Brief, 9.*

Pluddermann, A., Parry, C. D. H., Donson, H., & Sukhai, A. (2004). Alcohol use and trauma in Cape Town, Durban and Port Elizabeth, South Africa: 1991-2001. *Injury Control and Safety Promotion, 11,* 265-267.

Reddy, S. P., Panday, S., Swart, D., Jinabhai, C. C., Amosun, S. L., James, S. et al. (2003). *Umthente Uhlaba Usamila - The 1st South African National Youth Risk Behaviour Survey 2002* Cape Town: South African Medical Research Council.

Rehm, J., Rehn, N., Room, R., Monteiro, M., Gmel, G., Jernigan, D. et al. (2003). The global distribution of average volume of alcohol consumption and patterns of drinking. *European Addiction Research, 9,* 147-156.

Shisana, O., Rehle, T., Simbayi, L. C., Parker, W., Zuma, K., Bhana, A. et al. (2005). *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005* Cape Town: HSRC Press.

Stats SA. (2003). Census 2001 web page. Web address: http://www.statssa.gov.za/census01/html/default.asp Date accessed: 12 November 2006.

Taylor, M., Dlamini, S. B., Kagoro, H., Jinabhai, C. C., & de Vries, H. (2003). Understanding high school students' risk behaviour to help reduce the HIV/AIDS epidemic in KwaZulu-Natal, South Africa. *Journal of School Health, 73,* 97-100.

Uchtenhagen, A. (2004). Editorial: Substance use problems in developing countries. *Bulletin of the World Health Organisation, 82,* 641-642.

United Nation Office on Drugs and Crime (2006). *World drug report* Vienna: United Nations Office on Drugs and Crime.

United Nations (2004). *World Youth Report 2003* New York: United Nations.

United Nations (2005). *World Youth Report 2005: Young People Today, and in 2015* New York: United Nations.

Viljoen, D., Graig, P., Hymbaugh, K., Boyle, C., & Blount, S. (2003). Fetal alcohol syndrome - South Africa, 2001. *MMWR Weekly, 52,* 660-662.

Wechsberg, W. M., Luseno, W., Lam, W. K. K., Parry, C. D. H., & Morojele, N. K. (2006). Substance use, sexual risk and violence: HIV prevention intervention with sex workers in Pretoria. *AIDS and Behavior, 10,* 131-137.

World Health Organisation (2002). *World Health Report 2002: Reducing Risks, Promoting Healthy Life* Geneva: World Health Organisation.

Yach, D. & Bettcher, D. (2000). Globalisation of tobacco industry influence and new global responses. *Tobacco Control, 9,* 206-216.

APPENDIX 1:

LEGAL REVIEW

A) Methodology of Analysis

The approach to the legal review of the Prevention and Treatment of Substance Abuse Bill adopted the methodology of analysis and synthesis. In reviewing it, various other pieces of legislation were considered, for example and principally,

- the Prevention and Treatment of Drug Dependency Act 20 of 1992,
- the Child Care Act 74 of 1983 / Children's Act 38 of 2005,
- the Criminal Procedure Act 51 of 1977, and
- the Republic of South Africa Constitution Act, 1996.

The Bill was analysed in terms of its individual sections and then compared its provisions with the other relevant legislation. Finally, any legal obligations flowing from these provisions were extracted. Overall, the provisions of the Bill had to be considered in light of the Constitution.

Step #1

The initial step was to create a comparative table of the proposed Prevention and Treatment of Substance Abuse Bill (Second Draft) ('the Bill') and the Prevention and Treatment of Drug Dependency Act 20 of 1992 as amended by Act 14 of 1999 ('the Act').

This entailed considering all the various provisions in each of the respective Bill and Act and finding the correlation between sections/provisions in the two documents, those that were not retained in the Bill or those that were entirely new.

The result was that a number of provisions were present in both the Act and the Bill. However, a number of provisions of the Act did not appear in the Bill. Furthermore, the

Bill contains new provisions that did not appear in the Act. These distinctions can be gleaned from the document titled 'Comparative Table 1- Obligations.' The end result was a table that neatly outlined the differences between the above two pieces of legislation. This meant that the determination of the legal obligations that arise from the Bill could be done on a comparative basis.

Step #2

Having created a working table, we moved on to dealing with the various other pieces of legislation that impacted on both the Bill and the Act. The effects of these other pieces of legislation were included in the comparative table ('Comparative Table 1-Obligations') under the relevant sections of both the Bill and the Act.

Step #3

From the initial comparative table that we formulated, a second document was created. This document, entitled 'Sections of the 1992 Act that do not appear in the Bill', encapsulated exactly that information. It contains all the sections from the Act that no longer appear in the Bill.

The result was that the comparative table ('Comparative Table 1-Obligations') merely reflected the provisions of the Bill that already existed in the Act, and any new provisions that were created in the Bill.

Step #4

A third document was then drafted, entitled 'Obligations and Comments.' This contains the legal obligations that arise out of the applicable sections of the Bill only, together with detailed commentary on those obligations. The sections in the Bill that already existed in the Act merely required an examination of the legal obligations that were already in place.

As regards the new provisions that were inserted in the Bill, careful analysis was done in terms of the wording of its provisions. Using the comparative table that was initially created, it was possible to extract changes in the wording of the provisions of the Act and the Bill, and how they impacted on the obligations created by the Bill. The task further involved subjective interpretation of each of the various sections, and by a process of synthesis with parallel legislation, for example, the Constitution, comments were proffered on the impact of the Bill and the obligations created thereunder. Lastly, any areas and issues about which we were uncertain, and which required further clarification, were identified in the analysis.

B) Obligations and Comments

i) Preamble (See Page 2 of Comparative table 1)

Provides for the overarching obligations of the state, in the context of the Constitution in implementing the Bill. The focus is on the rights to dignity, equality and in particular, the prohibition against unfair discrimination.

New or Existing Mandate: New

This is an entirely new provision created. A Preamble Section does not exist in the 1992 Act.

Comments: This is particularly relevant, in the light of several provisions which make reference to the right of substance abusers not to be denied access to services.

---

ii) Section 1. Definitions (See Page 3 of Comparative table 1)

Introduces a number of new categories of persons/service providers, not referenced in the 1992 Act, such as addiction counselors community-based treatment services, social auxiliary workers, substance abuse specialists. The state will be obliged to provide for the identification, training, accreditation and registration of these various categories.

New or Existing Mandate: New/ Existing

The definition section exists in the 1992 Act; however there have been many new definitions added and simultaneously, many of the definitions of the 1992 Act no longer exist in the Bill. These changes are reflected below.

Comments: Amendments to several other definitions are largely to introduce more acceptable terminology, rather than changes of substance.

---

iii) Definition of "addiction counsellor" (See Page 3 of Comparative table 1)

The obligation created by the insertion of such a definition is that only an accredited counselor who has demonstrated proficiency in core addiction counseling competencies and has been duly accredited and registered by registration bodies can be appointed. Therefore there is an obligation on the state to ensure that the individuals appointed as addiction counsellors meet the above requirements.

New or Existing Mandate: New

The inclusion of the definition of 'addiction counselor' is entirely new.

---

iv) Definition of 'after-care' (See Page 3 of Comparative table 1)

This definition creates an obligation to offer ongoing support to a person who has received treatment for substance abuse, to enable him or her to maintain sobriety or abstinence, personal growth and enhance self reliance and optimal social functioning.

New or Existing Mandate: New

This definition is entirely new.

---

v) Definition of "Central Drug Authority" (See Page 3 of Comparative table 1)

There is an obligation on the State to establish a "Central Drug Authority". Details on this obligation are contained in Section 63 of the Bill. (See page 92 of the Comparative table 1)

New or Existing Mandate: Existing

This definition exists in both the definition section of the Bill and the 1992 Act.

---

vi) Definition of "community based treatment services" (See Page 3 of Comparative table 1)

This definition creates an obligation to deliver treatment interventions to persons affected by substance abuse, while such persons remain within their family and community.

New or Existing Mandate: New

This definition is entirely new.

---

vii) Definition of "halfway house" (See Page 4 of Comparative table 1)

This creates an obligation to create a halfway house in terms of Section 25 and 26. This obligation is discussed on page 14 of this document.

New or Existing Mandate: New/Existing

The definition of Halfway house is new but relates to an existing mandate. The equivalent provision in the 1992 Act is that of 'hostel'.

---

viii) Definition of "in-patient service" (See Page 4 of Comparative table 1)

This definition creates the obligation to have an **"in-patient service":** a twenty four hour treatment service provided in a facility, which also provides overnight accommodation, to persons affected by substance abuse, who attend the facility.

New or Existing Mandate: New

This definition is entirely new. It does not exist in the definitions section of the 1992 Act.

---

ix) Definition of 'management structure' (See Page 4 of Comparative table 1)

This creates an obligation on the management of halfway houses and treatment centres to manage in accordance to Section 34 of the Bill and Section 13 of the 1992 Act respectively. These obligations are set out under obligation number 41 on page 18 of this document.

New or Existing Mandate: Existing

This definition is contained in both the definition sections of the Bill and the 1992 Act.

---

x) Definition of "multi disciplinary team'' (See Page 5 of Comparative table 1)

The obligation here is to set up a multi disciplinary team consisting of a social worker, professional nurse and in case of children, child and youth care worker and any other professional deemed necessary by the treatment programme.

New or Existing Mandate: New

This definition is entirely new.

---

xi) Definition of "out-patient service" (See Page 5 of Comparative table 1)

The obligation here is on the State to create "out-patient service**"** where a service is provided to persons affected by substance abuse, and is managed for the purpose of providing a holistic treatment service and excludes overnight accommodation

New or Existing Mandate: New

This definition is entirely new.

---

xii) Definition of "substance abuse specialist" (See Page 7 of Comparative table 1)

Obligation here is on State to procure services of "substance abuse specialist**"** who is a social worker who has undergone specific training on substance abuse and accredited accordingly by the recognised body.

New or Existing Mandate: New

This definition is entirely new. It does not exist in the definitions section of the 1992 Act.

CHAPTER 1

OBJECTS, IMPLEMENTATION, APPLICATION AND GENERAL PRINCIPLES

1. Obligation 1

Section 2: Objects of the Act (See page 8 of Comparative table 1)

Spells out the intent behind this legislation. There is an Obligation to devise:

- Co-ordination strategy against substance abuse
- Effective service delivery
- Monitoring and Evaluation of programmes and best practises according to prescribed minimum norms and standards.
- Regulation of establishment of treatment centre
- Research and information management
- Establishment of CDA to oversee NDMP

New or Existing Mandate: New

This is a new inclusion in the Bill.

Comments:

It is not clear what 'non-statutory' services refer to.

---

2. Obligation 2

Section 3: Implementation of the Act (See Page 9 of Comparative table 1)

The section obliges all organs of state, which render services to substance abusers (at national, provincial and local levels) to do so in an integrated, co-ordinated and uniform manner. But these obligations are to be met through progressive realisation, not all at once, in view of available resources and competing socio-economic needs.

New or Existing Mandate: New

This section is entirely new.

Comments:

The Bill makes use of the terms 'may' and 'must' in several provisions. These terms are not used interchangeably, but have distinctive meanings attached to them. The use of 'may' indicates that there is a discretion on the relevant authority whether or not to discharge the obligation in question. Once the discretion is exercised in favour of providing the service or discharging the obligation, the peremptory provisions come into play. The use of 'must' indicates that it is compulsory on the authority to meet the obligation, which must not be departed from.

To the extent that the Bill imposes positive obligations on the state, they have to be effected within the parameters of the Constitution, namely:

- Progressive realisation and,
- Within available resources.

A discussion of these parameters follows.

The meaning of these qualifications (contained in the relevant sections dealing with the rights to housing and health, respectively) was interpreted by the Constitutional Court in *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) to mean that the right itself was limited by reason of the lack of resources. Thus, 'an unqualified obligation to meet these needs would not presently be capable of being fulfilled.'

It suggests that the positive obligations on the state are realized or fulfilled through state action 'progressively' or over a period of time. This does not absolve the state from taking those steps that are within its power immediately, and other steps as soon as possible. The state has to demonstrate that it is making progress towards the full realisation of the rights. Such an approach was adopted in *Government of the Republic of South Africa v Grootboom & others* 2001 (1) SA 46 (CC).

Furthermore, the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1997) maintains that while the state has a margin of discretion in determining which measures it will implement and how it will utilise its resources, it must show that it is exercising its discretion rationally and in good faith.

The rights are further limited by the qualification that their availability is subject to the extent that state resources permit. In the absence of available state resources, the failure of the state to address the realization of the rights will not constitute a violation of the rights. Should resources become available, it will be difficult for the state to justify its failure to devote the resources to the fulfilment of the rights. As more resources become available, more must be done to fulfil the rights

---

3. <u>Obligation 3</u>

Section 4: Application of Act (See Page 9 of Comparative Table 1)

Rights in Act supplement Bill of Rights.

Organs of State and officials must respect, protect and promote rights of abusers

New or Existing Mandate: New

This section is entirely new.

---

4. Obligation 4

Section 5: General principles (See Page 10 of Comparative table 1)

Two important sources of obligation emerge under this section:

- In implementing the Bill as well as in proceedings and decisions affecting a substance abuser, both the abuser and a person affected by the abuse **must** be protected from unfair discrimination on any ground.
- The proceedings **must** adopt alternative dispute resolution approaches, such as conciliation and mediation, rather than confrontational, adversarial approaches.

New or Existing Mandate: New

This section is entirely new. It does not exist in the 1992 Act

Comments:

Persons referred to in the Bill must be protected from unfair discrimination. While the right to equality does not prevent the government from classifying people and treating them differently for a variety of legitimate reasons, this must be distinguished from constitutionally impermissible differentiation. These are the listed grounds of unfair discrimination contained in section 9(3) such as race, gender, sex, pregnancy, marital

status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

What makes discrimination unfair is the impact of the discrimination on its victims. It means treating people differently in a way which impairs their fundamental dignity as human beings, who are inherently equal in dignity.

Consequently, substance abusers and other affected persons cannot be discriminated against on any of the listed grounds or analogous grounds (based on attributes or characteristics which have the potential to impair the fundamental dignity of persons as human beings).

The section also enjoins the authorities to adopt alternate dispute resolution measures in matters concerning substance abusers and other affected persons. This should be interpreted to require conciliation and mediation as the first steps, and the use of adversarial, confrontational approaches such as litigation, arrest, detention and other criminal sanctions as measures of last resort.

While such an approach is without doubt preferable, it appears to have been abandoned further along in the Bill e.g. ss 41(which makes provision for emergency detention orders) or 56 (relating to the arrest of an absconding service user).

CHAPTER 2

CREATING AN ENABLING AND SUPPORTIVE ENVIRONMENT FOR SUBSTANCE ABUSERS AND PERSONS AFFECTED BY SUBSTANCE ABUSE

5. Obligation 5

Section 6: Minimum norms and standards (See Page 12 of Comparative table 1)

The Minister **may** prescribe the minimum norms and standards defining acceptable levels of service provision, and for their monitoring and evaluation.

New or Existing Mandate: New

This section is entirely new.

---

6. Obligation 6

Section 7: Rights of abusers and persons affected (See Page 12 of Comparative table 1)

(7) (1) There is a general obligation that abusers and persons affected are not to be unfairly denied access to existing public care, treatment, rehabilitation and re-integration services, and children are afforded special protection.

(7) (2) Children are offered special protection

New or Existing Mandate: New

This section is entirely new.

Comments:

Children enjoy special protection under the Bill. This requires special protections, as well as the need for separate facilities, specialist assessments of their needs, individualized treatment plans, and provision for educational, vocational and guidance programmes.

The realisation of the rights available to children are not subject to the qualifications of progressive realisation and available resources, but must be actualised immediately (Sec 28 of Constitution).

---

7. Obligation 7

Section 8: Support for service delivered by third parties (See Page 14 of Comparative table 1)

The Minister **may** provide financial awards from the fiscus, to third-party service providers, on the basis of prioritisation of needs, by entering into contracts with them.

The Minister **must** prescribe the conditions under which this will happen.

The Minister **must** open and maintain a register of all assets bought with Government funds and prescribe conditions for the management of such assets.

New or Existing Mandate: New

This section is entirely new.

Comments:

While this section is not mandatory, once the relevant needs have been prioritised and a service provider identified, an obligation will arise to fund.

The term ‘financial awards’ is somewhat imprecise, and suggests that the quantum of the award will be subject to negotiation between the state and the service provider, at the time the contract is negotiated.

The Minister has to maintain a centralized asset register of all assets purchased with state funds, and prescribe the conditions for the management of assets, which may include repairs, upgrading, maintenance and write-offs.

---

8. Obligation 8

Section 9: Guiding principles for service provision(See Page 15 of Comparative table 1)

The environment in which services are provided **must** be sensitive to the social, cultural, economic, physical challenges, age and gender of abusers and persons affected

New or Existing Mandate: New

This section is entirely new. It does not exist in the 1992 Act.

Comments:

This requirement necessitates widespread education, participation and consultation with affected groups.

CHAPTER 3

MANAGEMENT OF SUBSTANCE ABUSE

9. Obligation 9

Section 10: Programmes for the management of substance abuse (See Page 16 of Comparative table 1)

The Minister **must** develop programmes for the holistic management of substance abuse, to be funded by the fiscus; located in designated areas; and including public and private facilities.

There is an obligation to provide the following programs:

10 (2) (a)(i) services that facilitates the prevention of drug use and must involve information, education and communication about the risks associated with the use of substances and how to avoid the use of drugs;

(ii) proactive measures that must target individuals before the onset of use, which may lead to abuse and to prevent persons from moving into the other levels of addiction, including statutory services; and

(iii) prevention measures which must target individuals, families and communities and to create awareness of risks of substance use and abuse, so as to identify problems at an early stage and be addressed

- early intervention

- treatment

- aftercare and reintegration

This includes departmental collaboration as well as the training, accreditation of persons involved in the programmes.

New or Existing Mandate: New

This section is entirely new.

Comments:

It is unclear where programmes will be located or how the Minister will determine this. The tenor of the Bill (and national needs) seem to suggest the priority will be disadvantaged areas and vulnerable groups.

The term ‘statutory services’ is not defined, but would refer to the various provisions and services envisaged under the Bill/Act, and includes committal to statutorily-established treatment centres, rehabilitation centres, as well as utilization of programmes available as a consequence of the Bill/Act.

Community policing forums are partnerships between communities and the South African Police Services about prevention, monitoring crime in general, and dealing with the consequences of crime. There is no specific reference to substance abuse, although it would be covered in general terms.

CHAPTER 4

PREVENTION SERVICES

10. Obligation 10

Section 11: Prevention programmes(See Page 19 of Comparative table 1)

The Minister **may** establish prevention programmes (with special emphasis on disadvantaged areas and vulnerable groups)

New or Existing Mandate: Existing

This section exists in the 1992 Act as Section 6.

Comments:

On the face of it, the Bill appears to offer less than section 6(e) of the 1992 Act does, in relation to 'the rendering of assistance to the families of persons detained in a treatment centre'

---

11. Obligation 11

Section 12: Accreditation and compliance with minimum norms and standards (See Page 20 of Comparative table 1)

This section contains an obligation on management to ensure that the prevention programs they manage comply with the minimum standards and norms.

New or Existing Mandate: New

This section is entirely new.

---

12. Obligation 12

Section 12(2): (See Page 20 of Comparative table 1)

Here there is an obligation on the minister to prescribe:

a) minimum norms and standards for prevention programmes to standardize services and for the
b) purposes of ensuring quality and for monitoring and evaluation;
c) conditions and procedures for the accreditation and the withdrawal or termination of accreditation of such programmes

New or Existing Mandate: New

This section is entirely new.

---

13. Obligation 13.

Section 13: Monitoring and evaluation (See Page 20 of Comparative table 1)

This section is an obligation on the Department to monitor prevention programmes within the framework of approved for prevention of substance abuse.

New or Existing Mandate: New

This section is entirely new.

CHAPTER 5

COMMUNITY BASED SERVICES

14. Obligation 14

Section 15: Establishment and development of community-based services (See Page 22 of Comparative table 1)

The Minister **may** establish community-based services in all communities of the RSA and **must** prescribe the minimum norms and standards for such services, including how service providers may be supported financially or otherwise.

Clear financial obligations are envisaged, including programme budgets, staff salaries, as well as the costs of administering new structures such as management committees.

New or Existing Mandate: **New**

This section is entirely new.

Comments:

Theoretically, such community-based services will provide the full suite of services envisaged under the Bill, and this represents a significant departure in the service provision model, with concomitant budgetary, monitoring and quality implications.

Community-based programmes include prevention, early intervention and community-based treatment programmes (treatment, aftercare and re-integration).

Interdepartmental co-operation would involve at least the following departments:

- Finance, which allocates the budget for the DOSD, including the substance abuse programme.
- Health, which will be drawn in on the treatment of various health-related matters arising from the substance abuse strategy.
- Justice, requiring the intervention of additional litigation or access to the criminal justice system.
- Police, which may be drawn into additional investigations etc (although, to some extent, this function is currently being served).
- Public Works, for the development, maintenance of buildings and other infrastructure.

Section 15(4): Financial support will depend on the scale of the services established within the community-based setting, and may vary from prevention-only programmes, to the full suite (prevention, early intervention, treatment, including provisions for drugs, administration, salaries etc)

---

15. Obligation 15

Section 18: Staff in Community Based Services. (See Page 24 of Comparative table 1)

This section is an obligation on management of Community based facilities to ensure that the multi-disciplinary team are registered accordingly.

There is a further obligation on the multi-disciplinary team to provide treatment services in community based setting

New or Existing Mandate: New

This section is entirely new.

Comment:

The section refers to ‘multi-disciplinary team rendering services’. Registration will be required of professional staff only, even if employed by CBO/NGO, not ‘lay’ staff.

---

16. Obligation 16

Section 19: Management structure of community based Services (See Page 24 of Comparative table 1)

A management structure must be established for each community based service according to prescribed minimum norms and standards.

New or Existing Mandate: New

This section is entirely new.

Comment:

The system of performance evaluation for management is not spelt out. Presumably, this will be a standard public service review/evaluation process.

---

17. Obligation 17

Section 20: Monitoring and Evaluation (See Page 26 of Comparative table 1)

This section is an obligation on the Department to monitor programmes within the framework of minimum norms and standards

New or Existing Mandate: New

This section is entirely new.

CHAPTER 6

CENTRE BASED AND OUTPATIENT SERVICES

18.Obligation 18

Section 22: Establishment/abolishment of a public treatment centre (See Page 27 of Comparative table 1)

The Minister **may** establish, manage and maintain treatment centres for the purpose of providing services. It includes centres currently in existence

The Minister may abolish treatment centres

New or Existing Mandate: Existing

This section already exists in the 1992 Act as section 7.

Comment:

Sections 22, 24,25,26, 31 may be compared as they all deal with the establishment or registration of the various facilities instituted under the Bill.

19.Obligation 19

Section 24: Registration and abolishment of a private treatment centre (See Page 28 of Comparative table 1)

Private treatment centres may be registered, on application to the Minister, and provided they comply with all necessary requirements. Includes centres currently in existence.

New or Existing Mandate: New and Existing

Most of this section correlates with section 9 of the 1992 Act.

Sections 24(1) to (3) of Bill equals Sections 9(1) to (3) of 1992 Act

Section 24(4) and (5) of the Bill is similar to Section 9(4) of the 1992 Act; the difference being the time periods. In the bill the time period has been reduced from 18 months (in 1992 Act) to 12 months for conditional registration.

Section 24(6) = Section 9(5)

Sections 24(7) to (10) are all new inclusions in the Bill, these sections do not exist in the 1992 Act.

Section 24(11) = 9(6)

Section 24 (12) = 9(7)

Section 24 (13) (a) and (b) = 9(8)(a) and (b)

Section 24(14) = 9(9)

Section 24(15) is a new inclusion in the Bill authorising the Minister to abolish treatment centres if he deems it fit.

Section 24 (16) = 9(10)

---

20. Obligation 20

Section 25: Establishment of a halfway house (See Page 32 of Comparative table 1)

25 (1) The Minister **may** establish, manage and maintain a halfway house for service users for periods not exceeding 12 months. This includes halfway houses currently in existence.

They must comply with Minimum norms and standards.

Caters for substance users discharged from treatment centre, committal from court order (43) or after conviction (44), voluntary (40), involuntary (41) – for a period of 6 months

25 (3) a-d Management must submit programmes for relapse prevention, community outreach programmes, education programme for children, youth and families, skills development programmes for substance abusers and re-integration into society

New or Existing Mandate: **New and Existing**

Most of this Section correlates with Section 10 of the 1992 Act.

Section 25 (1) (a) to (e) of the Bill is equivalent to Section 10 (10 (a) to 9e) of the 1992 Act

Sections 25(2) and (3) of the Bill are new inclusions. They do not exist in the 1992 Act.

Section 25(4) is equivalent to 10(2)

---

21. Obligation 21

Section 26: Registration of a private halfway house (See Page 34 of Comparative table 1)

Private halfway houses may be registered, on application to the Minister, and provided they comply with all the necessary requirements. Includes halfway houses currently in existence.

New or Existing Mandate: New and Existing

Most of this section correlates with Section 11 of the 1992 Act

Section 26 (1) of the Bill =Section 11(1) of the 1992 Act

26(2) =11(2)

26(3) and (4) of the bill are new inclusions.

26(5) and (6) = 11(3)

26(7) =11(4)

Section 26(8) is a new inclusion in the Bill.

26(9) (a) and (b) =11(5) (a) and (b)

26(10) =11(6)

26(11) =11(7)

Sections 26(12) and (13) of the Bill are new inclusions

22.Obligation 22

Section 27: Compliance with conditions for registration of a private treatment centre and a private halfway house (See Page 37 of Comparative table 1)

Obligation on operator of a registered private treatment centre to report to Minister any circumstances which may result in his or her inability to comply fully with any condition contemplated in section 24(4) and 26(3)

In deciding to close down a treatment centre, there is an obligation on the facility manger to consult with the Minister; to furnish minister with a full report on the accommodation of substance abusers and to hand over all assets bought with government funds.

New or Existing Mandate: New

This section is entirely new.

---

23. Obligation 23

Section 28: Monitoring and assessment of treatment centres and halfway house (See Page 38 of Comparative table 1)

28 (1) Monitoring and assessment team (social worker, nurse and others) to evaluate compliance with prescribed quality requirements and minimum norms and standards (treatment centres and halfway houses)

28 (6) composition and duties of assessment team will be as prescribed.

New or Existing Mandate: New and Existing

Most of this Section correlates with Section 12 of the 1992 Act.

28(1) (a) to (e) = 12 (1)

28(2) = 12(2)

Sections 28(3) and (4) are new inclusions

28(5) =12(3)

28(6) is new

---

24. Obligation 24

Section 29: Staff of treatment centre and halfway house(See Page 40 of Comparative table 1)

29 (1) Head must be registered professional in social sciences or medical field with experience in the substance abuse field

29 (3) appoint a multi-disciplinary team – composition, powers and duties as prescribed.

29 (6) Minister appoint professionals in public sector, prescribe their powers, duties and minimum qualifications

29 (7) Professional workers must in addition to qualifications undergo specialized training as prescribed

Minister **must** appoint specialised professional workers in the public sector to ensure quality service delivery. State has obligation to recruit, train and remunerate staff of these facilities

New or Existing Mandate: New and Existing

Most of this Section is new

Section 29(1) = 13(1)

29 (2) and (3) = 13(2)

Sections 29 (4) to (7) are new inclusions

---

25. Obligation 25

Section 30: Death of a Service User (See Page 42 of Comparative table 1)

Here there is an obligation on the facility manger to report the death of a service user to the Minister.

There is a further obligation on a police official to investigate the death.

30 (1) Report death to police and DG

30 (3) Failure to comply offence

30 (4) Police conduct investigation and inform DG

New or Existing Mandate: New

This section is entirely new.

Comments:

Generally will follow usual police proceedings for natural/unnatural death. If upon investigation, found to be an unnatural death, police may open docket for murder or culpable homicide.

Also obligation on facility manager or staff to co-operate with the police investigation.

---

26. Obligation 26

Section 31: Establishment of Outpatient services (See Page 42 of Comparative table 1)

31(1) Here the Minister may exercise his authority to establish treatment centres and prescribe minimum standards and norms. The Minister **may** establish outpatient services in all communities in the RSA for the provision of services.

31 (2) Minister may establish prevention programmes, early intervention programmes (including diversion for adults and youth), holistic treatment

New or Existing Mandate: New

This section is an entirely new inclusion in the Bill.

Comment:

The state is obliged to financially support treatment centres, halfway houses and outpatient services established or registered under these sections (as the case may be).

In turn, managers of such facilities are accountable to the Minister for full compliance with the conditions of their establishment or registration.

---

27. Obligation 27

Section 32: Admission to outpatient services (See Page 43 of Comparative table 1)

32 (1) No person must be discriminated against in accessing treatment.

32 (3) Apply for admission in the prescribed manner

32 (4) Application must be accompanied by social worker report and any medical or psychiatric report

New or Existing Mandate: New

This Section is entirely new**.**

Comment:

Refer to comment under section 5.

---

28. Obligation 28

Section 33: Conditions of service for volunteers (See Page 44 of Comparative table 1)

33 DG **may** appoint volunteers to assist with programmes and **may** prescribe conditions:

a) powers, functions, minimum qualifications

b) remuneration and compensation for expenses

c) registration and termination

Conditions include remuneration and compensation for expenses.

State obliged to finance this provision.

New or Existing Mandate: New and Existing

This Section in the Bill correlates with Section 14 of the 1992 Act but most o f the Sections dealing with volunteers in the 1992 Act have been scrapped.

33(a) to (d) = 14 (1) and (2)

Sections 14(3) and (4); 15; 16; 17;18; 19 and 20 (all of which deal with volunteers) no longer appear in the Bill.

Comments:

Liability for patrimonial loss arising from performance of service by volunteers (section 20 of Act) not re-enacted in Bill.

However, this will not absolve the State from such liability of the act or negligence of that of an accredited volunteer

---

29. Obligation 29

Section 34: Management structures of treatment centres and halfway house (See Page 45 of Comparative table 1)

The Minister **must** prescribe the composition, election, appointment, meetings of a management structure

34 (3) Management structure **must** ensure the facility:

a) provides a quality service,

b) training for staff

c) financial management system and reporting

d) monitors activities and deals with abuse of patients

e) complaints reporting system

New or Existing Mandate: New

These provisions are entirely new.

Comment:

State is obliged to establish and fund the operation of these structures.

The state will be obliged to fund all those functions which are intrinsic to the functioning of these structures

---

CHAPTER 7

AFETR CARE AND REINTERGRATION SERVICES

30.Obligation 30

Section 35: Establishment of programmes for after care and re-integration services (See Page 47 of Comparative table 1)

Minister **may** establish reintegration programmes in all areas of RSA; **must** prescribe minimum norms and standards.

Director-General **must** monitor re-integration programmes within norms and standards.

State obliged to finance this provision.

New or Existing Mandate: New

This section is entirely new

31.Obligation 31

Section 36: Compliance with minimum norms and standards (See Page 48 of Comparative table 1)

Obligation to manage a re-integration programme only if it complies with the minimum norms and standards

Minister is further obliged to prescribe minimum norms and standard for monitoring and evaluation

New or Existing Mandate: New

This section is entirely new

---

32. Obligation 32

Section 37: Monitoring and Evaluation (See Page 48 of Comparative table 1)

The Director-General must in the prescribed manner and on an ongoing basis monitor reintegration programmes within the framework of approved minimum norms and standards

New or Existing Mandate: New

This section is an entirely new inclusion

---

33. Obligation 33

Section 39: Support Groups (See Page 49 of Comparative table 1)

Envisages two types of structures:

a) organised after care structure for professional support services and skills development

or

b) established by service users and includes persons affected by substance abuse.

Purpose is to provide safe, less structured group experience to enable re-socialisation of recovered addicts who can serve as role models.

New or Existing Mandate: New

This section is new.

Comments:

Difference appears to be that point a) above will be:

- more informal
- professionals
- also includes skill development

whereas point b) above is informal, consisting of laypersons and primarily addresses socialisation issues.

CHAPTER 8

ADMISSION, TRANSFER AND REFERRAL PROCEDURE TO TREATMENT CENTRES

34. Obligation 34

Section 40: Admission of voluntary service user to treatment centre (See Page 50 of Comparative table 1)

Person submitting voluntarily to public or private centre entitled to appropriate treatment, unless disqualified for some reason. Facility manager obliged to admit.

New or Existing Mandate: New

This section is new.

Comments:

No provision equivalent to section 32(1) (admission to outpatient services) prohibiting unfair discrimination on any ground, but covered in terms of overarching provisions.

---

35. Obligation 35

Section 41: Admission of involuntary service user to treatment centre (See Page 52 of Comparative table 1)

Obligation on social worker, community leader or close associate of service user to make sworn declaration in writing to police or prosecutor, making averments.

Clerk of court to issues summons for user to appear before magistrate.

Police or prosecutor to facilitate issue of emergency detention order.

Magistrate may, on application, issue a warrant for arrest.

New or Existing Mandate: **New and Existing**

This Section in the Bill correlates with Section 21 of the 1992 Act.

Section 41(1) (a) to (f) and 41(2) = 21(1)

Section 41 (3) and (4) are new inclusions

Section 41(5) = 21(2)

Section 41(6) = 21(3)

Comments:

This section provides for the committal of a person upon the submission of a service statement by social worker etc. to the effect that the abuser has lost control of his life.

Provisions regarding arrest and detention appear to violate due process rights.

Compare provisions of section 60 (dealing with absconders).

Subsection (3) is problematic because it is poorly drafted, and does not amplify what is meant by the term ‘facilitate’.

As it is envisaged that the detention will take place ‘pending the outcome of the investigation’, it suggests a police officer or prosecutor will have the power to order detention, a function normally reserved for judicial officers (judges, magistrates).

The requirement of judicial oversight is fundamental to protection against the infringement of the liberty of citizens, and the subsection appears to bypass this.

Despite the requirement in section 5 to utilise conciliation, the Bill is conspicuously silent on the need to counsel an abuser, prior to resorting to drastic action such as arrest.

---

36. Obligation 36

Section 42: Admission and transfer of children (See Page 54 of Comparative table 1)

Minister **must** prescribe procedure and criteria for admitting and transferring children to public and private treatment centres

New or Existing Mandate: New

This section is new.

Comment:

The consideration spelt out under section 7(2) regarding special protection for children will come into play here.

---

37. Obligation 37

Section 43: Committal to treatment centre after enquiry / conviction (See Page 55 of Comparative table 1)

Magistrate before whom an involuntary user is brought **must** enquire whether s/he is dependent on drugs; evidence heard; and user entitled to legal representation.

Court convicting for any offence may commit to treatment centre in lieu of sentence.

Obligation on the state to provide legal aid for indigent persons, where substantial injustice may result.

Minister may contribute maintenance of any person detained in a public or private treatment centre etc. *NOT* maintained by the State.

New or Existing Mandate: New and Existing

This section correlates largely with section 22 of the 1992 Act, with only section 43 (10) in the Bill being the new inclusion.

Comments:

It is unclear what a 'public centre not maintained by the State' means.

---

38. Obligation 38

Section 47: Postponement of order (See Page 61 of Comparative table 1)

Magistrate may postpone making of an order for up to 3 years.

Director-General may at any time unconditionally discharge any such person.

New or Existing Mandate: Existing

This Section correlates with Section 23 of the 1992 Act. The section exists entirely in the1992 Act.

Comments:

Appears to constitute undue interference with judicial authority.

---

39. Obligation 39

Section 48: Temporary custody of person pending enquiry (See Page 63 of Comparative table 1)

Minister **may** contribute towards maintenance of person so detained in public, private centre, halfway house, children's home or any other place not maintained by state.

New or Existing Mandate: Existing

This Section correlates with Section 24 of the 1992 Act

48(1) and (2) = 24(1) (a)

48 (3) = 24(1) (b)

48(4) = 24(2)

---

40. Obligation 40

Section 50: Release on licence from treatment centre (See Page 65 of Comparative table 1)

Person ordered to be admitted must be so admitted until released on licence, discharged, transferred or returned to any other facility.

Facility manager of public or private treatment centre must furnish particulars if not discharged after 12 months.

Director-General **may** if deems it in the interest of user discharge user from effect of any order (such discharge not to preclude any subsequent committal or transfer).

If person under 18 to be detained in public or private treatment centre, D-G **may** direct be detained in a place of safety i.t.o Children's Act.

New or Existing Mandate: New and Existing

This section correlates with section 37 of the 1992 Act but only section 50(1) of the bill = section 37(1) and (2) of the 1992 Act.

Sections 50 (2) to 50 (5) are new provisions

---

41. Obligation 41

Section 51: Transfers of service users from and to a treatment centre (See Page 66 of Comparative table 1)

D-G **may** transfer user, other than a voluntary user, from one public/private treatment centre to another.

New or Existing Mandate: New and Existing

Section 51 correlates with section 27. These sections are existing provisions.

Section 51 = section 27 entirely

42. Obligation 42

Section 52: Transfer of persons from prison, children's home, secure care or child and youth centres to treatment centre or mental health care facility to treatment centre (See Page 68 of Comparative table 1)

Minister **may** transfer prisoner, detainee in children's home, or mental health facility to a treatment centre, if person likely to benefit

New or Existing Mandate: Existing

Section 52 of the Bill = Section 28, 30, 33 and 34 of the 1992 Act

---

43. Obligation 43

Section 53: Retransfers (See Page 72 of Comparative table 1)

The Minister may retransfer to prisons, children's homes, youth care centres, any person transferred to a treatment centre.

New or Existing Mandate: New and Existing

These sections correlate with Sections 29, 31, 33, 35 of the 1992 Act.

Sections 35 (1) and (2) of the 1992 Act no longer appear in the Bill

---

44.Obligation 44

Section 54: Leave of absence from treatment centre (See Page 75 of Comparative table 1)

Facility manager **may** if directed by D-G to grant leave of absence to any user in writing, on prescribed terms and conditions; and cancel leave if non-compliance.

New or Existing Mandate: New and Existing

Section 54 (1) to (3) of the Bill = Section 36 of the 1992 Act

Section 54(4) of the Bill is a new inclusion

45.Obligation 45

Section 55: Service users may be discharged (See Page 76 of Comparative table 1)

Facility manager **may** discharge user if so directed by D-G, on stipulated conditions.

User **must,** in accordance with regulations, remain under supervision of social worker, until discharge expires or is cancelled.

Obligation to treat continues until expiry of order

New or Existing Mandate: New

This section is entirely new

46.Obligation 46

Section 56: Revocation of discharge privilege (See Page 77 of Comparative table 1)

Facility manager **may** if believes user does not comply with conditions or is incapable of adjusting to normal life, revoke user's licence and direct that user return to treatment centre; on pain of being arrested.

New or Existing Mandate: Existing

This section exists in the 1992 Act as Section 38.

Comments:

Authority to order arrest appears suspect.

The direction to return to the centre does not amount to an authority to order an arrest. See also comments under section 41.

47.Obligation 47

Section 57: Admission to treatment centre of persons from territories outside RSA (See Page 79 of Comparative table 1)

If agreement with government of any country; Minister **must** publish same in Gazette.

Minister **may** order admission and detention in treatment centre of person whose detention for period not exceeding 12 months has been ordered by competent court in that country.

Management of facility not to grant leave of absence without approval of D-G.

Subject to provisions of agreement, only Minister can approve discharge of such person

New or Existing Mandate: Existing

This section is the equivalent of section 46 in the 1992 Act. These sections exist in both documents.

---

48. Obligation 48

Section 58: Service users to have access to management and vice versa (See Page 81 of Comparative table 1)

Right of personal access to one another.

New or Existing Mandate: Existing

This section correlates with section 42 in the 1992 Act. The section exists in the 1992 Act.

CHAPTER 9

BEHAVIOUR MANAGEMENT AND DISCIPLINARY INTERVENTION

49. Obligation 49

Section 59: Maintenance of discipline (See Page 82 of Comparative table 1)

Facility manager **may** hold enquiry in case user contravenes any regulation; **must** record proceedings and add remarks or keep written statements desired by user.

If user not satisfied with outcome, appeal to appeal committee.

Minister **must** prescribe measures and procedures for appeal committee.

Appeal committee **must** either set aside/correct proceedings and reduce/vary the discipline.

If user commits serious crime, facility manager **must** report to police to apprehend.

New or Existing Mandate: **Existing**

This section correlates with section 43. It is an existing provision.

Comments:

Section contains more acceptable administrative justice procedures.

The structures envisaged for the maintenance of discipline, as well as liaison with the police, are not specified in either the Bill or the Act. However, it is likely that several mechanisms have been set up in practice, and might indeed be functioning already. (This

information can be obtained from the Department). Obviously such practices and structures will inform the evolution of the new system.

The term ‘serious crimes’ will refer to criminal conduct which constitutes more than a mere breach of discipline. It would probably exclude eg petty theft or being involved in an affray, but include assault, other theft and more serious transgressions of the law.

---

50. Obligation 50

Section 60: Method of dealing with absconders (See Page 84 of Comparative table 1)

Facility manager **must** notify police to locate, apprehend and return user; request social worker to investigate circumstances of abscondment; as soon as possible bring user before magistrate.

Magistrate **must** after enquiry order return or detention in custody pending decision of D-G, and report results of enquiry to D-G.

D-G on consideration of reports **must** direct return/postpone order/discharge.

New or Existing Mandate: Existing

This Section correlates with Section 39 of the 1992 Act.

Comments:

Notable absence of conciliation approach (as mandated by section 5) in dealing with abscondment.

CHAPTER 10

RESEARCH AND INFORMATION MANAGEMENT

51.Obligation 51

Section 61: Research and information management (See Page 87 of Comparative table 1)

Minister **must** prescribe mechanism for research on substance abuse and systems on information management to service providers.

New or Existing Mandate: New

This section is new inclusion. It does not exist in the 1992 Act

Comments:

New capacity to be developed or outsourced, with concomitant budgetary implications.

CHAPTER 11

CENTRAL DRUG AUTHORITY AND SUPPORTING STRUCTURES

52. Obligation 52

Section 65: Secretariat of the CDA (See Page 95 of Comparative table 1)

Secretariat to consist of Director: Secretariat of the CDA and admin and support staff as necessary to perform functions

New or Existing Mandate: Existing

This section exists in the 1992 Act

---

53. Obligation 53

Section 66: Powers and Duties Central Drug Authority (See Page 97 of Comparative table 1)

66 a) Responsible for overseeing and monitoring implementation of the National Drug Master Plan;

66 j) ensuring effective strategies in place for programme delivery;

66 l) acting as advisor to government.

66 m) reviewing National drug Master Plan on five-yearly basis and amending as necessary

66 n) organising bi-annual summit on substance use.

New or Existing Mandate: New and Existing

This section correlates with that of Section 3 of the 1992 Act. It exists in the 1992 Act.

66(a) = 3(a)

66(b), (c), (d) = 3(c)

Section 3 (b),(d), (e) and (f) of the 1992 Act no longer exists in the Bill

Sections 66 (e) to (o) of the Bill are all new inclusions

Comments:

The Bill envisages the establishment of a significantly expanded CDA; executive and secretarial structures. State **will have to fund the administration of such a bureaucracy**

Previous Section 3(d) provides that the CDA 'may arrange conference' as opposed to section 66 (n) which mandates a bi-annual summit.

---

54. Obligation 54

Section 67: Provincial Substance Abuse Forums (See Page 99 of Comparative table 1)

67 (1) Minister **must** establish forums for each province, drawn from various sectors.

67 (3) Department to provide human and material resources and provincial co-ordinators.

67 (4) Adequate sustained funding will come from collaborating and related departments.

67 (5) Members who are not employed in the public service **must** be paid travelling and subsistence allowances for attending meetings of forums.

New or Existing Mandate: New

This is an entirely new provision.

Comment:

Refer to comment under section 59.

---

55. Obligation 55

Section 68: Functions of Provincial Substance Abuse Forum (See Page 100 of Comparative table 1)

To compile mini-drug master plan, forums to co-ordinate provincial plans; networking; submit quarterly reports

New or Existing Mandate: New

This is an entirely new provision.

Comments:

Funding arrangements are loose and potential for paralysis.

---

56. Obligation 56

Section 69: Executive committees of Provincial Substance Abuse Forums (See Page 101 of Comparative table 1)

Here there is an obligation on the provincial substance abuse forums to establish an executive committee

The executive must consist of members responsible for:

(a) treatment and after-care;

(b) prevention and education;

(c) community development; and

(d) research and information dissemination

New or Existing Mandate: New

This is an entirely new provision.

---

57. Obligation 57.

Section 70: Local Drug Action Committees (See Page 102 of Comparative table 1)

70(1) Local municipality **must** establish them, to represent each municipality and effect NDMP.

70(2) Minister **must** appoint members of committee.

70(3) Provincial co-ordinator to assist LDAC structures

70(4) Funding for LDAC from local municipality and other relevant departments

New or Existing Mandate: New

This is an entirely new provision.

Comments:

Positive step to increase grassroots participation in combating substance abuse.

Danger committees will get caught up in red tape, committees, and frequent reporting requirements.

Refer to comment under Section 59.

---

58. Obligation 58

Section 71: Functions of LDAC (See Page 104 of Comparative table 1)

71(a) Functions to ensure local action on NDMP;

71(d) implement plans;

71(e) report to provincial forum

71(g) report to CDA on quarterly basis.

New or Existing Mandate: New

This is an entirely new provision.

CHAPTER 12

GENERAL PROVISIONS

59.Obligation 59

Section 72: General Provisions (See Page 105 of Comparative table 1)

Minister **may** delegate any of powers to officer in department, except power to make regulations.

D-G **may** delegate any of conferred powers to officer in department. Likewise head of department.

Any delegation of power **must be** in writing; not prevent delegator from exercising that power; may be withdrawn in writing

New or Existing Mandate: Existing

This section correlates with section 47 of the 1992 Act. It's an existing provision.

60.Obligation 60

Section 74: Regulations (See Page 108 of Comparative table 1)

Minister **may** make regulations regarding any prescribed forms; prescribed matters; other matter deemed necessary/expedient to be prescribed to achieve objects of Act.

Regulations resulting in expenditure for the state **must** be made in consultation with Minister of Finance.

Regulations under subsection 1 **may** prescribe penalties for contravention.

If punishment prescribed for service users, regulations to specifically provide not be imposed unless medical officer certified not harmful to health of user.

New or Existing Mandate: Existing

This section correlates with section 48 of the 1992 Act. It exists in the 1992 Act.

APPENDIX 2:

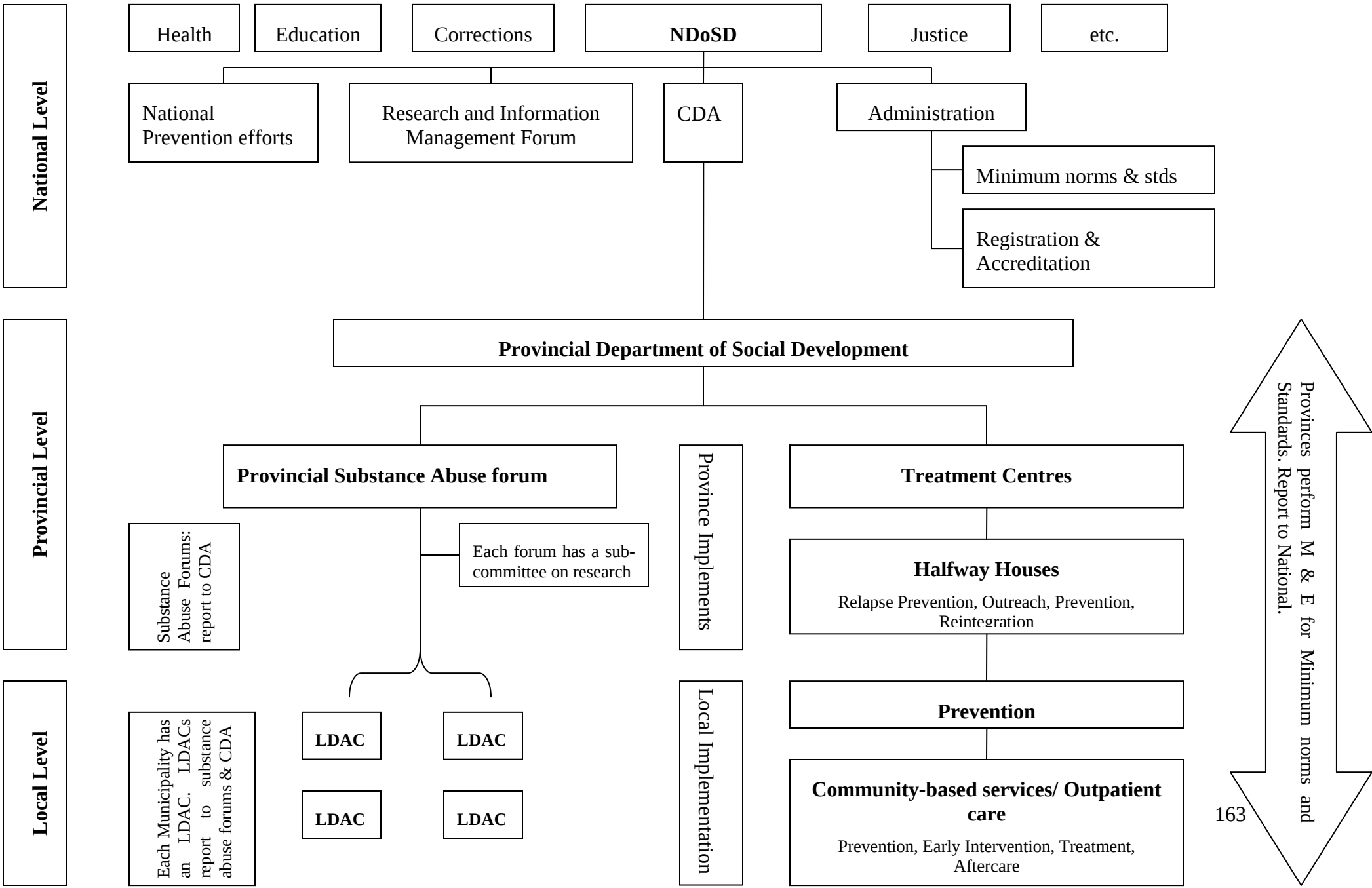
OVERVIEW OF PUBLIC

SUBSTANCE ABUSE

SERVICES IN SA

PUBLIC SUBSTANCE ABUSE SERVICES IN SA

(as outlined in the Prevention and Treatment of Substance Abuse Bill)



APPENDIX 3:

METHODOLOGY FOR THE

SELECTION OF PROVINCIAL

FIELD SITES

Criteria for selection of fieldwork sites

Multiple sources of information were considered to establish reasonable estimates of substance use dependence in South Africa and to verify the validity of data. While a number of smaller studies on substance use have been conducted, they are limited to specific geographic regions, population groups and subgroups of the population. Hence their generalisability is limited. The SACENDU data (South African Community Epidemiology Network on Drug Use) provides useful insight into the extent of substance use using data collected from patients attending special treatment centres around the country. However, the surveillance system is limited in that it cannot account for the proportion of the population experiencing dependence but not accessing treatment.

Two surveys - The South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005 (HSRC, 2005); and the South African Demographic and Health Survey -SADHS (1998, 2003) - provide nationally representative statistics on substance use. However, it must be noted that differing measures of substance use were used in the two surveys. Hence their comparability is also somewhat limited.

National rates of drug use are low (e.g., cannabis 2.1%, cocaine and sedatives 0.3%, amphetamines 0.2%, and inhalants, hallucinogens and opiates 0.1% each) as reported in the HSRC study (2005) and are in all likelihood underestimates as respondents are unlikely to readily admit to illegal drug use. They are therefore unreliable as estimates of the extent of substance use dependence in the country.

Thus, prevalence rates of alcohol dependence were used as they are more reliably reported. In addition, alcohol dependence is consistently reported as the primary drug of abuse for which treatment is sought within the SACENDU network, accounting for 54 percent of admissions to specialist treatment centres in Mpumalanga, 72 percent in East

London, 58 percent in Durban, 52 percent in Gauteng, and 49 percent in Port Elizabeth (SACENDU, 2006).

Measures

The SADHS surveys, conducted in 1998 and repeated in 2003, used the CAGE Questionnaire to determine lifetime use of alcohol among individuals 15 years and older, while the HSRC survey used the AUDIT measure which estimates usage over the past 12 months among individuals 15 years and older.

The CAGE Questionnaire is a 4-item scale measuring if the participant ever felt that he/she should cut down on their drinking, have been annoyed by being criticised for drinking, felt guilty about drinking or have ever had a drink first thing in the morning to steady nerves or get rid of a hangover. A score of 2 or more is indicative of dependence.

The AUDIT questionnaire is a 10-item scale that takes into account the quantity and frequency of alcohol consumed as well as symptoms of alcohol problems. Weighted scores are assigned to positive responses for each of the items and the respondent is classified as a high-risk drinker if he/she scores 8 or more on the scale.

Selection criteria

The three data sources (HSRC, 2005; SADHS, 2003; 2005) were used to develop a ranking system to establish alcohol dependence prevalence rates. Each data source contributed equally to the overall ranking of alcohol dependence. The choice of research sites, in a costing exercise of this nature is also impacted upon by existing infrastructure. These are more easily established and hence provided a second robust measure to rank sites per province. The distribution of treatment centres across provinces was used as a proxy for the availability of substance use infrastructure.

Ranking procedure

Each province was ranked on the basis of the actual survey results. For example, in the HSRC survey, the Western Cape ranked highest with regard to alcohol dependence (lower scores indicate greater prevalence of alcohol dependence). In the SADHS surveys, Western Cape was ranked 5th and 4th in 1998 and 2003 respectively using the CAGE measure of alcohol dependence. A sum of the ranking was then employed to establish an overall ranking. Data from the Department of Social Development provided the number of treatment centres in each province. This information was supplemented by data from SANCA regarding their treatment centre facilities nationally.

While the classification of each province on the basis of cut offs is somewhat arbitrary, it does help establish a consistent procedure. Using the median as an arbitrary cut off (50% above, 50% below) a total ranking of 12 or below was ranked as high prevalence, moderate prevalence if the score was between 12 and 20, and low prevalence if the score was between 21 and 24.

The final choice of provinces was then made on the basis of a mix of alcohol dependence and treatment infrastructure. Population density and urban centres that are considered ports of entry were also considered in providing a mix of provinces with each of these features.

An examination of the rates of alcohol dependence in the two SADHS surveys revealed that these show large declines in the case of two population groups. It is unlikely that dependence rates would decline by between 7% and 9% over a relatively short period of time. Such huge variation in rates suggests that the data related to the 2003 SADHS survey may be less reliable in reporting substance use. As a precautionary measure, the ranking procedure was repeated using only the 2005 HSRC study and the 1998 SADHS study. The outcome was the same.

Table A1 outlines alcohol dependency rates according to the three studies (HSRC, 2005; SADHS, 1998; 2003); while Table A2 provides the ranking of alcohol dependency rates and treatment infrastructure per province. Table A3 outlines the five provinces selected for fieldwork and the criteria on which selection was made. It must be noted that while face-to-face interviews will be conducted in the five selected provinces, a shorter version of the questionnaire will be administered telephonically to the remaining provinces.

Table A1: Percentage of the population classified as alcohol dependent per province

Province	**High Risk Drinkers (%)**	**SADHS 1998**		**SADHS 2003**	
		Male	**Female**	**Male**	**Female**
Eastern Cape	2.6	33.7	10.9	35.9	9.1
Free State	8.6	34.4	11.9	27.7	13.2
Gauteng	8.6	23.7	10.4	14.6	4.8
KwaZulu-Natal	5.6	22.5	6.9	11.4	1.9
Mpumalanga	4.5	38.2	11.5	18.1	2.7
North West	12.7	24.8	11.5	34.5	9.7
Northern Cape	11.6	38.6	18.5	38.o	18.8
Northern Province	3.6	23.7	6.1	23.1	9.4
Western Cape	15.6	27.6	11.7	31.0	9.6

Sources: HSRC (2005), SADHS (1998, 2003)

Table A2: Ranking of alcohol dependency rates and treatment infrastructure per province

Province	HSRC '05	SADHS '98	SADHS '03	Overall Ranking	Summary Prevalence	No. of Treatment Centres
Eastern Cape	9	4	2	15	Moderate	8
Free State	4	3	5	12	High	1
Gauteng	5	7	8	20	Moderate	19
KwaZulu-Natal	6	9	9	24	Low	21
Limpopo	8	8	6	22	Low	1
Mpumalanga	7	2	7	16	Moderate	2
North West	2	6	3	11	High	1
Northern Cape	3	1	1	5	High	3
Western Cape	1	5	4	10	High	16

Table A3: Provinces selected for fieldwork and criteria for selection

Province Selected	Prevalence	Infrastructure	Density	Urban Centres/ Ports of Entry
Free State	High	Low	Low	
Gauteng	Moderate	High	High	x
KwaZulu-Natal	Low	High	High	x
Northern Cape	High	Low	Low	
Western Cape	High	High	High	x

References

Department of Health, Medical Research Council, Measure DHS (1998). *South Africa Demographic and Health Survey 1998.* Pretoria: Department of Health, SA.

Department of Health, Medical Research Council, Measure DHS (2003). *South Africa Demographic and Health Survey 2003.(unpublished)*

Pluddemann, A., Parry, C., Cerff, P., Bhana, A., Harker, N., Potgieter, H., Gerber, W., & Johnson, C. (2006). Monitoring Alcohol and Drug Abuse Trends in South Africa (July 1996 – December 2005). *SACENDU Research Brief*, 9 (1), 1-13.

Shisana, O., Rehle, T., Simbayi, L. C., Parker, W., Zuma, K., Bhana, A., Connolly, C., Jooste, S., Pillay, V. et al. (2005). *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005.* Cape Town: HSRC Press.

APPENDIX 4:

GOVERNMENT PERSONNEL

INTERVIEWED

Table B: List of government personnel interviewed

Designation	Department	Level
0) National		
Chief Director: Welfare Service Transformation	Social Development	
Director: Prevention and Rehabilitation of Substance Abuse and CDA	Social Development	
Deputy Director: Substance Abuse	Social Development	
Social Work Manager: CDA	Social Development	
Advanced Social Work Specialist	Social Development	
Social Work Specialist	Social Development	
1) KZN		
Provincial Coordinator	Social Development	Provincial
Deputy Chief Education Specialist: Social Work	Education	Provincial
Deputy Director: Restorative Services	Social Development	Provincial
Salaries Clerk	Provincial Salaries	Provincial
2) Gauteng		
Deputy Director: Youth Strategy	Social Development	Provincial
Assistant Director: Substance Abuse	Social Development	Provincial
Region: Assistant Social Work Manager	Social Development	Regional
Assistant Director: Probation and Crime Prevention	Social Development	Provincial
Deputy Director: Magaliesoord Treatment Centre	Social Development	Provincial
Deputy Director: Partnerships	Social Development	Provincial
Deputy Director: Financing	Social Development	Provincial
3) Western Cape		
Provincial Coordinators	Social Development	Provincial
District Coordinator	Social Development	District

4) Northern Cape		
Provincial Coordinator	Social Development	Provincial
Deputy Director: Welfare, Financing and Monitoring and Evaluation	Social Development	Provincial
Finance Officer	Social Development	Provincial
Mental Health Coordinator	Health	Provincial
Deputy Director: Support Services (District)	Social Development	District
Area Supervisor: Social Workers (District)	Social Development	District
District Coordinator: Substance Abuse	Social Development	District
5) Free State		
Provincial Coordinators	Social Development	Provincial
District Coordinator: Substance Abuse	Social Development	District
Assistant Manager: Substance Abuse	Health	Provincial
6) Limpopo		
Provincial Coordinator	Social Development	Provincial
7) Mpumalanga		
Provincial Coordinator	Social Development	Provincial
8) North West Province		
Provincial Coordinator	Social Development	Provincial
9) Eastern Cape		
Provincial Coordinator	Social Development	Provincial

Where staff performed the tasks associated with more than staff designation, their primary designation has been listed in the table above. Please note that the table is not a

comprehensive list of respondents contacted for information as it excludes the details of respondents that were drawn from the NGO sector, multilaterals and a number of private organisations. These respondents were used as supplementary data sources for information on the costs of resource usage where the necessary information on expenditure was not available to the departmental staff contacted. Personnel details of these respondents are available upon request.