Implementation Guidelines
Substance Abuse Policy

Final Draft for submission

Prepared for
Department of Social Development
Prevention and Rehabilitation of Substance Abuse Directorate

by

smart

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Executive Summary

This aim of the Policy Implementation Guidelines is to enhance service delivery for the treatment and prevention of substance use disorders, and to set out feasible guidelines for translating and integrating the National Policy for the Management of Substance Abuse into practice.

The work was undertaken by Substance Misuse: Advocacy, Research and Training (SMART) who formed a consortium for the research and crafting of the report and co-managed the consultation process with the Department of Social Development.

Alcohol and drug abuse in South Africa, as in the rest of the world, reaches across social, racial, cultural, language, religious and gender barriers, and places an immense health and socio-economic burden on South African society.

Research has highlighted the link between alcohol and drug abuse and
- intentional and non-intentional injuries and premature death;
- dysfunctional family life;
- risky sexual behaviour;
- infectious diseases, such as tuberculosis and sexually transmitted infections including HIV/AIDS;
- cancers and foetal alcohol syndrome;
- crime (particularly crimes of violence, property crimes and crimes associated with the supply of or trafficking in substances);
- absenteeism and school failure; and
- loss of productivity, unemployment and other negative economic effects.

The Department of Social Development has the mandate to administer the Prevention and Treatment of Drug Dependency Act, and has developed supporting documentation such as the Policy on the Management of Substance Abuse, Minimum Norms and Standards for In- and Out-patient Substance Abuse Treatment Centres as well as Norms and Standards for Community Based Programmes.

The direction set out in these Policy Implementation Guidelines is based on a detailed analysis of all relevant documentation and gives service providers and other interested parties, step-by-step guidelines on how to translate policy into practice.
These Policy Implementation Guidelines are evidence-based where possible, and allow for the development of process, impact and outcome indicators, as well as for future monitoring and evaluation.

Substance use disorders, much like HIV/AIDS or diabetes, require social approaches to prevention and treatment, as well as medication and clinical interventions, and the WHO (1993) conceptualizes alcohol and drug services along a continuum, ranging from primary prevention activities that ensure a disorder or problem will not occur, through secondary prevention activities (including early identification and management of substance use disorders through the provision of treatment), to tertiary prevention activities that aim to stop or retard the progression of a disorder (e.g. treatment, aftercare and harm reduction activities).

A key component and crucial part of the Policy Implementation Guidelines development was a broad-based consultation process. 112 organisations and individuals were twice given the document for input, and some written responses were received and are attached as an Appendix C.

The consultation process consisted of 1) identifying and informing key stakeholders, 2) circulating the first Draft copy, 3) feedback review communication and incorporation, 4) circulating the second Draft copy, 5) stakeholders symposium, 6) feedback review, communication and incorporation.

One of the challenges during this process was terminology; different treatment models and individuals understand and use varying terminology, particularly with regard to levels of care and designations such as ‘addiction counsellor’. As a separate part of the consultation process a random selection of treatment service providers were asked to define the following terminology 1) addiction counsellor; 2) support counsellor; 3) recovery assistant; 4) primary treatment, 5) secondary treatment and 6) tertiary treatment. This has been addressed within the report and responses are attached as Annexure D.
The report has been divided into the following sections,

- Primary Prevention
- Early Intervention (Secondary Prevention)
- Treatment (Secondary and Tertiary Prevention)
- Detoxification
- In-patient treatment
- Out-patient and community based treatment
- Statutory treatment
- Aftercare and Reintegration Services
- Harm Reduction
- Management of Drug Treatment Practices
- Research and Information Management
- International Liaison
- Capacity Building
- Monitoring and Evaluation

Each section has a definition of the services and who should render them, as well as when they are appropriate and for whom; also included are desirable features for each level of intervention and suggested action steps.
1. **Goal of the policy implementation guidelines**

What is the overall goal of the implementation guidelines?
The overall goal is to enhance service delivery for the treatment and prevention of substance use disorders by giving step-by-step guidelines on how to translate policy into practice.

What is the scope of the implementation guidelines?
To develop comprehensive and feasible guidelines for translating and integrating National Policy for the Management of Substance Abuse into practice. The target audience for these guidelines consists of all stakeholders that provide prevention and/or treatment services for substance use in the country, as well as National and Provincial Departments of Social Development. These guidelines are evidence-based where possible, and allow for the development of process, impact and outcome indicators, and for future monitoring and evaluation of substance abuse policy implementation.

2. **Context of the policy implementation guidelines**

Substance abuse has placed a health and socio-economic burden on South African society that the country cannot afford. Its influence reaches across social, racial, cultural, language, religious and gender barriers and, directly or indirectly, affects everyone. Research has highlighted the link between substance abuse and

- intentional and non-intentional injuries and premature death;
- dysfunctional family life;
- risky sexual behaviour;
- infectious diseases, such as tuberculosis and HIV/AIDS;
- cancers and foetal alcohol syndrome;
- crime (particularly crimes of violence, property crimes and crimes associated with the supply of or trafficking in substances);
- absenteeism and school failure; and
- loss of productivity, unemployment and other economic effects.¹
The Department of Social Development has the mandate to administer the Prevention and Treatment of Drug Dependency Act, which provides for the establishment of the Central Drug Authority, the development of programmes and the setting up and management of treatment centres. (The Act is currently under review.\(^2\))

The Prevention and Treatment of Drug Dependency Act regulates the field of substance abuse and is supported by, but not restricted to, the National Drug Master Plan (NDMP)\(^3\) and the list of legislative frameworks and policies attached as Appendix A.

To achieve its aims, the NDMP has identified nine main areas of focus:

- Crime
- Youth
- Poor and vulnerable groups
- Health
- Research and information dissemination
- International liaison
- Communication
- Capacity building
- Occupational groups at risk.

The NDMP, it is a national strategy that guides the operational plans of all government departments and entities in the reduction of demand for and the supply of drugs, and outlines the role that each department should play. It summarises national policies authoritatively and defines priorities.

The Department of Social Development is guided by the following strategic objectives:

- To set strategic guidelines for service providers so that they can provide appropriate services, that is services that are constitutional and compliant with the mandates, norms and standards of the department and statutes applicable to the social development context.
• To ensure the provision of appropriate, coherent and holistic preventative programmes to individuals, families and communities.

• To ensure the provision of statutory and non-statutory in-patient and out-patient community-based treatment that is evidence-based.

• To ensure the provision of quality aftercare by professional services, support groups and self-help groups.

• To ensure the delivery of quality reintegration services at the following levels:
  - Residential
  - Skills development
  - Community-based programmes.

• To provide guidelines and mechanisms to build a skilled and well-trained base of service providers.

• To provide for the monitoring and evaluation of policy implementation.

• To provide a framework for the commissioning of research into matters related to substance abuse.

The department will also ensure that its substance abuse programmes are in line with the requirements of the NDMP.²

3. What is the Policy on the Management of Substance Abuse?

The Policy on the Management of Substance Abuse exists to ensure that substance abuse services within the social development sector are rendered in a coordinated, regulated and effective manner; that roles and responsibilities are defined, and that the following principles guide all substance abuse interventions.

Accountability

All service providers engaged in prevention, intervention, aftercare and reintegration should be held accountable for the delivery of an appropriate, quality service.

Gender inclusiveness

Services and programmes should promote equal opportunities for and participation by men and women.
Accessibility
Services and programmes should be available and accessible to all - especially in under-resourced areas.

Empowerment
The resourcefulness of people affected by substance abuse should be tapped into by providing opportunities for them to use and build their own capacity and support networks, and to act according to their own choices and sense of responsibility.

Effectiveness and efficiency
Prevention, treatment, aftercare and reintegration services should be delivered in the most effective and efficient way.

Integration
Services should be holistic, and should be delivered by a multidisciplinary team, wherever possible.

Intersectoral collaboration
Services and programmes should promote an intersectoral approach so as to facilitate the pooling of resources, alignment of policies and establishment of partnerships in programme planning and implementation.

Sustainability
The welfare (social, environmental, spiritual and material well-being) of all people affected by substance abuse should be continuously increased or at least maintained. This calls for human development initiatives, with poverty eradication and empowerment central to all initiatives.

Transparency
Services and programmes should ensure that consultation, communication and information are transparent at all levels.

Human rights
Services and programmes should facilitate respect for and protection of human rights, as enshrined in the Constitution.
Continuity of services
Services and support at all levels of engagement should be ongoing.

Cultural and spiritual diversity
Services and programmes should respect the diversity and richness of cultures and embrace them as resources for development in society.

Ubuntu
The principle of humanity and caring for each other’s well-being and upholding the rights and responsibilities of every citizen must be promoted at all levels of service delivery.

Family participation
All services should involve the family as a whole and be relevant to its needs where necessary.

Continuum of care
Substance users and their families should have access to a range of services on a continuum of care appropriate to their particular developmental and therapeutic needs.

4. Institutional arrangements
These guidelines recognize that the Department of Social Development delivers substance-related prevention and treatment services through partnerships with (i) Provincial Departments of Social Development; (ii) National and Provincial Departments of Health, Justice and Constitutional Development, Correctional Services, Safety and Security, SAPS and Education; as well as organs of civil society such as non-government organisations (NGOs), faith-based organisations (FBOs), and community-based organisations (CBOs).\(^4\) These partnerships are reflected throughout the policy implementation guidelines.
5. Implementation Guidelines

Intervention Strategies

Substance use disorders, much like HIV/AIDS or diabetes, require social approaches to prevention and treatment, as well as medication and clinical interventions. Substance use disorders are commonly understood to occur along a continuum of severity ranging from occasional/recreational use, to misuse, to abuse, with the end stage being dependence. The WHO (1993) recommends different intervention strategies for each level of severity, with interventions increasing in intensity as problem severity increases (see below).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Appropriate Intervention</th>
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<tr>
<td>Use</td>
<td>No treatment required</td>
</tr>
<tr>
<td>Misuse</td>
<td>Brief /early intervention</td>
</tr>
<tr>
<td>Abuse</td>
<td>Brief intervention and out-/or in-patient treatment services</td>
</tr>
<tr>
<td>Dependence</td>
<td>Detoxification and in/outpatient treatment, and sometimes mental health services, as well as continuing support services. Harm reduction services for individuals with chronic dependence.</td>
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More specifically, the WHO (1993) conceptualizes alcohol and drug services along a continuum, ranging from **primary prevention** activities that ensure a disorder or problem will not occur, through **secondary prevention** activities (including early identification and management of substance use disorders through the provision of treatment), to **tertiary prevention** activities that aim to stop or retard the progression of a disorder (e.g. treatment, aftercare and harm reduction activities).
5.1. Primary Prevention

What is primary prevention?

- All activities that (i) prevent initial psychoactive substance use and (ii) delay the onset of problematic substance use.

When are primary prevention activities appropriate?

- Primary prevention activities are appropriate to use among individuals and at-risk-groups that have not yet started using psychoactive substances.
- Primary prevention activities are also appropriate for individuals who use psychoactive substances occasionally, but do not display problems related to use.
- Primary prevention activities are not indicated for individuals with problems related to substance use (e.g. driving under the influence, absenteeism, family problems). For these individuals, secondary (and in some cases tertiary) prevention activities are more appropriate.

Who should primary prevention activities target?

- Children and adolescents.

Primary prevention around psychoactive substance use should start at as early an age as possible (e.g. 5-6 years), especially as South African statistics from SACENDU suggest that children as young as 8 years of age are utilizing treatment services.
• **Families**
  All primary prevention activities that target children and adolescents should also target their families and/or primary caregivers.

• **Vulnerable and at-risk population groups**
  A special focus should be given to vulnerable sub-groups within the population including family members of individuals with substance use disorders; youth in conflict with the law and/or who display other risky behaviours; marginalized, impoverished communities where there may be high levels of drug dealing and illegal liquor outlets; children living and/or working on the streets; people with physical and mental disabilities, the unemployed, immigrants and refugees; women; older persons; and people affected and infected by HIV, including child-headed households.

**Desirable features of primary prevention activities:**

• **Information provision is only one aspect of primary prevention.**
  Other important aspects include interventions that (i) reduce factors associated with increased risk for and (ii) enhance factors that protect against the initiation of substance use.

• **Programmes that include information provision as part of their activities should:**
  Explore socio-cultural norms around drinking and drug use, provide accurate information about substance use disorders and the risks associated with substance use, and should include information about treatment and other interventions for substance use disorders.

• **Programmes must be adapted to suit target groups and communities**
  No single prevention programme will suit every community or target group - especially given South Africa’s diversity. Programmes therefore need to be age-appropriate (i.e. adapted to meet the developmental needs of children in specific age groups), gender-sensitive, and culturally appropriate (i.e. programmes need to be linguistically appropriate and contextually correct).
• *Internationally accepted principles of effective prevention programmes should be adhered to.*

While recognizing that internationally-developed prevention programmes need to be adapted to suit the South African context, principles of primary prevention programmes should always be adhered to. These principles are outlined in Box 1⁷ and in the Guidelines for Substance Abuse Prevention amongst the youth of South Africa⁸. One principle is that the younger ages require more systemic interventions due to the strong influence that the environment (such as family) plays on individual outcomes.

• *Primary prevention programmes should be sustainable and should avoid once-off interventions that use scare tactics and broad prevention messages.*

Once-off interventions that simply educate persons about the dangers of alcohol and drug use do not prevent the initiation of alcohol and drug use or elicit behaviour change among persons currently using substances. The use of scare tactics and one-line blanket messages such as “Just say No” have also been proven to be ineffective.

• *Primary prevention programmes should be interactive and should rely on experiential learning methods instead of didactic teaching techniques.*

The use of experiential learning techniques including visual aids, small group exercises and the use of multiple media has been shown to be more effective than traditional didactic teaching techniques.

**Action steps:**

Primary prevention programmes should:

• Explore the values, perceptions, expectations and beliefs that the community or target group associates with alcohol and drug use and substance-related problems;
• Educate the individual, family and community about the risks of alcohol and drug use;
• Educate the individual, family and community about responsible alcohol consumption;
- Raise awareness within families and communities about substance abuse and the related physical and mental health problems as well as social problems;
- Raise community awareness about possible early intervention and treatment options, should a problem arise;
- Impart life and social skills (such as decision-making, conflict resolution, and assertiveness training) to individuals as a way of reducing factors that place individuals at risk for using substances;
- Include health promotion activities that target young people and increase their capacity to make informed and healthy choices;
- Strengthen families and other pro-social institutions (including faith-based organisation and cultural organisations) as a means of enhancing the factors that protect against the initiation of substance use;
- Improve parenting skills among families at risk. Positive parenting approaches that include appropriate discipline, communication, and displays of warmth and affection have been identified as factors that protect against substance use initiation.
- Strengthen community structures and improve neighbourhood environments so that neighbourhood disorder (characterised by poverty, dilapidated buildings, poor services, overcrowding and open drug dealing) can be addressed. Neighbourhood disorder is a significant risk factor for the initiation of substance use;
- Programmes should strive to address sexual risk behaviour among programme participants, in order to reduce the risk of contracting or transmitting HIV and other STIs, and avoiding unplanned teenage pregnancy;
- Messaging in prevention programmes needs to be evidence-based and consistent across all government departments and sectors of civil society;
- Primary prevention activities should include both universal messaging (i.e. blanket media campaigns) and messages that target high-risk groups (i.e. pregnant women and children).
**Entities responsible for primary prevention programmes:**

These include:

- The National and Provincial Departments of Social Development together with:
- The Department of Health (focusing specifically on health promotion and communities);
- Department of Education: focusing on school-based prevention programmes,
- SAPS, Department of Safety and Security,
- Local Government: focusing on community based prevention and information provision
- Organisations such as National Youth Commission and NGOs, CBOs and FBOs working in communities and with at risk population groups.
5.2. Early intervention (Secondary Prevention)

According to the WHO (1993), secondary prevention consists of identifying and treating potentially harmful substance use prior to the onset of overt symptoms or problems, as such this includes early interventions for substance use disorders.

What are early interventions?

• Early intervention focuses on preventing serious harm to individuals who have not become addicted to substances, and do not yet require formal treatment.
• Early interventions involve screening for problematic substance use so that it can be detected at an early stage and addressed prior to the onset of more serious problems.
• Early interventions include brief counselling interventions that aim to reduce or eliminate risky and problematic substance use.

When are early interventions appropriate?

• Early interventions are appropriate to use when the problem is acute, to avoid further harms;
• Early interventions are appropriate to use among individuals who are starting to experience some problems related to substance use, but have not yet developed obvious signs of dependence (e.g. loss of control, tolerance, withdrawal);
• Early intervention activities are not appropriate to use as a form of “low intensity treatment” among individuals who have already developed a substance dependence disorder;⁹
• However, some forms of early intervention can be used to motivate individuals with substance dependence to enter more intensive substance abuse treatment services (e.g. brief motivational interventions);

Who should early interventions target?

• All individuals who are misusing or consuming substances at risky levels.
• Early interventions should specifically target those persons who are displaying some problems related to their substance use.
  For example:
  • Individuals with driving under the influence of alcohol/drug offences,
• Individuals who present at trauma units with alcohol or drug-related injuries,
• Server interventions for individuals who consume risky amounts of alcohol in drinking settings,
• Individuals who present at health care settings with alcohol or drug-related health problems,
• Children and adolescents found in possession of drugs at school,
• Individuals found in possession of drugs.

Desirable features of early interventions:

• *Empathy vs confrontation*
  Service providers conducting early interventions should display empathy and concern. Early interventions should not be confrontational in nature.

• *Individual choice*
  Service providers can give clear advice and information to service users, but should not impose their choices upon individuals. Information and advice should not be provided in a dictatorial manner.

• *Should be interactive and should rely on experiential learning methods instead of didactic techniques.*
  Early interventions should be interactive in nature rather than rely on the service provider telling the service user what to do. As such, service providers should use therapeutic techniques such as reflective listening, affirmations, and open-ended questions. In this approach, service providers facilitate change, but are not the active agents of change.

• *Brief motivational interventions*
  Brief motivational interventions (BMI) are a particularly effective form of early intervention.

  These interventions focus on building rapport with service users, displaying empathy and actively working with service users in a partnership to help them make decisions to change. BMI have been shown to be effective in changing a wide range of health-related behaviours, including risky drinking and smoking.
Action steps:

- **Screen for risky or problematic substance use.**
  All early interventions should screen individuals for risky or problematic substance use. At a minimum, screening should include questions about the quantity and frequency of consumption. Several internationally validated screening tools have been adapted for use in South Africa, including the Alcohol Use Disorders Identification Test (AUDIT; a screening tool for alcohol use disorders) and the WHO-ASSIST (for smoking and involvement in substance use). Various health-related tests can also be conducted to screen individuals for liver damage and other health-related problems.

- **Provide feedback on results from screening**
  Early interventions should provide individuals with feedback on the results of their screening and how their current substance use is affecting their health and well-being.

- **Emphasize personal responsibility for change and set goals for change**
  These interventions should assist individuals in setting goals related to changing their substance use (e.g. reducing consumption).

- **Provide clear advice to change**
  Early interventions need to provide individuals with clear advice about the need to quit or reduce their substance use. Early interventions should also strive to address sexual risk behaviour and other problem behaviours that may be associated with substance use.

- **Provide a range of change options**
  Early interventions should provide individuals with information about how to change their substance use as well as a range of options relating to how they can do this. These options may include more intensive treatment, if required.

- **Monitoring & referral**
  Where possible, early interventions should include a monitoring component; this monitoring involves tracking service users’ progress in attaining their substance-related goals. Should service users not be successful in meeting their goals, the service provider may wish to refer service users to more intensive treatment options.
Entities responsible for early interventions:

These include:

- The National Department of Social Development together with:
- The Department of Health (focusing specifically on early interventions in community and primary health care clinics, and trauma units by specially trained nurses and physicians)
- Provincial Departments of Social Development (focusing specifically on the provision of early interventions by specially trained intake and fieldwork social workers in district offices)
- Local Government departments of Social Development and Health
- Health, social services and allied professionals working in treatment centres, NGOs and CBOs who have been trained in early intervention techniques.
5.3. Treatment (Secondary and Tertiary prevention)

In the last decade, research into the treatment of substance use disorders has taken giant leaps forward and is now regarded by the WHO as a medical and behavioural sciences specialty.

**What is treatment?**

- Treatment is the provision of specialised medical, psychiatric and social services to individuals with substance use disorders, and their families, in order to stop or retard the progression of these disorders.
- Treatment focuses on halting, reducing, or reversing the negative health and social consequences associated with substance abuse and dependence.
- Treatment also focuses on preventing further health and social harms related to continued substance use (e.g. harm reduction interventions to reduce HIV-risk among injection drug users).
- Depending on the model of treatment used, the goals of treatment may include abstinence, reduced substance use, and/or harm reduction.

**When is treatment indicated?**

- Specialised treatment services are appropriate for individuals with substance abuse and dependence disorders.
- Specialised treatment services are not indicated for individuals with low levels of problem severity (e.g. “recreational” drug users or individuals with substance misuse). For these individuals, early interventions are more appropriate.
- Where early interventions have not been successful, specialised treatment services may be indicated for individuals with lower levels of problem severity.

**Desirable features of treatment services:**

- Treatment services must be adapted to suit individuals, vulnerable groups and in some cases, target communities.
  
  No single treatment programme is appropriate to all individuals, families, target groups or communities. Treatment programmes need to be service user centred and adapted to meet diverse needs.
More specifically, treatment needs to be age-appropriate (i.e. adapted to meet the developmental needs of children in specific age groups, and the needs of older persons), gender-sensitive and culturally appropriate (i.e. linguistically appropriate and sensitive to cultural diversity).

- **Internationally accepted principles of effective treatment should be adhered to.** While recognizing that internationally-developed treatment models need to be adapted to suit the South African context, principles of effective treatment should always be adhered to. These principles are outlined in Box 2.

- **Treatment services should be accessible**
  Treatment services should be readily accessible to those who seek them. Treatment programmes should strive to limit barriers to treatment such as lengthy waiting lists, high costs, and negative perceptions about the effectiveness of treatment.

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**Box 2**

**Principles of effective treatment**

- No single treatment is appropriate for all individuals
- Treatment needs to be readily available
- Effective treatment attends to multiple needs of the individual not just his/her substance use
- An individual’s treatment plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness
- Counselling (individual and/or group) and other behavioural therapies are critical components of effective treatment
- Medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies
- Dependent or abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way
- Medical detoxification is only the first stage of treatment and by itself does little to change long-term substance use
- Treatment does not need to be voluntary to be effective
- Possible substance abuse during treatment must be monitored continuously
- Treatment programmes should include assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counselling to help patients modify or change behaviour that place themselves or others at risk of infection
- Recovery from substance dependence can be a long-term process and frequently requires multiple episodes of treatment

The National Institute of Drug Abuse, NIH 00-4180
Treatment services in South Africa:

In South Africa, treatment is either voluntary or statutory and includes detoxification, inpatient, outpatient and community-based services, as well as aftercare and reintegration services. These services are discussed, below:

5.3.1. Detoxification

What is detoxification?

- When a person uses substances frequently, their body adapts to the drugs so that higher doses are required to get the same effect or if they continue to use the same amount, the drugs begin to have a diminished effect. This is called tolerance.
- If they stop using the substance, they may experience withdrawal symptoms.
- Detoxification is often the first step of treatment, which then allows the addict to engage in the second and most important step of treatment, namely treatment for relapse prevention.
- Detoxification involves a graded and controlled reduction in tolerance, thereby minimizing unpleasant withdrawal symptoms.
- Detoxification is a medical process and should only be undertaken by qualified medical personnel.

When is detoxification indicated?

- Detoxification is indicated when withdrawal from a substance is dangerous (e.g. alcohol or benzodiazepine withdrawal)
- Detoxification is indicated where withdrawal is highly uncomfortable, thus predisposing the individual to relapse (e.g. opioids).

Desirable features of detoxification services:

- Should be an integrated part of treatment
  Detoxification should ideally be an integrated part of treatment. This is not always possible, because many service providers are NGOs or FBOs, which are often not able to afford the required medical cover. In these cases, detoxification should be offered by primary healthcare facilities, supported by district and regional hospitals or by registered private hospitals.
• **Detoxification should always be followed by a more comprehensive treatment programme**
  Detoxification is not the entire treatment for substance use disorders and should always be followed by an inpatient or outpatient programme. It should be timed so that the individual engage in their treatment programme as soon as possible after detoxification. In cases where the service user attends an outpatient programme, detoxification should be delayed until the service user has engaged in the programme.

• **Detoxification requires medical personnel and medical facilities**
  Treatment centers that detoxify their own service users should have adequate medical cover by staff with experience in the field of detoxification and medication should only be administered by trained medical staff. Only safe, internationally recognized, evidence based treatment protocols should be used. Centers should have adequate facilities for the safe storage of medication and should have the necessary resuscitation instruments and training.

**Action steps:**

*Treatment services that provide detoxification should have*

- Adequate and appropriate medical cover (i.e. 24-hour nursing cover)
- Resuscitation back-up
- Registered nurses or medical practitioners to administer medication
- Use safe, internationally recognised, evidence based treatment protocols
- Safe storage facilities for medication

*Treatment services that do not provide detoxification*

- Should ensure that they have an arrangement to ensure that their service users are safely detoxified prior to attending the programme.

*Healthcare facilities that provide detoxification should ensure that*

- They use safe, internationally recognised, evidence-based treatment protocols
- Staff are adequately trained to provide safe detoxification
- Service users are provided with access to inpatient or outpatient treatment services immediately following detoxification.
Entities responsible for detoxification services:

- Department of Health
- In and outpatient treatment services that provide detoxification
- Private hospitals.

5.3.2. Inpatient Treatment

In South Africa, a range of inpatient treatment services are available which vary in duration; the type of treatment model used; the experience, skills and qualifications of service providers; and the kinds of populations served. While some facilities do use evidence-based treatment models, many do not. This contributes to community perceptions that treatment does not work. In addition, while many service providers have professional qualifications, many facilities rely heavily on “support counselors” and “recovery assistants”, who generally are individuals who have been through treatment themselves, but have no counseling qualifications, and few counselling skills.

What is inpatient treatment?

- Inpatient treatment programmes provide a 24-hour group living environment for four or more individuals while providing for or arranging for the provision of specialized treatment for substance use disorders.
- Inpatient treatment involves the provision of structured, professional, 24-hour therapeutic care that is more intensive and restrictive than that provided in outpatient settings.
- Inpatient treatment programmes for substance use disorders include hospital-based programmes, psychiatric hospital services, and stand-alone residential treatment facilities.
- In South Africa, inpatient treatment for substance use disorders varies from intensive 6 week and 21-28 day programmes, which may or may not be followed by less intensive inpatient treatment in different facilities that last for anything from 3 to 12 months or more, and generally consists of providing service users with a sheltered living environment as well as some group and individual therapy (know as secondary care, tertiary care, halfway houses and satellite houses); to programmes that offer treatment in the same facility for 3, 6, 9 and sometimes 12 months and more.
When is inpatient treatment appropriate?

- Inpatient treatment services are most appropriate for individuals with a substance dependence disorder.
- Inpatient treatment services are also appropriate for individuals with a substance abuse disorder who have failed at a lower level of care (e.g. outpatient treatment).
- Inpatient treatment services are especially indicated for individuals with little/no support for treatment, with co-occurring psychiatric disorders, with complex substance-related health problems that require management, and who have had multiple attempts at treatment.
- Inpatient treatment services are not indicated for individuals with low levels of problem severity (e.g. “recreational” drug users or individuals with substance misuse).
- The service user does not have to be motivated to enter treatment in order for the treatment to be successful. Treatment readiness and motivation to change can be developed during the course of treatment.

Desirable features of inpatient treatment services:

- **Inpatient treatment services must be adapted to suit individuals, especially individuals from vulnerable groups.**
  Inpatient treatment should be age-appropriate (i.e. adapted to meet the developmental needs of children in specific age groups), gender-sensitive and culturally appropriate (i.e. linguistically appropriate and sensitive to cultural diversity).

- **Internationally accepted principles of effective treatment should be adhered to.**
  As mentioned earlier, these principles are outlined in Box 2.

- **South African norms and standards for inpatient treatment services should be adhered to.**
  These norms and standards outline the minimum requirements for inpatient substance abuse treatment facilities.
Inpatient treatment services should only be provided by suitably qualified personnel as stated in the Norms and Standards for Inpatient Treatment Services

In South Africa, there is considerable variation in who provides inpatient treatment services. As substance use disorders require specialized treatment services, all staff (whether they have had their own substance-related problems or not) should hold recognized qualifications and be registered with a professional body. These qualifications should include training in ethics, basic counselling skills, substance abuse treatment models, the etiology of substance use disorders, and other conditions related to substance use disorders.

**Action steps:**

Inpatient services should:

- Only be provided by licensed, registered facilities;
- Be regularly monitored to ensure that minimum norms and standards are adhered to. Where norms and standards are not adhered to, treatment facilities should be given an opportunity to meet these norms;
- Provide a safe environment for their service users. This includes the absence of alcohol, illicit drugs and weapons on the premises;
- All staff providing inpatient treatment services should be qualified to provide specialized substance abuse treatment services. At the very minimum, staff must have a recognized counselling qualification and completed ethics training;
- Related to this, all staff that provide individual, group, educational or support services to service users must receive regular supervision from an external supervisor (e.g. a psychiatrist, psychologist or social worker);
- Assessment and counselling services should only be provided by registered professionals;
- All inpatient facilities should have registered nurses available to monitor and care for service users;
- A comprehensive assessment should be completed within the first 7 days of admission and a treatment plan written based on the assessment, identifying clear measurable goals of treatment. This should be conducted by a suitably qualified professional and placed in the service user's file;
- Facilitate access to detoxification services (where needed) by suitably qualified and trained personnel;
- Facilitate access to mental health services (where needed) by mental health professionals;
- Treatment models used in inpatient treatment facilities should be evidence-based. Evidence-based models include, but are not limited to 12-step facilitation therapy, cognitive-behavioural models, including relapse prevention; motivational enhancement therapy, and eclectic models such as the Matrix Model.
- Inpatient services should provide the service user with a comprehensive menu of services that target their individual needs. These include the following:
  - Education for the service user and their family about substance use disorders and related health and social problems;
  - Life and social skills training (such as decision-making, conflict resolution, and assertiveness training);
  - Activities that improve problem recognition/denial, increase readiness for treatment and enhance motivation for change among service users;
  - Rapport-building activities that enable the service user to develop a therapeutic relationship with the treatment staff (which facilitates service user engagement and retention in treatment). To facilitate this, the service user should be assigned one counsellor who will be responsible for his/her care;
  - Relapse prevention activities
  - Family services such as family therapy and family education services;
  - Harm reduction activities (e.g. addressing sexual risk behaviour among service users, including testing for HIV and other STIs, hepatitis B and C, and TB);
  - Facilitate access to continuing care services such as aftercare services, self-help/mutual-help support groups.
- Provide special services for female service users, including trauma-related services, special services for pregnant women (including parenting and baby care), women-only groups (where possible), and match female service users with female counsellors;
- Provide mental health services so that patients with co-occurring psychiatric disorders/co-morbidity can be treated in an integrated way;
• Provide age-appropriate services for young people. Treatment models need to be adapted to meet the developmental needs of young people and should actively involve the family/caregivers in the treatment process. Young people should receive separate services from adult service users and should not be placed in adult groups.

• Provide appropriate services for older persons.

**Entities responsible for inpatient treatment services:**

These include:

- The National Department of Social Development
- Provincial Department of Social Development (responsible for registering and overseeing all inpatient facilities);
- The National and Provincial Departments of Health (focusing specifically on detoxification and mental health service provision for service users with substance use disorders)
- State inpatient substance abuse treatment facilities;
- Registered private for profit and not for profit inpatient substance abuse treatment facilities
- Private psychiatric clinics providing inpatient substance abuse treatment services
- Health and allied professionals (such as social workers) working in registered inpatient substance abuse treatment services.
5.3.3. Outpatient Treatment & Community Based Programmes

What is outpatient treatment?

- Outpatient treatment programmes provide non-residential specialized treatment services for individuals, families or groups with substance use disorders.

- Outpatient treatment involves the provision of structured, professional, therapeutic care. It is less structured, intensive and restrictive than inpatient treatment and allows participants to return to their usual living environment after each counselling/therapy session. Individuals can thus continue with their employment, education and family responsibilities.

- In South Africa, outpatient treatment programmes for substance use disorders vary in intensity and include day-patient services (where service users attend a facility on a daily basis), intensive outpatient services (where services are provided 3-5 times per week), and less intensive options where service users attend a facility 1-2 times per week.

- Generally these services are provided in stand-alone outpatient facilities, but can also be provided as part of outpatient services at in-patient treatment facilities, psychiatric facilities and other general healthcare facilities.

- As outpatient facilities are often located within specific target communities they are also sometimes referred to as community-based treatment programmes. As such, they are often more accessible than inpatient services.

Box 3: Key points of out-patient draft Norms & Standards

Prevention
- Early intervention
- Treatment (including court mandated patients)
  - Prevention
  - Early intervention
  - Treatment (including court mandated patients)
  - Treatment protocols
  - Patient/Service user assessment
  - Appropriate placement
  - Individualized treatment planning
  - Structured treatment programmes and daily activities
  - Release, readmission and aftercare
  - Family therapy and support and involvement counselling
  - Vulnerable Groups such as children, people infected and affected by HIV/AIDS, women, the elderly etc
  - Pharmacotherapy and medical care
  - Detoxification

Treatment Centre Management
- Environment and amenities
- Legal status
- Financial management and planning
- Service improvement and monitoring
- Data collection and reporting Document management procedures and protocols
- Human resources management
- Staff qualifications and competencies
- Staff development
- Ethics and staff conduct:
  - Clinical/Case supervision:
When is outpatient treatment appropriate?

Outpatient services are appropriate for adults and adolescents. Some of the criteria used to determine whether persons are appropriate for outpatient services include the following:

- No signs or symptoms of withdrawal, or withdrawal can be safely managed in an outpatient setting;
- Health conditions, if present, are sufficiently stable to allow the service user to participate in outpatient treatment;
- The service user’s mental status does not interfere with his/her ability to understand the information presented and participate in the treatment process;
- The service user expresses a willingness to participate in treatment;
- The service user’s significant others and/or work environment are supportive of the recovery effort, adequate transportation is available, and outpatient facilities are easily accessible.

Desirable features of outpatient treatment services:

- Outpatient treatment services must be adapted to suit individuals, with sensitivity shown to gender, age, cultural, religious, and intellectual differences. Outpatient treatment should be age-appropriate (i.e. adapted to meet the developmental needs of children in specific age groups), gender-sensitive and culturally appropriate (i.e. linguistically appropriate and sensitive to cultural diversity).

- Wherever possible, outpatient treatment services should be community-based and easily accessible.
  In other words, outpatient services should be located in target communities with high levels of substance-related need, should be relatively accessible to members of these communities in terms of transport and costs, and programme content should be adapted to be contextually relevant to the specific community.

- Internationally accepted principles of effective treatment should be adhered to.
  As mentioned earlier, these principles are outlined in Box 2.
- **South African norms and standards for outpatient treatment services should be adhered to.**

These norms and standards outline the minimum requirements for outpatient substance abuse treatment facilities (see Box 3).

- **A service user-centred approach should be adopted**

The service user should be the focus of treatment and should be fully involved in treatment planning and goal setting.

- **Outpatient treatment services should only be provided by suitably qualified personnel.**

In South Africa, there is considerable variation in who provides outpatient treatment services. As substance use disorders require specialized treatment services, all staff (whether they have had their own substance-related problems or not) should hold recognized qualifications. These qualifications should include training in ethics, basic counselling skills, substance abuse treatment models, the etiology of substance use disorders, and other conditions related to substance use disorders. Even though outpatient services are of lower intensity than inpatient services, these services still need to be provided by well-trained and skilled staff who understand substance use disorders.

**Action steps:**

Outpatient services should:

- Only be provided by licensed, registered facilities;
- Be regularly monitored to ensure that minimum norms and standards are adhered to. Where norms and standards are not adhered to, treatment facilities should be given an opportunity to meet these norms;
- All staff providing outpatient treatment services should be qualified to provide specialized substance abuse treatment. At the very minimum, staff must have a recognized counselling qualification and training in ethics;
- All staff that provide individual, group, educational or support services to service users must receive regular supervision from an external supervisor (e.g. a psychiatrist, psychologist or clinical social worker);
• Assessment and counselling services should only be provided by registered professionals;
• The service user should be comprehensively assessed and a treatment plan written based on the assessment;
• Treatment models used in outpatient treatment facilities should be evidence-based. Evidence-based models for outpatient treatment include cognitive-behavioural models, such as relapse prevention; motivational enhancement therapy, 12-step facilitation, and the Matrix Model for outpatient treatment services.
• Outpatient services should provide the service user with a comprehensive menu of services that target their individual needs. These include the following:
  • Education for the service user and their family about substance use disorders and related health and social problems;
  • Life and social skills training (such as decision-making, conflict resolution, and assertiveness training);
  • Activities that improve problem recognition/denial, increase readiness for treatment and enhance motivation for change among service users;
  • Individual or group counselling services that address substance use issues such as craving, triggers and relapse prevention;
  • Family services such as family therapy/counselling and family education services;
  • Harm reduction activities (e.g. addressing sexual risk behaviour among service users, including testing for HIV and other STIs, hepatitis B and C, and TB);
  • Facilitate access to continuing care services such as aftercare services, self-help/mutual-help support groups.
• Provide special services for female service users, including trauma-related services, child care, and match female service users with female counsellors;
• Provide age-appropriate services for young people. Treatment models need to be adapted to meet the developmental needs of young people and should actively involve the family/caregivers in the treatment process. Young people should receive separate services from adult service users and should not be placed in adult groups.
Entities responsible for outpatient treatment services:

These include:

- The National and Provincial Departments of Social Development (responsible for registering and overseeing all outpatient facilities);
- State substance abuse treatment facilities;
- The Department of Health (focusing specifically on detoxification and mental health service provision for service users with substance use disorders);
- Local Government departments of Health and Social Development;
- Registered private for profit and not for profit substance abuse treatment facilities;
- Private psychiatric clinics providing out-patient substance abuse treatment services;
- Health and allied professionals (such as social workers) working in NGOs and CBOs providing registered substance abuse treatment services.

5.3.4. Statutory Treatment, Alternative Sentencing & Diversion Options

What is Statutory Treatment?

Some offenders with drug related crimes are given alternative sentencing, which means that the individual is sentenced to treatment rather than a correctional facility. There is no formal Drug Court system in South Africa and alternative sentencing to treatment programmes for individuals who have committed substance abuse related crimes is often at the discretion of the magistrate. Most individuals are sentenced to state inpatient treatment facilities. These facilities are discussed in section 5.3.2.

Treatment does not need to be voluntary to be effective. External factors can provide strong motivation to utilize treatment services. These external motivators include sanctions or enticements in the family, employment setting and criminal justice system which can increase treatment retention rates and treatment outcomes.\(^\text{16}\)

Individuals can also be committed to a treatment institution by their families with supporting clinical reports; these statutory committals are usually to private in-patient centres.
There is however a gap in terms of correctional facility-based services, with little (if any) substance abuse treatment services being provided for offenders within the correctional service settings.

**Desirable features of alternative sentencing services:**
Treatment services are discussed in Sections 5.3.1 & 5.3.2, and they do not change for statutory patients.

**Diversion options for substance abusing offenders:**
Individuals are not sentenced to diversion programmes; they voluntarily elect to be diverted out of the Criminal Justice System and agree to complete a programme. Should they not be compliant they can be taken back to court and the legal process can continue. Diversion programmes are regulated by the Department of Social Services, but the intervention itself is overseen by the Department of Justice. The same principles for primary prevention and early intervention apply as discussed above. Diversion options are particularly suitable for young people.

**Action steps:**
- Court support, e.g. through Reception Assessment and Referral Centres;
- Specialised education for prosecutors, magistrates, probation officers and other relevant court officials.

**Entities responsible for court mandated, Alternative Sentencing and Diversion services:**
These include
- The Department of Justice and Constitutional Development;
- The Department of Social Development (including probation services);
- Registered inpatient substance abuse treatment facilities;
- Registered out-patient substance abuse treatment facilities;
- The Department of Health (focusing specifically on detoxification and mental health service provision for service users with substance use disorders);
- Private psychiatric clinics providing inpatient substance abuse treatment services;
- Health and allied professionals (such as social workers) working in NGOs and CBOs providing substance abuse treatment services/diversion programmes.
5.4. Aftercare, support & reintegration services

For many individuals, particularly those with substance dependence, detoxification and formal treatment are only the beginning of the recovery process, with aftercare and ongoing support and reintegration services being an essential component of successful interventions. Aftercare is also termed continuing care services.

What is aftercare?

- Aftercare services provide continuing support and intervention services to individuals who have completed substance abuse treatment;
- These ongoing services are of lower intensity than either inpatient or outpatient treatment;
- Aftercare services aim to provide individuals with additional tools that equip them to maintain their treatment gains, including remaining alcohol and/or drug free, avoiding relapse, and rebuilding their lives and re-integrating into society;
- As such, aftercare services may include the following components: low intensity family services, ongoing mental health services, ongoing low intensity relapse prevention and skills training services, and social support services;
- Aftercare services can be provided in individual or group formats, although in South Africa these services typically occur in groups.
- In South Africa, aftercare services are provided in both formal treatment settings (typically by service providers who also provide inpatient or outpatient settings) as well as by the lay sector, specifically self-help/mutual-help organizations such as Alcoholics Anonymous and Narcotics Anonymous.

When is aftercare/continuing care appropriate?

- Aftercare services are indicated for individuals who have already completed a treatment episode.
- Aftercare is not appropriate for individuals who need more intensive services who have not yet accessed treatment.
Desirable features of aftercare/continuing care services:

- **Allow service users to interact with other service user/families/communities.**
  This allows service users to develop new social networks that are substance-free and facilitates the development of positive sources of *social support*. This also promotes group cohesion. The maintenance of relationships with other recovering people can maintain abstinence.

- **Allow service users to share long-term sobriety experiences.**
  Service users with long periods of abstinence from alcohol/drugs can act as mentors and sources of support for service users who are relatively new in their programme. Aftercare is a forum in which service users may explore successes, obstacles, and day to day issues that confront them, receiving feedback and support from the group facilitator and other participants.

- **Aftercare/continuing care programmes must be tailored to meet the individual service user’s needs.**
  Aftercare programmes should provide services that continue to target the individual’s needs, as outlined during the initial assessment process.

- **Aftercare/continuing care programmes must be structured.**
  These programmes should be goal-directed, activities should be structured, and the programme content should be structured around addressing specific needs.

- **Aftercare services should only be provided by suitably qualified personnel.**
  Formal aftercare services that involve continued individual/group counselling services need to be run by suitably qualified professionals (e.g. psychologist or clinical social worker). These professionals can be assisted by individuals in recovery (see guidelines) or support counsellors. The exception to this is the self-help/mutual-help organizations (such as AA), which are run by people in recovery for people in recovery.
**Action steps:**

Aftercare services should:

- Be tailored to the individual’s needs
- The counsellor in these programmes takes on more of a monitoring and case management function
- Halfway houses and sober living environments that provide residential aftercare and support services need to meet all health codes and safety standards and should be registered with the Department of Social Development
- These halfway houses should provide safe environments for service users that are free from alcohol and drugs and supervised by a suitably qualified person on a 24-hour basis
- Aftercare for women needs to address the challenges of maintaining treatment gains if the spouses/partner continues drinking.
- Aftercare for adolescents must address the challenges of maintaining treatment gains if peer networks are using alcohol and/or drugs.
- Aftercare/continuing care programmes must be structured. Issues addressed in these programmes typically include:
  - Intrapersonal issues
  - Interpersonal dynamics (e.g. relationship and marital issues)
  - Environmental factors (e.g. vocational rehabilitation, finding work, securing safe housing and a sober living environment)
- Formal aftercare services should also facilitate access to self- and mutual-help organisations. These organisations provide service users with ongoing support for abstinence and are described below.
**What are self-help/mutual-help support groups?**

The most common self-help/mutual help organisations are the 12-step support groups. These groups are based on the principles of Alcoholics Anonymous\textsuperscript{17}, and are found worldwide. These community-based groups provide support for the person with the alcohol/drug problem, and derivates of these groups provide support services for families affected by alcohol and/or drugs (see Box 4). All 12-step groups run autonomously through their world service organisations and South African Regional and Provincial Area Offices; they have literature in four South African languages, standard meeting formats, are non-religious, community-based and they are free of charge.

Several studies have demonstrated that service users involved in a 12-Step support group either during or post-treatment display better treatment outcomes than service users without this 12-Step involvement.\textsuperscript{18} Internationally, involvement in community-based self-help support groups for people with alcohol and drug problems is believed to be an important component of treatment and aftercare.\textsuperscript{12}

| Box 4 |
|-----------------|--------------------|
| **Alcoholics Anonymous (AA)** | for people who think they have a drinking problem and have a desire to stop |
| **AlAnon Family Groups** | for people who have a family member or friend who has a problem with alcohol |
| **Alateen** | for teenagers whose parents drink too much |
| **Narcotics Anonymous (NA)** | for people who have a problem with drugs and have a desire to stop |
| **NarAnon Family Groups** | for people who have a family member or friend who has a problem with drugs |

Apart from these 12-step support groups, there are also other support groups run by faith based organisations such as Christian Action for Dependents (CAD) and Alcoholics Victorious; as well as secular organisations such as Toughlove.
Entities responsible for aftercare, continuing care and support groups

These include:

- The National and Provincial Departments of Social Development (responsible for registering and overseeing all facilities).
- Registered in- and out-patient substance abuse treatment facilities providing aftercare services.
- Halfway houses and sober living environments that as yet do not have to be registered, but that do provide aftercare, reintegration and support services.
- NGOs, CBOs and FBOs providing aftercare and support services including 12-Step self-help/mutual-help groups, run by their regional and provincial area offices.

5.5. Harm Reduction

What is harm reduction?

Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.

Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

However, Harm Reduction Coalition (HRC) considers the following principles central to harm reduction practice. 19

- Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
• Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use - as the criteria for successful interventions and policies.

• Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

• Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

• Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.

• Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

• Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

*When is harm reduction appropriate?*

For people who cannot or will not stop using drugs and alcohol, harm reduction strategies and interventions are particularly suitable. Harm reduction fits firmly alongside drug use prevention, drug treatment and law enforcement as an approach for tackling societal use of drugs.

*Desirable features of harm reduction*

Harm reduction is a client directed, strengths based approach to working with someone who uses drugs. It does not expect an individual to make unrealistic changes in lifestyle, but sets pragmatic goals a person can see immediate positive results.
Entities Responsible for Harm Reduction

- The National Department of Social Development together with:
- The Department of Health
- Provincial Departments of Social Development
- Local Government departments of Social Development and Health
- Health, social services and allied professionals working in treatment centres, NGOs and CBOs who have been trained in harm reduction techniques.

5.5. Management of drug treatment practices

The following guidelines should steer drug treatment practices:

- All treatment facilities (whether inpatient, outpatient, halfway house or aftercare) must be registered with the Department of Social Development.
- All treatment facilities (whether inpatient, outpatient, halfway house or aftercare) must at all times be compliant with the South African Constitution, and South African laws and regulations governing the provision of health, including mental health, and social services. They must also comply with local laws and by-laws regarding business permits and health and safety regulations. (See Appendix A)

Corporate Governance

- All non-government treatment facilities (whether inpatient, outpatient, halfway house or aftercare) must be registered legal entities and compliant with the Companies Act 61 of 1973 (as amended), Non-Profit Organisations Act 71 of 1997 (as amended) if applicable, Income Tax Act 36 of 1996 (as amended) and Value Added Tax Act 89 of 1991.

- Private organisations
  These are companies registered under the Companies Act 61 of 1973 (as amended) and governed according to their Articles of Association and other founding documents. They could be either Close Corporations (cc) which are small private partnerships or individuals; or Public Limited Companies (plc) where the management is undertaken by a board of directors who are paid for their services. In both cases any profits are distributed amongst members or shareholders.
• **Non-Profit Organisations**
  Registration under the NPO Act is voluntary, but to be eligible an organisation must meet certain governance criteria, some of which are:
  - It is established for a public purpose,
  - It does not distribute income or property to members or officers except for “reasonable compensation for services rendered”;
  - It is not “an organ of state”; and
  - It includes certain internal governance provisions in its constitution.\(^20\)

An organization seeking NPO status must apply to the Department of Social Development, Directorate for Non-profit Organisations. If the organisation qualifies, the Directorate issues a certificate and registration number. To retain this status, the organization must submit narrative and financial reports to the Directorate annually. The following organisations are eligible for NPO status:

- Non-Governmental Organisations (NGO)
- Community Benefit Organisations (CBO)
- Faith Based Organisations (FBO)
- Voluntary associations not for profit
- Trusts
- Section 21 Companies

• **Voluntary Association** requires that three or more people agree to achieve a common objective, other than making profits. It must be structured to continue despite changes in membership, it must be able to hold property distinct from its members, and no member can have any rights to the property or assets of the association. All of these policies, as well as policies regarding management and financial and operational structures are written down in a constitution.\(^21\) Other than the Director, staff members of the organisation do not sit on the management board. The management board is the governing body responsible for the overall operation of the association and ensures compliance with all laws and registration standards.
• **Section 21 Company.** The South African Companies Act provides for an “association not for gain in terms of Section 21”, commonly called a “Section 21 Company”. A Section 21 Company must have at least seven members and must register with the Registrar of Companies, as well as be compliant with all laws regulating business practice, employment, and taxation. Section 21 Companies have legal personality and therefore offer limited liability to their member and management board/directors.

The company’s Articles of Association are the founding documents that drive the corporate governance procedures. If a Section 21 Company registers as an NPO, the constitution is aligned with the Articles of Association.

The directors/management boards of Section 21 Companies do not get paid for their services, and there are no profits/dividends for distribution to members. Other than the Director, staff members of the organisation do not sit on the management board. The management board is the governing body responsible for the overall operation of the organisation and ensures compliance with all laws and registration standards

• **Trusts** are governed under the Trust Property Control Act\(^22\) and a trust can be established for private benefit or for a charitable purpose, depending on the trust deed. The Master of the Supreme Court has jurisdiction over a trust, he/she holds the trust instruments, oversees the appointment of trustees, and polices the trustees' performance with respect to the trust property. A trust does not have separate legal personality, though it may enter into contracts in its own name if the trust deed so allows. All rights and responsibilities vest collectively in the Trustees.
Registration and registration renewal

- Registration of in-patient and out-patient treatment centres and community-based programmes should be legislated and guidelines provided on the requirements and procedures for such registration. Guidelines should be provided on how members of the public and service users can make formal complaints and report critical incidents.

- All treatment facilities (whether inpatient, outpatient, halfway house or aftercare; and irrespective of level of care) shall be registered with the Department of Social Development as a substance abuse treatment facility. This registration should involve the completion of application forms that include, at a minimum:
  - Facility philosophy, goals and objectives
  - Admission procedures, including duration of treatment
  - Treatment models and activities
  - Discharge policies (including discharge during a treatment episode for infringement of programme rules)
  - Follow-up policies
  - Information about the management structure/governing body
  - Organisational structure (staffing and job descriptions)
  - Use of other community resources

- Approved minimum norms and standards (as well as current regulations governing treatment facilities) should guide the development of uniform procedures for the registration and management of substance abuse treatment practices.

- An investigation of a substance abuse treatment programme for initial registration shall occur within a 3-month period of receipt of the application form, or 3-months prior to registration renewal. Registrations need to be renewed on a two yearly basis.

- No service users can receive services at facilities that are unregistered or until registration has been approved.
• The DOSD may make visits to treatment facilities (whether inpatient, outpatient, halfway house or aftercare; and irrespective of level of care), or conduct investigations, as it deems necessary. These investigations may include, but are not limited to, inspections of:
  • The organisation’s founding documents and financial records
  • Staff policies and records (including assessments, continued professional development, supervision etc)
  • Programme records and documentation
  • Interviews with staff, service users or concerned members of the public.
  • The DOSD will give written feedback to the facility regarding the inspection within three months.

• All substance abuse services should be assessed and monitored by the DOSD annually.

• Registration may be denied or revoked for one of the following reasons:
  • Violation by the facility or any of its staff of any South African law governing the regulation of treatment facilities
  • Permitting, aiding or abetting the commission of an unlawful act
  • Conduct or practices found to be harmful to the welfare of service users
  • Deviation by the facility from the plan of operation for which the facility was originally granted registration, which affects the character, quality or scope of services provided to service users
  • Submission of false information to the DOSD

• Mechanisms and procedures to be developed whereby the public can report unregistered centres, violations, complaints and critical incidents.

**Occupational Health and Safety Regulations**

• All treatment facilities (whether inpatient, outpatient, halfway house or aftercare: and irrespective of level of care) shall abide by all statutory health and safety regulations including; fire clearance, food service, personnel requirements, physical environment and personal rights; as well as all occupational health and safety by-laws.
Insurance and professional indemnity

• All treatment facilities (whether inpatient, outpatient, halfway house or aftercare; and irrespective of level of care) shall comply with the statutory insurance requirements with regard to service users' health and safety.

• All professionals working in the field should carry professional indemnity insurance.

Quality Assurance System and Procedures Manual

• All treatment facilities (whether inpatient, outpatient, halfway house or aftercare; and irrespective of level of care) shall have a Quality Assurance System which includes a procedures manual that clearly and accurately reflects programme activity. The organisation’s management board/governing body shall annually review and update the operating procedures manual. This manual must contain:
  • Admission criteria
  • Intake procedure including assessment and programme duration
  • Programme content
  • Discharge and termination criteria
  • Confidentiality procedures
  • Follow-up procedure after termination
  • Organizational structure, including staffing
  • Aftercare procedures
  • Service user/patient rights
  • Complaints/grievance, disciplinary and critical incidents procedures for service users and staff

Personnel

• All treatment facilities (whether inpatient, outpatient, halfway house or aftercare; and irrespective of level of care) shall be compliant with Basic Conditions of Employment Act 1997 and Labour Relations Act 1995:

• Staff, volunteers and students who are not South African citizens require the relevant work and residency permits; and the onus is on the management board to ensure that these are in order.
• There should be written job descriptions for all part- or full-time administrative, therapeutic and voluntary positions; and these job descriptions must comply with the relevant legislation as well as the minimum norms and standards for treatment facilities. They should include:

  • Job title, tasks and responsibilities
  • Skills, knowledge, training, education and experience required for the job

• Staff, volunteers and students who have a criminal record are required to disclose this to the management board and any relevant professional body; and the onus is on the management board to make decisions regarding conditions of employment for these individuals. Failure to disclose could lead to sanctions for both the individual and the facility.

• The management board is responsible for ensuring that the organisation/facility is staffed by competent staff members who are registered with their professional bodies, such as the South African Health Professions Council and/or the South African Council for Social Service Professions.

• “Addiction counsellors” who are not registered with the South African Health and Social Service Professions Councils, should be trained, accredited and work under the supervision of professional staff.

  o Registration with international bodies governing “addiction counsellors” in the UK, USA\textsuperscript{24} or elsewhere, does not automatically afford the counsellor South African registration.

• A South African national body for the registration, training and continuing professional development, and regulation of all addiction professionals needs to be formed as a matter of urgency. This body would also be responsible for the requirements and certification of all “Addiction Counsellors”.
• All clinical staff including ‘counsellors’ and registered professionals who have had their own substance abuse problems should follow the guidelines set by South African legislation and by international agencies regarding minimum periods of uninterrupted sobriety/clean time. For instance, Alcoholics Anonymous recommends that prior to studying or being employed in the substance abuse field, members have “five years of good uninterrupted sobriety”\(^{25}\), Narcotics Anonymous follows suit, and international and National Accreditation Bodies also recommend the same.

• All staff members including clinical staff and counsellors should be evaluated according to their job description on an annual basis. Staff members should be encouraged to review and comment on the evaluation.

• All staff members including clinical staff and counsellors should remain current in their knowledge and training by attending courses, training workshops and similar as a form of CPD (continuing professional development)

**Accessibility**

• Treatment services should be accessible (ie affordable, logistically accessible, and available) and of good quality, as well as gender and culturally appropriate.

• Treatment programmes can be funded at provincial level to ensure their availability and accessibility to vulnerable groups, as well as being gender and culturally sensitive.

**5.6. Research and information management**

Research and information management play an important role in guiding policy development and implementation. More specifically, these activities help ensure that policies are responsive to local and international information on substance abuse and that services are guided by information on evidence-based practice.

South Africa is reasonably well resourced in terms of research infrastructure, with researchers at various research councils (e.g. the Medical Research Council, Human Sciences Research Council and the Council for Scientific & Industrial Research), university-based researchers and NPOs becoming involved in conducting research.
The role of the National Department of Social Development:

Some of the challenges facing the National Department of Social Development include (i) how to access both local and relevant international research and (ii) how to ensure that this research is translated into a comprehensible and usable format to its own staff; officials working in provincial departments of social services and other relevant government departments; and persons working for NGOs, CBOs, and FBOs.

Accessing local and international research:

The National Department of Social Development can improve access to local and international substance abuse research by:

- Hosting biennial substance abuse summits in conjunction with the Central Drug Authority.

These summits can serve as platforms for the presentation of local and international research on substance abuse epidemiology, interventions and other relevant topics.

<table>
<thead>
<tr>
<th>Box 5: Recommended fields for an searchable database on South African substance abuse research</th>
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</thead>
<tbody>
<tr>
<td><strong>Study type</strong></td>
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<tr>
<td><strong>Principal Investigators</strong></td>
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<tr>
<td><strong>Funders</strong></td>
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<tr>
<td><strong>Study site(s)</strong></td>
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<td><strong>Sample characteristics</strong></td>
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<tr>
<td><strong>Aims of the study</strong></td>
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<tr>
<td><strong>Study period</strong></td>
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<tr>
<td><strong>Study abstract</strong></td>
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<tr>
<td><strong>Study outputs</strong></td>
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</table>
Facilitating the development and maintenance of a national data information system and an electronic database of current and past substance abuse research in South Africa.

This can be done directly by the National Department, or indirectly, through a sub-contract. Such a database should be searchable and should include information on a variety of fields. (See Box 6 for recommended fields).

This would help the department as well as researchers identify gaps in current research.

An example of such a database (without the links to study outputs) is the Computer Retrieval of Information on Scientific Projects (CRISP) database of federally-funded biomedical research projects, which is maintained by the US National Institutes of Health (http://crisp.cit.nih.gov/).

This should include an electronic repository (and possibly also a physical repository) of resource material such as: local and international research reports and trends, health promotion material, training materials, guidelines for evidence-based substance abuse interventions, treatment manuals, and other resource manuals.

Possible responsibilities of such a clearing house would include: maintenance of an up-to-date website (and possibly physical library); responding to requests for information; preparation and release of periodic newsletters, fact sheets and briefing documents.

This would necessitate employing appropriate information management staff with the analytic capacity to access and review local and international material and to translate it into a usable format for local audiences, including service providers.

An example of such a clearinghouse is the one maintained by the US Substance Abuse & Mental Health Services Administration (http://ncadi.samhsa.gov/).
**Funding for local substance abuse research:**

The National Department of Social Development also has an important role to play in funding substance abuse research in key areas that are unlikely to be funded without its input. The Department should also influence the substance abuse research agenda and funding priorities of other government departments (such as Health, Community Safety, Trade & Industry, and Education), other bodies likely to fund research (e.g. the National Research Foundation and the Medical Research Council), private foundations providing funding for research, and international bodies and donor agencies working in the region such as the World Health Organization (WHO) and the UN Office on Drugs & Crime. There is a need to mandate treatment and prevention agencies to provide ongoing statistical information on the characteristics of the service users they serve as a requirement of them receiving funding.

**Relevant research topics in the field of substance abuse**

Relevant research topics for funding include the following:

- **Regular national epidemiological research and local surveys to identify changing trends, patterns and types of drugs used by different communities and to establish the need for targeted prevention and treatment programmes.**
  
  This research should gather information on drug trends and related intervention needs from a variety of sources including routinely collected household and school surveys on substance use and related needs (at least every two years), surveys of sentinel population groups (e.g. stimulant and/or injection drug users in community samples), ongoing surveillance of treatment demand/utilization from substance abuse treatment centres, and key informant surveys.

- **Substance abuse intervention research to develop, implement and evaluate new interventions for the range of substance use disorders and related risks (e.g. sexual risk behaviours).**
  
  This research should be geared to identify ways in which particular kinds of drug-related harms can be prevented, eliminated, and/or reduced. It should focus on developing and testing the effectiveness of new and existing interventions in real world settings.

  Findings can be used to develop new intervention services and also to improve the quality and effectiveness of existing services.
• **Substance abuse services research** to describe current prevention and treatment systems; identify gaps and overlaps in service coverage, quality, and access; and to facilitate the design of systems-wide interventions to strengthen prevention and treatment services.

A core component of services research involves monitoring and evaluating current services (e.g. through regular audits of prevention and treatment services). This monitoring provides information on the extent to which norms and standards and evidence-based practice are followed, and can be used to guide capacity and service development efforts. Service monitoring and evaluation also helps ensure that decision-making around service planning and resource allocation is knowledge-based.

**Action steps:**

- The National Department of Social Development should directly or indirectly develop an electronic database of South African substance abuse research

- The National Department of Social Development should directly or indirectly maintain a National Clearinghouse of Substance abuse resource material. This should be in electronic format and maintained by suitable personnel with analytic and communication skills.

- The National Department of Social Development should earmark monies to fund substance abuse research and should influence the research agendas of other relevant government departments and donor agencies.

**The following research is needed:**

- Bi-annual household and school surveys that examine the prevalence of substance use, include screening tests for substance use disorders (reflecting need for services), examine perceived need for and desire for treatment, prior treatment experiences, and difficulties in accessing treatment.

- Ongoing monitoring of substance-related harms in the general population and specified sub-groups. This could include the routine collection of substance-related morbidity and mortality data, a register of substance-related crime, a register of substance-related infectious disease cases, and the routine collection of substance-related hospital admissions.
- Ongoing monitoring of treatment utilization at treatment centres (e.g. socio-demographic characteristics of people who are able to access services, types of substances used, and prior treatment history).

- Annual national audits of drug treatment centres in terms of adherence to national norms and standards. This treatment mapping exercise provides a national map of services in terms of programme content, programme staff, and evidence-based practices.

- National audits of substance abuse primary prevention programmes.

- Development and testing of innovative responses to substance use disorders (e.g. new treatment technologies).

- Prevention and treatment outcomes research that examines the effectiveness of existing services

5.7. International liaison

South Africa contributes to the global campaign against substance abuse and participates in global decision making, notably international forums such as the United Nations Commission on Narcotic Drugs, the World Health Organisation and the International Labour Organisation. South Africa also encourages bilateral cooperation around the drug problem. The country, and specifically the Department of Social Development, has entered into a number of formal agreements on drug demand reduction with countries in various parts of the world.

In 1998, with the adoption of action plans by the 20th Special Session of the United Nations on the issue of illicit production, sale, demand, trafficking and distribution of narcotic drugs and psychotropic substances, member states of the United Nations were provided with guidelines for comprehensive drug control strategies. An action plan was also adopted for the implementation of the declaration on the guiding principles of drug demand reduction. South Africa pledged its support of the action plans in 1998 and again committed itself to the action plans in 2003 during a high-level ministerial meeting of the United Nations Commission on Narcotic Drugs. The action plans are to be implemented by 2008.
The South African government places the highest priority on the fulfilment of its obligations under international drug control instruments and is a party to the following:

- Single Convention on Narcotic Drugs, 1961
- Convention on Psychotropic Substances, 1971
- United Nations Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, 1988

As a signatory to these conventions South Africa will continue to also submit to the United Nations a completed Annual Reports Questionnaire (ARQ).

South Africa’s legislation provides the necessary support for the implementation of the international drug control conventions. South Africa will also continue to participate in strategies to combat the drug problem regionally by implementing the Drug Protocol of the Southern African Development Community as well as the action plans of the African Union.

5.8. Capacity building

At present, service providers in the substance abuse prevention and treatment arenas have variable capacity to provide evidence-based services; with their substance-related knowledge, intervention skills and experience differing widely. Few health and social work professionals working in these arenas have received specialised training in substance use disorders and many “addiction counsellors” are qualified by experience only.

Moreover, many organisations rely on volunteers and lay counsellors to provide prevention, community outreach and other intervention services. However, as these volunteers often have unresolved issues with substance use, very little academic training, few counselling skills and little or no supervision, they often cause more harm than good - despite their best intentions.

Relying on untrained, unqualified and unsupervised individuals to provide complex behavioural health interventions is dangerous both to the recipients of these services as well as the community at large, especially as it hampers access to care by contributing to a perception that there is “no effective help available.”
Given this context, the Department of Social Development urgently needs to develop and support an integrated capacity-building programme for various categories of staff working in the prevention and treatment fields (including volunteers, lay counsellors, those recovering from their own substance problems, and health and social work professionals).

This capacity-building programme needs to include an accreditation process for the course content and for individuals who complete the programme. This accreditation should culminate in registration with a Board for Substance Abuse Practitioners under the Health Professionals Council of South Africa, by which all professional and non-professional practitioners in the substance abuse field working in the treatment and prevention area will be required to be registered; will be required to participate in continuous professional development activities; and will be subject to regulation, monitoring and disciplinary procedures.

This will protect both the public and other professionals working in this field against unscrupulous and unethical service providers.

**Action steps:**

**Treatment**

- In partnership with professional boards and councils, academic institutions and the South African Qualifications Authority (SAQA), develop unit standards for all training & capacity-building programmes that target volunteers, “addiction counsellors” without professional qualifications, and health and social work professionals.

- In partnership with professional boards and councils, academic institutions, the South African Qualifications Authority (SAQA) and government departments, develop a qualification framework for substance abuse counsellors in line with internationally accepted accreditation for addiction counsellors working in the substance abuse treatment field. Graphic 6 provides an overview of the 12 core competencies required of professional addiction counsellors internationally.20
graphic 6

12 core functions
of the certified counsellor:

1. Screening
2. Intake
3. Orientation
4. Assessment
5. Treatment Planning
6. Counselling
7. Case Management
8. Crisis Intervention
9. Service user Education
10. Referral
11. Record and Record Keeping
12. Consultation with Other Professionals

knowledge & skills

this area demonstrates what knowledge and skills are essential for certification ranging from ethics, human behaviour, continuum of care, counselling, case management, professional responsibility, etc. the applicant must have a minimum of 270 hours of education in the knowledge and skills area. eighty of these hours must be alcohol and drug specific - hours indicated in ( ).

1. Pharmacology (20)
2. Signs & Symptoms (15)
3. Human Development (32)
4. Counselling (133)
5. Special Populations (12)
6. Case Management (17)
7. Professional Ethics (6)
8. Any other AOD knowledge area (35)

- Develop an integrated plan for the relevant skills development of health and social work professionals providing early intervention, treatment and aftercare services to individuals with substance use disorders.

- Develop best practice guidelines for treating alcohol and other drug problems in South Africa.

- Ensure appropriate skills development for regional hospitals to manage a range of services for patients with substance use disorders including screening and assessment, diagnosis, early interventions, detoxification, and harm reduction services, with one substance abuse specialist per regional hospital.

- Review training and continued professional development of health and social work professionals in the management of patients with substance abuse problems.

- Develop capacity among general practitioners to screen and conduct brief interventions for substance use disorders. This capacity development should be aligned to continuous professional development points.27
- Further develop capacity among state social workers (e.g. intake workers and probation officers) in clinical assessment, evidence-based early interventions, and referral.

- Further develop capacity and skills of psychologists, social workers and other relevant staff in the Department of Correctional Services to conduct substance abuse screening tests, evidence-based early interventions, and referral.

- Develop a Board for Substance Abuse Practitioners with the Health Professionals Council of South Africa that serves to manage, regulate and discipline both professionals and nonprofessionals working in the treatment field. This Board should have statutory powers, should consist of national and international experts in substance abuse treatment, and should be guided by evidence-based practice and ethical principles.

**HIV/AIDS**

- Develop capacity among persons providing drug and HIV services to address HIV risk behaviour among their service users and conversely to support the development of the capacity of HIV AIDS service providers to address alcohol and other drug-related risk behaviour among their service users.

- Coordinate drug abuse treatment and HIV services among drug using vulnerable populations by the provision of confidential, routine HIV counseling and testing in substance abuse programmes and adapting VCT to be more localized, mobile, population-specific and include risk reduction counseling that focuses on HIV and drug risks.

- Build the capacity of NGOs/CBOs with potential for addressing both drug and HIV risks.

- Scale up and tailor community-based outreach to drug users in high risk areas that addresses HIV/AIDS risks and links with appropriate drug treatment and HIV/AIDS prevention, care and treatment services.
Primary prevention

- Develop best practice guidelines and minimum standards for service providers conducting primary prevention activities.

- In partnership with professional boards and councils, academic institutions and the South African Qualifications Authority (SAQA), develop unit standards for all training and capacity-building programmes that target volunteers and other persons conducting primary prevention programmes.

- In partnership with professional boards and councils, academic institutions, the South African Qualifications Authority (SAQA) and government departments, develop a qualification framework for individuals working in the primary prevention field, in line with internationally accepted accreditation for prevention workers. Both the programmes and the individuals providing these programmes should be accredited, particularly when these programmes are targeting young people (e.g. in schools).

5.9. MONITORING AND EVALUATION

The National Department of Social Development’s progress and achievement with regards to policy implementation and service delivery must be monitored and evaluated on an ongoing basis. Timely information on whether or not the policy responds to the needs of the people affected by substance abuse will allow for the policy to be reviewed and adjusted, if necessary.

To enable monitoring, the Department of Social Development should design efficient and accurate mechanisms for collecting data on (i) the impact of prevention and treatment services, as this relates to population needs for substance abuse services; and (ii) capacity development and other initiatives to improve service quality.

Indicators for monitoring the impact of prevention and treatment services

Indicators should be developed for each of the following domains:

- **Prevalence of alcohol and other drug use**
  
  This information can be obtained from regular household and school surveys, ongoing surveillance of treatment demand/utilisation, police forensic science laboratory information on drug-related seizures and cases.
This information will reflect changes (including possible decreases) in substance use trends in general and for specific sub-populations such as youth, women, and rural populations. This also reflects the size of the treatment need, with changes in need over time reflecting the impact of prevention and treatment on substance use disorders.

- **Negative consequences associated with alcohol and other drug use.**
  This information can be obtained from data on arrests for drink/drug driving, alcohol and drug-related injuries and deaths, substance abuse-related school suspensions and expulsions, alcohol and drug-related infectious diseases, alcohol and drug-related arrests, and alcohol and drug-related hospital admissions.

  Sources for this data may include the police, the criminal justice sector, the health sector, and the education sector. Monitored over time, this information will reflect changes (including possible decreases) in substance-related harms for both the general and specific population sub-groups as well as population-based needs for substance abuse services. This indirectly reflects the impact of prevention and treatment systems on the substance abuse problem.

- **Outcomes of interventions to prevent, treat or reduce the harms associated with substance abuse**
  This information can be obtained from outcome evaluations of prevention programmes, and treatment services. For treatment outcomes in particular, data should be collected from service users on abstinence from and/or reductions in substance use; changes in health; changes in psychological, social and occupational functioning; changes in quality of life; and satisfaction with treatment services.

  Other outcome indicators include treatment retention and completion. Where possible, service users should be monitored over time to determine whether these changes are sustained. This information will reflect the effectiveness of existing services.
Monitoring capacity-development and service improvement initiatives

The following areas should also be monitored:

- **Access to and quality of existing prevention and treatment services, including indicators such as waiting periods for services, barriers to service utilization, service coverage, breadth of services provided, adherence to norms and standards, and use of evidence-based practices.**
  
  This information can be obtained from regular audits/surveys of service providers working in the prevention and treatment sectors. Self-report data should be supplemented with observational data, where possible. This information will provide insight into the quality of existing services, and when monitored over time may reflect improvements in services that arise from system-level interventions and capacity-development initiatives.

- **Progress being made in terms of capacity-development.**
  
  Indicators may include the number of capacity development/training initiatives for service providers in the substance abuse field; the effect of these initiatives on service providers’ knowledge, skills, and practice; the development of guidelines and protocols for prevention and treatment practice; and the development of evidence-based manuals for prevention and treatment programmes.

  Other indicators include service providers’ access to information on evidence-based interventions and the extent to which they find it comprehensible and useful.

**Action steps:**

In order to facilitate monitoring and evaluation, the following monitoring and evaluation tools need to be developed:

- Monitoring and evaluation tools and systems for primary prevention initiatives.

- Monitoring and evaluation tools and systems for early intervention treatment and aftercare initiatives. These should include an examination of service quality issues such as access, service coverage and breadth of services.
• National outcome domains and national outcome measures for substance abuse prevention and treatment services. These can be used to guide the evaluation of services. Here South Africa can be guided by SAMHSA’s outcome domains and the WHO’s instrument for assessing substance abuse prevention and treatment systems (WHO-SAIMS).

• Monitoring and evaluation tools and systems for capacity development initiatives. These should also examine the impact of training and capacity development on practice, as well as access to and the use of substance-related information.

• In order to monitor the impact of services on substance abuse, data on indicators of population-based needs relating to substance abuse (i.e. prevalence of substance use disorders and substance-related harms in the general population and specific sub-groups) needs to be regularly collected. To facilitate this, research specified in section 5.6 needs to occur.

• To ensure accountability, findings from monitoring and evaluation should be regularly reported to parliament and the people of South Africa.

**Entities responsible for monitoring and evaluation**

These include:

• The National Department of Social Development, specifically the Ministerial Council of the Department of Social Development;

• Other government departments conducting substance-related interventions

• The National Council of Provinces;

• The Central Drug Authority;

• Independent evaluators with experience in conducting monitoring and evaluation;

• Research organizations (e.g. the MRC, HSRC, CSIR and university-based researchers);

• All private for profit and not-for-profit substance abuse service providers (providing prevention and treatment services).
References

15. South African National Department of Social Development; Draft Community Based Model Pretoria, 2006
17. Alcoholics Anonymous, Alcoholics Anonymous World Service Inc 1939
19. Harm reduction Coalition website www.harmreduction.org
23. Prevention and Treatment of Substance Abuse Bill (Draft)
24. National Association of Alcohol and Drug Abuse Counsellors (NAADAC) USA,
25. A.A. Guidelines for A.A. Members Employed in the Alcoholism Field. 5M-6/00 MG 10
Appendix A - Legislation

- National Drug Master Plan
- White Paper on Social Welfare Services
- Drugs and Drug Trafficking Act (Act 140 of 1992)
- Criminal Procedure Act (Act 51 of 1977)
- Mental Health Care Act (Act 17 of 2002)
- Medicines and Related Substances Control Act (Act 101 of 1965)
- International Co-operation in Criminal Matters Act (Act 75 of 1996)
- Institutes for Drug-Free Sport Act (Act 14 of 1997)
- National Road Traffic Act (Act 93 of 1996)
- Single Convention on Narcotic Drugs, 1961
- Convention on Psychotropic Drugs, 1971
- Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, 1988
- African Union Plan of Action for Drug Control in Africa and Programme of Action for Drugs and Crime in Africa
- Southern African Development Community Drug Control Protocol (SADC Drug Control Programme)
- United Nations Guiding Principles on Drug Demand Reduction
- National Crime Prevention Strategy
- Child Care Act (Act 74 of 1983)
- Child Justice Bill
- Probation Services Act (Act 116 of 1992)
- Domestic Violence Act (Act 116 of 1998)
- South African Schools Act (Act 84 of 1996)
- Minimum Norms and Standards for In-patient Treatment Centres
- Companies Act (Act 61 of 1973)
- Non-Profit Organisations Act (Act 71 of 1997)
- Value Added Tax Act (Act 89 of 1991)
- Other relevant legislation and policy frameworks
Appendix B - Comments from symposium

Primary Prevention

_Suggested:_

‘Minimum norms & standards for primary prevention are incorporated’.

The UNODC guidelines for South Africa are cited as well as international principles of primary prevention, we were unable to find any other minimum norms and standards for primary prevention programmes.

‘Prevention programmes must be monitored etc’ added.

This is covered comprehensively in the research section of the document, and it is assumed that service providers will monitor their own programmes.

Early Intervention:

_Notated:_

‘Definition of Early Intervention’ is not the same as that in the Policy.

This document has used the internationally understood definition. The team could find no national or international literature that supported the definition in the Policy.

_Suggested:_

‘Empathy vs Confrontation’ be changed to Empathy and Confrontation.

According to all national and international literature the lack of confrontation is one of the underpinning principles of Early Interventions.

_Developmental Confrontation and Constructive Confrontation be added and defined._

This terminology cannot be found in literature relating to Early Interventions. It is used by some South African and US service providers for a technique also called Structured Intervention. This is not an appropriate technique for Early Interventions, but is a technique used when all else has failed to get someone into in-patient treatment.
Treatment

Suggested:

Additions to Box 2
We cannot do this as these are the evidence based principles of treatment from NIDA. There are separate evidence based guidelines on what treatment should include.

That treatment facilities only be required to re-register every 5 years.
This has remained unchanged. The dynamics in treatment centres change very rapidly and therefore we would recommend if it is not possible for the Department of Social Development to manage an annual re-registration process, it should at least be every 2 years.

Noted:

Detoxification: Recommended more consultation.
The Department of Health has developed detoxification protocols. There are also international protocols which were used in this document.

What is Inpatient? Clarity needed on different tiers of treatment and halfway houses should be removed
Many private treatment centres use the terminology Primary, Secondary and Tertiary Care as well as Halfway House and Satellite House. These may or may not be owned by the same service provider and time periods are extremely fluid. The service providers who use this terminology were unable to come together with one single definition. Primary care is usually 21 - 28 days; Secondary anything from one month to 6 months; Tertiary from 1 month to 6, and satellite houses are where about 5 people pay rent to a treatment facility for staying in a ‘clean house’ with minimum monitoring and one or two groups per week for anything up to 24 months. (Definitions from service providers attached as Appendix D)

Clarification re registration of companies needed.
The DTI and SARS websites can be consulted.
Addiction Counsellor

The Draft Bill defines an addiction counsellor thus

“Addiction counsellor” means an accredited lay counsellor who has demonstrated proficiency in core addiction counselling competencies and has been duly accredited and registered by recognized training and registration body

The term ‘addiction counsellor’ is extremely fluid in South Africa. The international accrediting body for addictions counsellors and all other addictions professionals is NAADAC.

NAADAC, the Association for Addiction Professionals, is the largest membership organization serving addiction counsellors, educators and other addiction-focused health care professionals, who specialize in addiction prevention, treatment and education. With nearly 11,000 members and 46 state affiliates, NAADAC's network of addiction professionals spans the United States and the world. NAADAC's members work to create healthier families and communities through prevention, intervention and quality treatment. Established in 1990, the NAADAC Certification Commission instituted credentials specifically for alcoholism and drug abuse counselors. The three levels are:

- National Certified Addiction Counselor, Level I (NCAC I)
- National Certified Addiction Counselor, Level II (NCAC II)
- Master Addiction Counselor (MAC)

National Certified Addiction Counselor, Level I (NCAC I)

To qualify for the NCAC I certification, you must have:

- A current state certificate or license as a substance abuse counselor
- 270 contact hours of substance abuse counseling training, including six hours of ethics training and six hours of HIV/AIDS training
- Three years full-time work experience or 6,000 hours of supervised experience as a substance abuse counselor

Eligibility Requirements for National Certified Addiction Counselor Credential, Levels I
National Certified Addiction Counselor, Level II (NCAC II)
To qualify for the NCAC II certification, you must have:

- A Bachelor’s degree from an accredited college or university
- A current state certificate or license in your profession
- 450 contact hours of substance abuse education and training, including six hours of ethics training and six hours of HIV/AIDS training
- Five years full-time experience or 10,000 hours of supervised experience as a substance abuse counselor

Eligibility Requirements for National Certified Addiction Counselor Credential, Levels II

Master Addiction Counselor (MAC)
To qualify for the MAC, you must have:

500 hours of education and training to include Master’s degree in the healing arts-counseling, social work, family therapy, nursing, psychology, or other human services field

Current state certificate or license in your profession, such as an LPC (Licensed Professional Counselor) or an LSW (Licensed Social Worker)

Three years of supervised experience - two-thirds of which must be post-master’s degree award

Substance Abuse Professional (SAP)
A Substance Abuse Professional (SAP) evaluates workers who have violated a DOT drug and alcohol program regulation and makes recommendations concerning education, treatment, follow-up testing, and aftercare.

For the SAP qualification, applicants must currently hold one of the following credentials:

- Licensed physician (Doctor of Medicine or Osteopathy)
- Licensed or certified psychologist
- Licensed or certified social worker
- Licensed or certified employee assistance professional
- Alcohol and drug abuse counselor certified by NAADAC Certification Commission or ICRC Alcohol and Other Drug Abuse
For the SAP qualification, applicants must possess knowledge of:

- Clinical experience in the diagnosis and treatment of substance abuse-related disorders
- Understanding how the SAP role relates to the special responsibilities employers have for ensuring the safety of the traveling public
- Part 40, permanent DOT agency regulations, these SAP guidelines, and any significant changes to them
- Degrees and certificates alone do not confer to you these knowledge requirements

**Recredentialing**

*Recredentialing is required every two years or upon the expiration of the credential.*
Appendix C - Written comments

----- Original Message -----  
From: Narconon Cape Town  
To: Sarah Fisher  
Sent: Thursday, March 08, 2007 11:02 PM  
Subject: Re: Substance Abuse Policy Implementation Guidelines for comment  

Hi Sarah,

I have read this and it is very good. You did a great job on it. I have one comment;

- In 5.3.2 Inpatient Treatment, under "Action Steps" you mention "evidence-based treatment models". This should include Narconon as it has been in operation since 1967 and has a lot of support at government level in many countries. However, if one were to look at web sites that are designed to denegrate Narconon, you will not find this. But, those providing services need to be properly trained by centres authorized by Narconon International to do so. Our model is effective and needs to be included and properly investigated by those who do not have vested interests and who are willing to really find out what we do. Narconon Internationally have thousands of people who will attest to the effectiveness of the program as they are still drug free and doing well and that is the acid test of a program-in what condition does a person graduate in. We have enough evidence to support the fact that we are a valid alternative and that with proper and authorized training are valid.

This is my only concern and one which needs to be addressed.

Best Regards,
Robert van der Feyst
Executive Director
Narconon Cape Town
Tel: 083 653 8008
Fax: 086 611 5306
Web: www.narconon.org.za

----- Original Message ----- 
From: Narconon Johannesburg  
To: Sarah Fisher  
Sent: Friday, March 09, 2007 12:45 PM  
Subject: RE: Implementation Guidelines for the Policy on the Management of Substance Abuse  

Hi Sarah

Good to hear from you. Thank you for the guidelines that you e-mailed to NN which, I have started to read. I managed to get to page 16 and had really no motivation to continue. As you know, Narconon (member of CARF) is a global structure that handles all aspects of drug intervention, treatment and prevention and does not adhere to the use of psychiatric medication in the treatment of substance abuse. We unfortunately cannot compromise on this point.

I however wish you luck with your undertaking.

Regards

Paul Kruger
ED: NN JHB
7 march 2007

Hi Sarah

OASIS fully supports SMART’S efforts to try and bring professional accountability to the management of the Substance Abuse Policy in SA – especially with regard to the mushrooming of treatment centres around the country. We feel it is a great idea to have a Board for Substance Abuse Practitioners.

Some of our concerns are

- The use of recovering addicts as Counsellors does have incredible value. However, without professional supervision and guidance, a substantial period of sobriety, training and qualifications under South African Registered criteria or internationally verified bodies, this area is open to widespread abuse.
- The ratio of accredited Counsellors to trainee or volunteer Counsellors on the team at any given time.
- The ratio of Counsellors to people in treatment.
- Accredited Counsellors need to be answerable for their conduct to a National/International governing body.

Maybe to look at the possibility of being accredited in SA if one is already accredited by a recognized International body elsewhere in the world, i.e.grandparented in.

Professional Indemnity Insurance is essential.

It also seems that the Dept. of Social Development and Welfare, despite the Legislation, appears not to have the authority to close down unregistered treatment centres or to maintain and manage the ongoing credibility of registered treatment centres.

Kind regards,

Ansticce Wright M.Sc.BACP
Helen Schaffer B.Soc.Sc.Hons.SW
Mark Bowey Addictions Counsellor
OASIS COUNSELLING CENTRE
Dear Sarah

Thanks for the opportunity to view the Guidelines for the Policy(Shamim has sent it to the various SANCA provincial reps)

I feel that I need to respond to Pt 5.6 particularly "Maintaining a clearinghouse of substance abuse information"

I think that is would be remiss of this report not to mention the SANCA Information and Resource Centre. (SIRC)
This entity has operated since 1986 as a fully functioning specialised library on substance abuse. It is also an international member of SALIS(Substance Abuse Librarians & Info Specialists) and RADAR(network of prevention specialists); also a member of the National Library Inter Library Loan system.
Since the establishment of the CDA until recently, when the subsidy for SIRC from Department of Social Development was cut, I had lobbied this group to consider that SIRC was ideally placed to take on the challenges of the Clearinghouse.
SIRC fulfilled all these requirements of a clearinghouse(see attached brochure)

Public Health Service & the Department Of Health & Human Services (USA)

define a clearinghouse as a program that

1. Has a specific focus or subject area
2. Acquires information-published or unpublished, print and electronic
3. Organises and indexes the collection
4. Accepts inquiries
5. Responds to inquiries in both a routine and customised manner
6. Conduct and provides systematic searches of its information collection
7. Engages in outreach and dissemination for current and potential users

However as you know that didn’t happen. There is a hiatus in terms of their plans to provide this clearinghouse.
This is a bit of background, as I feel that the Guidelines need to take cognisance of SIRC--as it is still around eventhough in a somewhat reduced capacity.

With regard to research I think that under the section "Accessing local and international research" one needs to be aware of the SANCA national database which has already published the Treatment profile of patients attending SANCA clinics nationwide. We intend to broaden this database in time. (see attached). This report which is updated 6 monthly will add to the important data on treatment indicators.

Thanks
Judith Shopley, SANCA Information and Resource Centre
2006 AUCKLAND PARK Tel: 011 7816410 Fax: 011 781 6420
sanca@sancanational.org.za www.sancanational.org.za
COMMENT:

* Section 25 (5) (e) of the Older Persons Act, Act No. 13 of 2006 describes an older person who “abuses or is addicted to a substance and without any support or treatment for such substance abuse or addiction” as an older person who is in need of care and protection.

* The Regulations to the Older Persons Act is in the process of being drafted. As soon as this Act and Regulations are promulgated it will place a statutory obligation on the Department to provide for treatment of older persons who is in need of care and protection and abuses or is addicted to substances.

* Provision should be made in this policy for principles to guide substance abuse interventions related to older persons.

* Treatment programmes are needed for older persons who are recognized as a vulnerable and at risk group.

* Early intervention programmes must be developed to target older persons who abuses medicines that contains addictive substances (eg cough medicines)

* The reluctance to admit older persons to rehabilitation centres remains an obstacle. Treatment programmes should be adapted to suit the needs of older persons.

* Age appropriate services are required. In-patient services should provide for the elderly.

Sarah, thanks.

1) Do not see the UN conventions and their implementations, SA signed, for tobacco, alcohol and other drug use, this includes issues on sales to minors, many aspects should be included in the implementation policy

2) Driver rehabilitation is not mentioned, it should be made mandatory. Refilwe, can add here

3) Server intervention, nothing mentioned here; Shandir can add here

4) Effective measures for drinking and driving include e.g. road block testing, Little is mentioned on evidence based injury preventions

5) National surveys, should include a drug use and treatment (not only prevalence) household survey

6) "Effective" interventions, we normally talk about evidence based, this needs to be specified, what are they.

7) Little evidence reference is made to major research other docs attached

Kind regards

Prof Karl Peltzer, Research Director, Social Aspects of HIV/AIDS and Health, Private Bag X41, PRETORIA 0001, RSA
Tel.: 0027-12-3022637; Fax: 0027-12-3022601 Email: KPeltzer@hsrc.ac.za
----- Original Message ----- 
From: SCRC 
To: Sarah Fisher  
Sent: Wednesday, February 28, 2007 2:06 PM  
Subject: Re: Substance Abuse Policy Implementation Guidelines for comment  

Good afternoon

Thank you for the opportunity to provide a limited amount of input.

It is obvious that a great deal of thought has gone into the development of this document.

I was particularly pleased to see a number of critical areas addressed regarding treatment, detox., registration etc.

I have a couple of points:

1. Page 23, point no. 7: I question whether one counsellor for the duration of the programme would maximise the recovery potential.....different counsellors have different strengths and weaknesses. The point remains however that the therapeutic relationship is critical.
2. Page 23, last line: Is it always appropriate to match females clients with female counsellors? This, I believe, needs to broader.

3. Page 33, point 3: I believe that the Department is trying to establish, critically, minimum norms and standards for halfway houses?

I will give this doc to my Social Workers and counselling staff for their input. We are going on an outreach to Mozambique on Friday and will only be back on Tuesday, so it is cutting the time quite short.

Please do not hesitate to contact us if there is any way we are able to assist you.

Regards & God bless

Conrad Cooper 
South Coast Recovery Centre 
www.scrc.co.za

4. Page 33, point 5: Should this not apply across the board where there is a potential abuse at home and/or continued drinking by other family members ?? 

----- Original Message ----- 
From: John Brock - Stepping Stones  
To: Sarah Fisher  
Sent: Wednesday, February 28, 2007 8:29 AM  
Subject: Re: Substance Abuse Policy Implementation Guidelines for comment  

Overall comment: outstanding!

Couple of further comments from a non-professional after a first-look at this.
- P17 - surely involvement of family/significant others should be a principle of effective treatment.
- Typo p46 - indemnity
- P41 - while international accreditation should not afford automatic SA registration (once SA has an accreditation body in place - which could be some years away), NCAC & IC&RC are robust, internationally recognized accreditations/certifications which the SA treatment environment can & should be utilising right now. From my perspective, we don't necessarily have to reinvent the wheel on this one.

Cheers John
----- Original Message -----  
From: Petrus Theron  
To: 'Sarah Fisher'  
Sent: Tuesday, February 27, 2007 8:53 AM  
Subject: RE: Substance Abuse Policy Implementation Guidelines for comment  

Dear Sarah  

Just a quick response to your well written comprehensive drafted document. In the Secondary treatment section (5.3) what is treatment? Perhaps one should include a sentence such as the following :  

Treatment should include the development of the essential psychological skills/attributes to empower patients to be able to formulate an adequate and optimally effective response to the challenges, opportunities, problems and demands that life present without needing psychoactive substances ie selfefficacy, selfconfidence, selfworth/respect etc.  

Regards,  

Petrus  

P.L Theron  
Telefoon : 021 9392033  
Faks : 0219303123  

----- Original Message -----  
From: Dan Stein  
To: 'Sarah Fisher'  
Cc: dabw@CURIE.uct.ac.za ; 'Ian Lewis'  
Sent: Monday, February 26, 2007 1:39 PM  
Subject: RE: Emailing: First draft for stakeholders IGSAP.pdf  

Dear Sarah  

I had a very brief squizz, and am impressed with the quality of your document. Although perhaps written from a Soc Dev perspective, it clearly highlights is consistent with the idea that substance use disorders are medical conditions, requiring comprehensive medical assessment, and the participation of the Dept of Health.  

As I mentioned to you, other sub-specialities of medicine and psychology are taught at the University, and registered through the HPCSA. Thus a psychiatrist or psychologist does an M Phil in child psychiatry/psychology through our Dept of Psychiatry, and then registered via their professional body at the HPCSA as a sub-specialist. This process is essentially funded by the Dept of Health, which provides posts for senior registrars in child psychiatry. In other countries, the same would hold in addiction medicine (although these posts are often made available to physicians, not only psychiatrists). This has relevance to your proposal on p42 for a registration body. We would argue that because the Dept of Health has not provided funding for senior registrars in addiction medicine, we do not have enough qualified people in this category. This is essentially what we are seeking funding for – a mechanism, paralleling that in all other areas of medicine – to create trained people. The idea is not to create tertiary level sub-specialists, but rather to create a mechanism that extends into the community and ultimately enhances primary care.  

Best,  

Dan
Appendix D - Definitions from Treatment Centres

----- Original Message -----  
From: "Hugh Robinson" <hugh@cybersmart.co.za> 
To: <sfisher@mweb.co.za> 
Sent: Sunday, February 25, 2007 8:43 PM 
Subject: Definitions 

Hi Sarah 
Sorry about the delay in getting back to you. Hope it's not too late. 
DEFINITIONS: 
  a) addictions counsellor-
Someone trained in some capacity to counsel people struggling with addiction. Training can 
be a professional qualification such as a Social Worker, Psychologist or Occupational 
Therapist with some knowledge or understanding of addiction issues. It can also be someone 
with personal 
addiction experience who has subsequently been trained in counselling- an example of this 
training might be a diploma at the South African College of Applied Psychology. As you 
said, addiction counsellors overseas who are trained in this way are recognised by addiction 
counselling bodies but there as yet no such recognition in South Africa. An addiction 
counsellor describes someone who would work individually with patients/clients and facilitate 
group therapy in a treatment centre. An addiction counsellor who is also in a personal 
recovery programme would need to have a minimum of 2 years of personal recovery before 
beginning training in addiction counselling. 

  b) support counsellor-
Usually someone in recovery( minimum 2 years ) or another responsible person who works 
in a treatment centre with the role of providing support to an inpatient community after hours 
and during weekends, when addiction counsellors are not there. Support counsellors might 
also play a role in providing support to a counselling team in some aspects of their work, such 
as overseeing written work time, leisure time or other activities. Support counsellors would 
neither work one-on-one with patients nor would they facilitate group therapy sessions 

  c) recovery assistant-
Not sure, presumably another name for a support counsellor. 

1 Primary Care-
An in-patient treatment centre or programme for individuals in active addiction. The duration 
of these programmes can vary from 3 weeks to 12 weeks to even longer depending on the 
particular treatment centre. Primary Care would provide a full counselling and support team, 
offering individual counselling, group therapy and other recovery-based and educational 
activities. 

2 Extended Primary Care-
A programme designed for individuals who have completed Primary Care at a shorter stay 
treatment centre but who still require further in-patient Primary Care at a centre with a longer 
treatment programme.
3 Secondary Care-
A centre for individuals who have completed Primary Care who still require further assistance in adapting to the outside world. While still receiving individual counselling and group therapy, residents would have some freedom of movement outside the centre and may even become involved in voluntary, part-time or full-time work.

4 Tertiary Care-
Usually the final stage of addiction treatment, Tertiary Care is a centre for individuals who have completed Primary or Secondary Care. Traditionally it is a safe and recovery-based house offering support and community to recovering people adapting to life in the outside world. Residents are usually expected to be working or to be actively seeking employment. These centres are usually staffed by a resident support counsellor and may offer a limited number of group activities to assist the residents. Residents at Tertiary Care are expected to begin taking responsibility for their lives and sobriety while receiving some support. Some Tertiary Care centres may offer further support in the form of individual counselling with an addictions counsellor.

I hope you are well and that this is of some assistance.

Warm regards,
Hugh

----- Original Message ----- 
From: gus van niekerk 
To: sfisher@mweb.co.za 
Sent: Thursday, February 15, 2007 6:22 PM 
Subject: re: Implementation Guidelines 

Dear Sarah 

My input on the definitions (I am relating from our context, referring to Serenity Care Centre):

Addiction Counsellor
An individual who has clean time for longer than two years who provides individual and group addiction counselling to recovering addicts and their families.

Support Counsellor
An individual who is in extended care with supervision and operational responsibilities.

Recovery Assistant
An individual in long-term treatment who completed a primary care programme with supervision responsibilities.

Primary Care
A unit with an inpatient treatment programme which includes detoxification, physical restoration, an addiction programme (12-Step programme) and structure.

Extended Primary Care
A programme catering for an individual whose addiction difficulties did not respond to the standard primary care programme.

Secondary Care
A separate facility with a monitoring system through continuous addiction support, but with less supervision and structure.

Tertiary Care
A residential facility offering a supportive therapeutic community to live in and work from.

Kind regards 
gus van niekerk
Therapeutic coordinator
Recovery Assistant
Dear Ms Fisher,

Pursuant to your request for our understanding of the meaning of the terms below please find below our comments for your review.

**Addictions counselor**
An addictions counselor is a counselor who specializes in the diagnosis, management, and treatment of a Substance Abuse Disorder (as per the DSM definitions) and the allied concerns that often present as co-morbid features of this primary diagnosis.

Further specialist training should be undertaken to be able to effectively treat process based addictions (such as Eating Disorders, Sexual Addictions, and Gambling Addictions).

The standards for being an “Addictions Counselor” are currently alarmingly low. Most problematically there is no professional board to hold “Addictions Counselors” accountable to a code of practice.

The HPCSA requires, inter alia, a 4 year Honours Degree in Psychology and an internship at a recognized institution to register as a counselor. It is a sad fact that many addicts are calling themselves “counselors” in this specialist field without meeting these board requirements. Specifically, a diploma course from SACAP simply cannot be compared to the HPCSA requirements.

We do not accept sobriety or abstinence from alcohol/drugs as a qualification for the designation “Addictions Counselor”, unless the person has worked in a therapeutic role in an addictions facility for at least 5 years and so has gathered a wealth of in-service experience and knowledge.

**Support counselor**
We do not make use of this term in our treatment centre and due to the above legal ramifications have great difficulty in allowing unqualified people to present themselves in this manner.

**Recovery Assistant**
We similarly do not use this title in our treatment centre. We do not encourage non-qualified people to take therapeutic roles. Most Recovery Assistants appear to be addicts with just a few years of recovery and seemingly no relevant academic background. They are not held accountable to any code of practice.
Primary Care
We understand Primary Care to be the first point of care within our model of treatment. A client will be admitted to Primary Care where they will undergo medical detoxification. We understand a Primary Care program to focus on deconstructing denial and other defense mechanisms while at the same time educating the client on the nature and consequences of his/her condition.

Extended Primary Care
We understand this term to imply that a longer term program is used to address the “primary” issues of denial. This may mean that a less confrontational style of counseling may be employed. Extended Primary may blur into Secondary Care in that some Secondary Issues may also be dealt with.

Secondary Care
To be eligible for Secondary Care one must have completed Primary Care and should be referred by a counselor. At Secondary Care treatment goals with a wider scope than Primary Care can be addressed. Such issues can address aspects of Personality, Developmental concerns, Family concerns, Occupational concerns, and so forth. We expect our clients to be medically and psychiatrically stable when they are admitted to Secondary Care.

Tertiary Care
Our understanding of this term in our model of treatment is that this is a final stage of treatment wherein the client is slowly re-integrated into society. In this respect the goals of Tertiary Care will be to restore relationships with support structures (family, religious bodies, community, etc). Another goal will be to support the client in finding gainful employment or at least developing a means to become employable. At this stage of treatment most of the responsibility for his/her recovery rests on the client and the facility simply offers a safe, structured environment and the opportunity to consult with a therapeutic team on a limited level.

Kind regards,
Andy Beak
Continuum of Treatment

Primary

- Detoxification (where necessary)
- Diagnosis of co-morbid conditions with initiation of appropriate treatment
- Initiate required change in beliefs, attitudes and behaviour
- Lay the foundation for long-term recovery
- Education – nature of the disease of addiction
- Acceptance of the impacts of addiction on one’s life
- In 12-Step Terms – start Steps 1 & 2
- Introduction to 12-Step Fellowships
- Identification of high risk situations – relapse prevention
- Family members understanding of addiction, their role and provision to them of necessary support & therapy
- 4 weeks clean time
- Discharge summary and recommendations
- Aftercare

Extended Primary

- Implemented where the individual’s addiction/co-morbid condition and/or lack of emotional resources require more than 4 weeks intensive primary treatment.
- Step down facility – financially affordable.

Secondary

- Application of principals and recommendations ex primary treatment in a less constrained environment
- Follow up treatment of co-morbid conditions
- Reinforce & progress required changes in beliefs, attitudes and behaviour
- Development of self awareness and life skills
- Regular attendance of 12-Step Meetings
- Continued abstinence

Tertiary

- Practical application of recovery principals and life skills in freer yet secure environment.
- Utilisation of fellowship resources.

John

----- Original Message ----- 
From: Rodger Meyer
To: ‘Sarah Fisher’
Sent: Friday, February 09, 2007 3:00 PM

Hi S
Both documents look impressive. I shall try and add to the general body of knowledge this weekend. I note that job titles that I have introduced over the years like support counselor and recovery assistant have now become part of the formal local treatment industry vernacular.

Best,
Dr Rodger Meyer
Kenilworth Clinic - Addictions
32 Kenilworth Rd, Cape Town. 7700
+27 21 7634501 www.kwplace.com
Hi Sarah

Hope this email finds you well.

An addictions counsellor in my mind has 4 years SUPERVISSED face to hours with patients, and 450 hours of class room theory.

I feel it’s crucial that we set up a national accrediting body for this purpose. I have made some initial in-roads with the IC&RC who appear willing to consider the prospect of flying a team out here to assist in this regard. There are other key movements I believe the treatment industry here needs to make – however we can discuss those in CPT perhaps.

Support counsellor – Works under the direction of an addiction counsellor / case manager. The role is varied, being involved in different aspects of treatment delivery, including dealing with administrative duties and co-ordination, as a supportive function for the counselling team, perhaps as a stepping stone towards being a trainee counsellor.
   • Needs to be proactive and open to taking direction.
   • Undergo an extensive background check including any prior criminal offences, including sexual ones, and perhaps even a psychological profile.
   • Personal and professional reference checks
   • Ideally be CPR/First Aid Certified
   • Have a minimum of 3 years active recovery or related professional experience
   • Participate in ongoing professional training.

(b) Recovery assistant –

   • Works under the direction of the Head of Counseling assisting in the transition between formal treatment and reintegrating into work, home and play (living in recovery)
   • An ally for the professional working with the Client in Recovery.
   • A resource for individuals who have often undergone primary and extended treatment, are prone to relapse and need intensive support in their own living environment.

Recovery assistants must also undergo

   • Undergo an extensive background check including any prior criminal offences, including sexual ones, and perhaps even a psychological profile.
   • Personal and professional reference checks
   • Ideally be CPR/First Aid Certified
   • Have a minimum of 5 years active recovery or related professional experience
   • Participate in ongoing professional training.

(c) Addictions counsellor from http://www.fdap.org.uk/certification/ncac.html
   • Competence in the full range of ‘core functions’ of drug & alcohol counselling.
   • A clear personal philosophy and approach to counselling.
   • An on-going commitment to professional development.
In addition, they must have:

- Four years of work experience as a counsellor - at least 2.5 yrs in substance use field.
- 600 hours of supervised face-to-face individual, couples or group counselling - at least 400 hours in substance use field.
- A further 300 hours of supervised experience related to other ‘core functions’ - at least 200 hours in substance use field.
- 450 hours of training relevant to the counsellor's role in the drug & alcohol field.

1. Primary - Detoxification and issues relating directly to the patients ability to maintain abstinence (once applicable for inpatient primary treatment setting controlled using and experiencing an improvement in their quality of life is no longer possible - the difference between Substance abuse and dependence)
2. Extended Primary - those that require more time to get through the above mentioned phase
3. Secondary - for severe dependencies, exploring unresolved trauma, abuse and ensuring any co-morbidity treatment is responding well.
4. Tertiary - halfway houses / sober homes - providing a safe environment for the patient to re-engage their lives with meaning.

----- Original Message ----- 
From: Oasis Counselling Centre
To: sfisher@mweb.co.za
Sent: Thursday, February 08, 2007 1:12 PM
Subject: TERMINOLOGY CLARIFICATION

8 Feb. 2007

Dear Sarah,

The OASIS thoughts on the terms :

A. Support Counsellor
B. Recovery Assistant

are as follows:

Support Counsellor
- An unqualified person who is in training and under supervision.
- Who is not responsible for a case-load and does not facilitate a therapy group

Recovery Assistant
- an unqualified person who has personal experience and/or understanding of addiction and has at least 1 year clean-time.
- they assist in supporting people in treatment but do not get involved in counselling

The phases of “care” as perceived by the OASIS team are:

1. Primary: The first 28 days of treatment, including detox.
2. Extended Primary: the extra time following the 28 days that the team and client agree is necessary.
3. Secondary: the period following the Primary and possibly Extended Primary when it is possible to explore deeper core issues that may present problems for a sustainable recovery.
4. Tertiary: a half-way house. A bridge between in-patient treatment and complete self-responsibility. Represents a supportive safe place to come home to for those to whom this is not available elsewhere.

Regards