AN OVERVIEW OF THE MANAGEMENT OF THE DRUG SITUATION IN SOUTH AFRICA

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I. INTRODUCTION

South Africa is by far the largest market for illicit drugs entering Southern Africa. Its relative affluence within the region makes it a tempting 'emerging market' in its own right. The country's geography, porous borders and international trade links with Asia, Western Europe and North America have made it an attractive drug transit country. Drug trafficking and abuse have escalated in recent years, with the point of escalation traceable to the liberalization of most aspects of society in the years immediately surrounding the country's first democratic elections in 1994. The relaxation of strict controls of land, air and sea borders, along with the enhancement of international trade and commerce, plus the influx of new cultural trends among the more affluent segments of the population, are all associated with the increase in drug trafficking and abuse as well as violent and organized crime. To a greater degree than in many other countries, the drug trafficking activities of organized crime groups are linked to a multitude of other criminal acts, ranging from car hijackings and robberies to the smuggling of firearms, stolen cars, endangered species and precious metals.

South Africa is a society in transition. Drug use correlates strongly with the pressures placed upon social capital by rapid modernization and the decline in traditional social relationships and forms of family structures. Another factor contributing to the increased prominence of illicit drug use in South Africa is high unemployment. Using the expanded definition of unemployment (including people who are unemployed and looking for work, as well as those who are too discouraged to try to find a job or too poor to travel to look for one), the general unemployment rate in 2000 was 40,9% and that for young males (15-24 years) 53,3% and for young women 57,9%.

In its ninth year of democratic government, South Africa is a major power in Africa, carrying with it an enormous burden of regional leadership on most political and economic issues. Difficulties of social transformation in South African society are exemplified by the somewhat slower than expected pace of the redistribution of economic power throughout the society. Huge gaps remain in the distribution of wealth. South Africa's gross national product was 129 billion US Dollars in 2001. The richest fifth of the population earns 22 times more than the poorest fifth. Compared to the United States this figure is 9 times and even if compared with developing countries in sub-Saharan Africa, the existing income gaps in South Africa are large. The figure for Zimbabwe is 12 and 13 for Nigeria. This has a number of implications:

- Relatively higher levels of income in S.A. – even for the underprivileged – make the country attractive as a location for immigration which, as experience has shown, tends to create a favourable climate for drug trafficking activities;

- At the same time, strong income inequalities raise the readiness of underprivileged groups to participate in illegal activities, including drug trafficking;

- The high levels of income among the wealthy make the country attractive for drug imports from abroad.

Social transformation is also hampered by the harsh realities of an HIV/AIDS pandemic whose impact is falling principally upon the black community. According to available statistics 5 million people lived with HIV/AIDS in 2001 and 360 000 people died from AIDS in 2001.The medium to long-term effects on social

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capital of a generation of "AIDS orphans" (it is estimated that this number could be as high as 300 000 at present) are only now being calculated. South Africa combines, in many respects, the characteristics of a highly industrialized country with those of a developing country in sub-Saharan Africa. The geography, population, economic wealth and income distribution, economic growth and unemployment explains the special vulnerability of the country to drug abuse, drug trafficking and crime in general. According to Statistics South Africa, South Africa's population was estimated at 44.3 million in 2001 (the fifth most populous country in Africa). Of these 77.8% were Black/African, 10.2% White, 8.7% Coloured and 2.5 % Indian/Asian. Approximately 58% of the population lives in urban conglomerations compared with 34% in sub-Saharan Africa and 40% in developing countries on average.

II. CURRENT SITUATION

A. Illicit Drug Trends in South Africa

1. Cannabis

Cannabis is the most prevalent illicit drug used in South Africa. Most of the cannabis cultivation takes place in small, remote plots in the following provinces (by order of importance): Eastern Cape, Kwazulu-Natal, Limpopo (formerly Northern Province) and Mpumalanga by poor rural people. Some cannabis is also imported from Swaziland, Malawi and Lesotho. Much of the cannabis trafficking to Europe is reportedly in the hands of British and Dutch expatriates living in South Africa, working in conjunction with South Africans. Western Europe in general, and the United Kingdom and the Netherlands in particular, are the main final destinations. In 2000, an estimate based largely on an aerial survey undertaken either by the South African Police's Service's Aerial Application Unit or subcontractors (both are related to crop eradication efforts) estimated 1,247 areas under cultivation. The average size of a cannabis field in South Africa is 300 square meters which will earn about R1 200.

2. Mandrax

Mandrax (methaqualone*)* is the second most commonly-used illicit drug. After the Second World War, mandrax emerged as another important psychoactive substance. Following the identification of its abuse potential, mandrax was removed from the legal market and classified as a prohibited dependence-producing drug in part 1 of the schedule of the South African narcotics law (Act 41 of 1971). However, following its official withdrawal from the local market, mandrax tablets were diverted from international distribution channels-mostly originating in India and China. In recent times, they have also been manufactured in neighbouring African countries as well as in South Africa itself. In 2002, eight laboratories where mandrax was manufactured were detected and dismantled in South Africa. Abuse was originally primarily concentrated in South Africa's ethnic Indian/Asian population. It has since spread to other ethnic groups, notably the Coloured community. Mandrax is frequently smoked with cannabis, a combination which is referred to as "white pipe" (this is apparently a phenomenon rather unique to South Africa).

Although the use of *heroin*, *cocaine* and *ecstasy* is less prevalent, this has increased notably since the mid-1990's. Treatment data suggests that cocaine use is substantially more prevalent than heroin or ecstasy use. The number of people seeking treatment for cocaine use since mid-2000 has been broadly similar to that for mandrax. Worryingly, heroin use has also increased significantly in major urban areas, particularly in Gauteng (which includes Johannesburg and Pretoria) and Cape Town. In 2001, among treatment patients reporting heroin as their primary drug of abuse, evidence points to 51% of such patients in Cape Town reporting some injecting (or "intravenous") use and 36% doing so in Gauteng. One risk associated with injecting heroin is the spread of HIV/AIDS. The second half of 2001 also witnessed the appearance of heroin users among the Black/African communities in South Africa's urban and peri-urban areas.

3. Cocaine

South Africa's *cocaine* market originally catered to upper-income consumer groups, with trafficking originally controlled by White networks. Following the influx of Nigerian criminal organizations in the early to mid-1990's, the cocaine import and distribution markets have come under the control of these groups. These criminal organizations tend to operate out of residential hotels in the large urban centres (Johannesburg, Cape Town, Durban and Port Elizabeth), but have been concentrated – until very recently – in the Hillbrow area of Johannesburg. *Crack* use has also become prominent among vulnerable groups in society, for example commercial sex workers.

4. Heroin

Heroin is sourced by criminal organizations from markets in Southeast and Southwest Asia. As a low-volume/high-value item, it is couriered into South Africa principally via Johannesburg International Airport. Other sources of supply do exist, but these primarily involve seaport entry principally via Mombasa, Kenya and Dar Es Salaam, Tanzania. The drugs are then transported down East Africa's main arterial road networks toward South Africa.

The use of *'club drugs'* **(**principally *ecstasy and LSD*, but including a wide range of substances) has grown dramatically in the white community since the early 1990's, in part due to active interaction with the youth cultures of industrialized nations. While amphetamine-type stimulants, notably ecstacy, are mainly imported from Europe to satisfy domestic demand in the club scene, there is also evidence of local manufacturing of these substances.

Although increasing social ethnic integration is evident, the drug consumption markets of South Africa remain ethnically differentiated. The extreme income inequalities between the different broad ethnic segments affect drug affordability and thus consumer choice.

Ongoing research in South Africa is demonstrating a link (other than that related to injecting drug use) between substance abuse and the spread of HIV/AIDS. It indicates that adolescents who use alcohol and other drugs are more likely to engage in sex and in unsafe sex than are adolescents who abstain from using them.

B. Drug Trafficking

Following a decade of opening up to the outside world, South Africa has now unfortunately become part of the major international drug trafficking networks. These are often organized by West African –principally Nigerian-criminal groups which since the late 1990's have established permanent operational bases in Southern Africa in general and South Africa in particular. Over the past few years, these groups have integrated South Africa into their pre-existing networks linking the drug producing countries of Latin America (cocaine) and Asia (heroin) with the "traditional" cocaine and heroin consuming markets of Western Europe and North America. Cannabis trafficking networks from South Africa to Western Europe tend to involve white South Africans and Dutch and British expatriates living in South Africa. There have been recent inroads into this market chain, however, by other organized criminal groups in the context of reported bartering arrangements (or at least two-way sales) of cannabis for other drugs which are then consumed within South Africa. Trafficking of illicit drugs has increased dramatically in South Africa over the last decade. Aside from the fact that drugs are highly associated with dependency or addiction and thus the frequently desperate search for instant cash – often through prostitution or acquisitive crime – there are other obvious links to criminal activity. Drug trafficking is an extremely profitable enterprise for organized crime syndicates which are often heavily engaged in numerous other criminal acts, ranging from car hijackings and robberies, to the trafficking of illegal firearms, stolen cars, endangered species and precious metals. For example, organized crime syndicates have also become involved in stealing vehicles and trading them across South Africa's land borders in exchange for drugs. South Africa now features prominently in international drug trafficking networks. Drug trafficking and organized crime have unquestionably grown in a symbiotic relationship in South Africa since the mid-1990's. In 1997, the South African Police Service (SAPS) conducted a survey which demonstrated the existence of 192 organized crime groups operating in South Africa of which 92 were primarily focused on the international smuggling of drugs. This survey formed the basis of the SAPS Organized Crime Threat Analysis (OCTA) system. The SAPS OCTA (2002) showed 238 threats.

C. Drug Use and Crime

Within the past three years, ground-breaking research work by the South African Medical Research Council and the Pretoria-based Institute for Security Studies has confirmed a high positive correlation between drug use and crime. Results of the 3-Metros Arrestee Study (in Gauteng, Cape Town, Durban) conducted between August 1999 and September 2000 among a representative sample of arrestees (n=2 859) has revealed much about the drugs/crime link in South Africa. The study found that the percentage of arrestees testing positive from urinalysis for at least one drug was 46%. Positive tests for cannabis, mandrax and cocaine occurred in 40%, 21% and 4% of cases respectively (Parry, Louw and Pluddeman 2001). Arrestees under the age of 20 were most likely to test positive for some substance (66%). Those testing

positive for a substance (51%) were more likely than those who tested negative (29%) to have been arrested before (ISS 2002). The research suggests a very strong link between drug use and various crimes. For example, the percentage of arrestees testing positive for any drug (excluding alcohol) in connection with housebreaking, motor vehicle theft and rape was, respectively , 66%, 59% and 49%. Up to one-third of arrestees who indicated that they were under the influence of substances at the time that the crime took place stated that they had used substances to assist them committing the offence.

The current situation in respect of drug abuse in South Africa must be viewed against four milestones in the history of our country, namely:

- The emergence of South Africa out of apartheid isolation in 1994
- Accession by South Africa in 1995 to the United Nations (UN) signing of The Single Convention on Narcotic Drugs, 1961 and the 1971 Convention on Psychotropic Substances
- Accession to the UN Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, 1998
- The development of a National Drug Master Plan (NDMP) 1998

The re-entry of South Africa into the international arena brought with it prosperity and commitment on the one hand and a range of new problems and challenges on the other hand. The rapid expansion of international air links, combined with our geographic position on major traffic routes between East Asia and the Middle East, America and Europe, a well-developed transportation infrastructure, modern international telecommunications and banking systems, long porous borders and weak border control, make South Africa a natural target for drug traffickers. The winds of change, however refreshing, thus brought with it a sober chill.

D. Basic Policies and Strategies in South Africa

1. South African National Drug Master Plan

The basis for the national drug control framework is the (5 year) National Drug Master Plan adopted by Parliament in February 1999. The elaboration of such a plan was necessary as the Government's response to the drug problem – as stated in the Master Plan – had become "disjointed, fragmented and uncoordinated". A number of national plans and strategies to address different aspects of substance abuse were drafted during the 1980s and early 1990s. They did not, however, provide a comprehensive response to the deteriorating drug problem of South Africa, and they were not properly implemented. Thus in 1997, the Minister of Welfare and Population Development requested the Drug Advisory Board to develop a Drug Master Plan for South Africa to rectify these problems "in accordance with international practice".

Taking a balanced approach to reducing the supply and demand for drugs, the overall objectives of the Master Plan are "to build a drug free society together and to make a contribution to solving the global problem of substance abuse" The Master Plan's six priority areas are: (a) to reduce drug-related crime, (b) protect youth, (c) support community health and welfare, (d) strengthen research and information dissemination, (e) encourage international involvement, and (f) improve communication on substance abuse with all groups in South Africa's highly diverse population.

One aspect of the Government's demand reduction policies includes "harm reduction" which aims to reduce the negative social and health consequences associated with drug use rather than to reduce or eliminate drug use per se.

The Master Plan sets forth a broad strategy for integrating the efforts of various government departments and civil society to prevent and reduce drug-related problems, substance abuse and illicit trafficking in South Africa. Recognizing the social costs of addiction, the document calls for greater resources to be diverted to disadvantaged communities. It calls for a workable strategy at the community level through *Local Drug Action Committees* (in all 382 magisterial districts) and *Provincial Drug Forums* comprising the various government agencies, the private sector, experts and community organizations. It stresses the importance of

shifting the focus from supply to demand reduction and from the individual to the community. Further, the Master Plan aims to ensure that "all educational material and other information (that) is disseminated is contextually correct, that is in a form and language appropriate to the culture, language, level of education and socio-economic background of its intended recipients". (South Africa has 11 official languages.)

2. Central Drug Authority

A Central Drug Authority (CDA) compromising both governmental appointees and experts from the non-governmental sector was established in 2000. Representatives from the Departments of Justice, Health, Education, Welfare, Correctional Services and the South African Police Services among others serve in the Central Drug Authority. The selected members of civil society come from research councils, universities, trade unions and business establishments concerned about drugs. The CDA is charged with giving a lead to the nation's drug control efforts and monitoring implementation. The CDA is required to report back to Parliament on regular occasions regarding progress achieved.

Local drug action committees and provincial drug forums are in various stages of formation and readiness. The entire Master Plan architecture can be considered to be only slowly making progress.

E. Legislation

The control of licit drugs in South Africa is organized and managed through a number of pieces of legislation, two of which are of special note:

(i) The Medicines and Related Substance Control Act (101/1965): This supports the processes set out in the major UN Conventions on drug control and provides the definitional and conceptual basis for drug control policy in South Africa.

(ii) The South African Drugs and Drug Trafficking Act (140/1992): This makes it an offence to supply substances to anyone while knowing or suspecting they will be used for the manufacture of illegal drugs. The Act further prohibits any person from converting property that he or she knows or suspects to be gained from the proceeds of drug trafficking, and it makes dealing in dangerous and undesirable drugs an offence punishable by up to 25 years imprisonment. The maximum sentence for the possession of drugs is 15 years. There are no prescribed minimum sentences.

Other relevant laws governing this field are:

- The Prevention and Treatment of Drug Dependency Act, 1992 (Act 20 of 1992).
- The Criminal Procedure Act, 1977 (Act 51 of 1977).
- The Extradition Act, 1962 (Act 67 of 1962).
- The Criminal Procedure Act, 1977 (Act 51 of 1977) with special reference to the Witness Protection Programme established in terms of section 185A of 1992.
- The Extradition Amendment Act, 1996 (Act 77 of 1996).
- The International Co-operation in Criminal Matters Act, 1996 (Act 75 of 1996).
- The Proceeds of Crime Act, 1996 (Act 76 of 1996).
- Institute for Drug-Free Sport Act, 1997 (Act 14 of 1997).
- Road Transportation Act, 1977 (Act 74 of 1977).
- Prevention of Organised Crime (Act 121 of 1998).

F. Drug Control Institutions-Supply and Law Enforcement

At present the South African Police Service's Narcotic Bureau (SANAB) is giving the lead on the enforcement side primarily in detecting and investigating drug crimes. However there is also an important profiling, interdiction and controlled delivery role for SAPS Border Police and SARS (South African Revenue Service) Customs. Border control coordination takes place under a Border Control Coordinating Committee.

Over the past two years a series of restructuring initiatives were undertaken in the SAPS. Thus the Organized Crime "component" has been given the responsibility for drug law enforcement. This component serves as the reporting entity for several units including the Specialized Investigating Units, one of which is SANAB. The Organized Crime component also has 24 "task teams" reporting to it from throughout the country, each of which in principle contains at least one officer with specialized narcotics expertise. The specialized investigation units are being phased out of the police force and staff are being integrated into the police organized crime component. With some 40% of SANAB offices already closed in this manner, the future of the remaining units is still uncertain. The impact of this on the country's medium- to long-term capacity to deal effectively with the threat posed by organized criminal groups dealing in drugs is unclear. In late 1999, a new unit entitled Directorate for Special Operations (more commonly known as the "Scorpions") was launched under the authority of the National Director of Public Prosecutions, who reports to the Minister of Justice but is required to report on issues related to the Scorpions directly to the President. The Directorate, combining elements of criminal justice and prosecution, was formed to tackle high profile crimes and corruption, including drug crimes.

The four Drug Sections of the SAPS Forensic Science Laboratory (based in Pretoria, Cape Town, Port Elizabeth and Durban) deals with analysis, crime scene attendance, illicit laboratory investigations, drug intelligence, and recording and keeping of seizures. The SAPS established a Chemical Monitoring Programme in 1999 primarily to prevent the diversion of precursor chemicals from the licit market to illicit drug manufacturing.

International involvement is achieved through the posting of an international Drug and Organized Crime Liaison Officer (DOCLO) in the United Kingdom and Brazil and the appointments of DOCLOs to Pakistan, India, Argentina, Thailand, Kenya, Nigeria, Zambia and Zimbabwe have been approved. The expansion of the DOCLO network is intended to enhance cooperation on intelligence sharing and joint investigations with participating countries.

In terms of regional cooperation, S.A. is also a signatory to the *Protocol on Combating Illicit Drug Trafficking* in the *Southern African Development Community (SADC)* region. South Africa also participates actively in the *UN Commission on Narcotics Drugs (CND)* and cooperates with *Interpol.*

G. Drug Control Institutions-Demand Reduction, Prevention and Treatment

Prevention programmes are the responsibility of the Department of Social Development (formerly Welfare), while treatment falls under the auspices of the Department of Health. However, the respective roles are blurred in practice and constraints also exist with regard to funding. Treatment facilities are unevenly distributed throughout the country and the health and education sectors are minimally involved in prevention programmes. The latter gap is filled in part by a highly dedicated group of NGOs and concerned citizens, but their capabilities and mandates are limited. Government thus largely provides resources for the treatment of persons having substance abuse problems through NGOs such as the South African National Council on Alcoholism and Drug Abuse (SANCA). SANCA has a network of drug treatment and outreach centres around the country (38 centres and 76 satellite offices in all 9 provinces) and also trains drug abuse counsellors and others in related roles (e.g. teachers and social workers). As SANCA'S main objectives are prevention and treatment, it also has public education programmes in high schools e.g. TARDA (Teenagers against Drug Abuse). The treatment objective is achieved through the provision of treatment services for chemically dependent people and their families as well as support groups in high schools.

1. Department of Social Development

Treatment falls into the following categories: (a) voluntary treatment in the community; (b) voluntary institutional treatment and (c) statutory treatment under the terms of the Prevention and Treatment of Drug Dependence Act (1992) This department is providing interim secretariat services for the functioning of the

Central Drug Authority. The Department has developed a prevention strategy aimed at youth, which is currently in the form of a discussion document.

2. Department of Education

This Department is implementing its Revised Curriculum 2005 initiative. This includes a Life Orientation Area of Learning which has a component that seeks to address adolescent risk behaviours, such as drug use and teenage sexuality as part of a holistic initiative aimed at the healthy development of young people. The substance abuse component is currently being reviewed and made stronger in order to address the escalation of the drug abuse problem within South Africa. The Department has developed a "Policy Framework for the Management of Drug Abuse by Learners in Schools and Further Education and Training Institutions" which is intended to give guidance to schools in developing substance abuse policy. The policy also calls for all teachers, both pre-and in-service, to receive appropriate education on substance abuse, as it does for all parents.

3. Department of Health

Although the main role of this department pertains to treatment, it also provides different levels of tertiary prevention. The Department's aim is to ensure greater access to treatment via (a) primary care, (b) general hospitals, and (c) existing treatment centres. This Department is also involved in an initiative to develop a five-year community-based project, aimed at the primary prevention of substance abuse among young people.

4. Soul City

Soul City is a multi-media health education/counter-advertising initiative seeking to address a range of risk behaviours, including alcohol/smoking and violence against women, through a very popular prime-time sitcom aired on TV, as well as on radio and via the printed media. Soul City is considering broadening its message base to include substance abuse with a focus on drugs.

5. SACENDU (South African Community Epidemiology Network on Drug Use)

SACENDU was established in 1996 by the Medical Research Council of South Africa and the University Of Durban-Westville's School of Psychology with the technical assistance of the WHO/PSA and the U.S. National Institute on Drug Abuse (NIDA). It is a network of researchers, practitioners and policy makers (e.g. law enforcement, health and welfare treatment services, and public health research) from 5 sentinel areas in South Africa (Cape Town, Durban, Port Elizabeth, Gauteng and Mpumalanga). Members of SACENDU meet every 6 months to report on alcohol and other drug (AOD) use trends and associated consequences through the presentation and discussion of quantitive and qualitative research and other data.

6. MRC – Medical Research Council

MRC is primarily engaged with epidemiological research into the nature and extent of AOD use and with measuring the health impact of the misuse of AOD. Another key focus is in the area of formulating local and national policy.

7. CSIR-Council for Scientific and Industrial Research

Its research mainly focuses on alcohol, and drug-related traffic infringements.

8. HSRC – Human Sciences Research Council

HSRC researches all aspects of substance abuse through its Centre for Alcohol Drug Related Research. Its research includes major surveys that target specific population groups, national surveys and expert analysis of statistical data.

9. SAAPSA – South African Alliance for the Prevention of Substance Abuse

SAAPSA was established in 1995 with the assistance of WHO/PSA. It includes members from 70 organizations. Its goal is to "facilitate networking among all organizations, government and civil society, concerned with drug and alcohol abuse in S.A. with a view to optimizing cooperation in the prevention and treatment of alcohol and drug abuse".

10. Other NGOs prominent in the drug field

- Cape Town Drug Counselling Centre (treatment, training, prevention and research)

- Narcotics Anonymous
- Bridges (prevention programmes in schools)
- RaveSafe (harm reduction at major rave parties)
- Drug Wise (Counsellors)
- Elim Clinic (Treatment)
- Stepping Stones (Treatment)
- Institute for Security Studies (includes drug-related research)

There is a relatively wide network of public and private substance abuse treatment facilities in South Africa. These include some 300 organizations where support and after-care are provided: 67 community treatment facilities, 147 provincial and private hospitals and psychiatric hospitals, 12 detoxification facilities and 25 specialist in-patients units/half-way houses. All these facilities are largely in urban areas. The overcrowded former townships, informal settlements and rural areas are grossly under-serviced.

H. Programmes and Service Providers Utilized by the Department of Correctional Services

- Most of the programmes used in Department of Correctional Services includes Awareness of the dangers of drug abuse as well as Life Skills training. Counselling is also part of these programmes. The Social Workers are usually the professionals dealing with drug abuse in prevention programmes. Due to their large case loads, the programmes are usually presented to groups of inmates. In prisons there are Drug Awareness Programmes for all inmates and Intervention and Treatment Programmes for individual problem cases. The Drug Awareness programmes consist of the sharing of knowledge, acquisition of skills, individual growth and role play. Some of these aspects are also included in individual therapy.

- *Ekuseni Youth Development Centre's Alcohol and Drug Programme* consists of three modules:

  Module 1: Orientation on Alcohol and Drugs (8 sessions)
  Module 2: Personal values on drug use and its effects (6 sessions)
  Module 3: Me and my drug – self-appraisal and assertiveness (7 sessions)

- *SANCA* will launch the *Aganang (Let's work Together) Programme* in conjunction with Dept. of Correctional Services in June 2003 in seven prisons with juvenile offenders countrywide. The 13-session Programme's focus is on substance abuse and Life Skills. The programme is based on the Alcohol and Substance Programme of Ekuseni Youth Development Centre.

- *DRUG WISE* strives to provide an accessible community based, multidisciplinary service for drug related problems. Drug education, early identification, intervention and sympathetic counselling is a more effective tool against drug abuse than a judgmental anti-drug approach. This is achieved by positioning the community pharmacist as the first port of call for all medicine and drug related problems. Drug Wise also provides school education programmes as well as Teacher Training Programmes and Parent Education. The latter aims at assisting parents in understanding the adolescent drug scene, what their children are exposed to and how as parents they can intervene.

  In some prisons Drug Wise has also started Drug Peer Counselling Training through *Khulisa*, an organization whose main objective is the prevention of crime. The Drug Peer Counsellors who completed the training are very enthusiastic and play an important role in addressing the drug abuse problems in prisons where overcrowding is a big problem and professional staff members, such as social workers, are battling with large case loads.

- Other Substance Abuse Programmes used by Dept. of Correctional Services are regionally based to take into consideration the differences in culture for example. The main objectives of these programmes are to make offenders aware of the dangers of substance abuse and the consequences hereof; addiction, types of drugs, defence mechanisms, withdrawal symptoms and the availability of treatment programmes.

- For the ongoing development of such programmes, it is of vital importance that proper and relevant statistics should be kept – especially of successes, reoccurrences of problems, time periods, number

of inmates reached by programmes, referrals to other agencies etc. For research purposes it is also very important that statistics are obtained and kept in a uniform way so that it is easily accessible.

I. Community Mobilization and Collaboration with Relevant Sectors

In South Africa networking exists among different health care and welfare agencies as well as state departments such as Department of Correctional Services, Department of Justice and the South African Police Service.

- When *Correctional Supervision* instead of imprisonment is recommended for an offender, he/she will have to attend a certain number of sessions of a specific programme designed for the type of offence he/she has committed, as part of his/her sentence. If the offence was drug abuse, the programme will be regarding the dangers of drug abuse, long term effects on health, family, social aspects etc. Experts from e.g. health care services will be invited to certain sessions to share their knowledge on the specific subject.

- The same goes for the *Diversion Programmes,* which were designed to keep children under the age of 18 out of prison, to prevent them from having a criminal record and to give them a second chance. The relevant agencies (such as Dept. of Social Development) will play a role in the specific diversion programme as well as some non-governmental organizations such as *Khulisa*. Khulisa's main objective is crime prevention. Khulisa is concentrating its efforts mainly on the youth, both in prisons and in the community. In prisons they conduct a Life Skills Programme called "My Path" consisting of three phases of twelve modules each. The programme runs for one year and participants attend a two hour session each week. The rest of the work is self-study. The programme in the community is called "Make it Better" and equips youth leaders with the necessary skills to make a difference in their own communities and to make life better out there. The main focus still remains crime prevention. Sixty percent of Khulisa's employees are ex-offenders.

These are just a few examples of the collaboration that does exist. Local funding for such projects still remains problematic as there are so many social issues in our country that need attention and funding. Therefore the collaboration with foreign countries, especially for funding of specific projects, is still much needed at this stage.

III. POSSIBLE SOLUTIONS TO ENHANCE EFFECTIVE PREVENTION OF DRUG ABUSE AND TREATMENT OF DRUG ABUSERS

1. Training of counsellors who can operate in their own mother-tongue (11 languages).

2. Existing programmes in use should be tailor-made for use in the different departments.

3. In the Department of Correctional Services every employee is now seen as a rehabilitator. For that reason the disciplinary staff should also receive training in drug abuse programmes as they spend more time with the inmates than the education and therapeutic staff.

4. The Diversion Programmes for children under 18 should be expanded rapidly with properly trained facilitators.

5. All stakeholders who supply either preventative or treatment services should keep statistics. These statistics must be kept at a central place-easily accessible in order to be available for evaluating and planning processes. Success/failure stories regarding specific programmes and the reasons why it works/does not work (evidence-based) should also be available at a central place.

6. Different professionals working for example in one department, should put professional jealousy aside in order to obtain better results in their fight against drug abuse. Experts in this field should also be willing to travel and to share information at regional workshops.

7. Modern technology e.g. the Internet, could also play a vital role in getting information to the people to deliver a better service to the community at large.

8. Large campaigns should be launched nationally with participation from every Government Department, Local Authorities and the media to make people at the grassroots level aware of the dangers of drug abuse and where help can be obtained. This must be an ongoing project with a change in focus from time to time to keep people's attention.

IV. FUTURE PROSPECTS AND CONCLUSIONS

During my research for information to compile this paper, it came to my attention that quite a number of senior state employees who are experts in the field of drug abuse, resigned and took jobs in the private sector or with other organisations working in the field of drug prevention and treatment. We need their expert knowledge in the Criminal Justice System and must plead with the Government to try and keep them in the service of the government. We cannot afford this brain drain from the Criminal Justice system. They are especially now needed in the Department of Correctional Services where rehabilitation has become a core function next to safe custody.

- We must continue on the guidelines set out in the National Drug Master Plan, but at the same time not refrain from making valuable recommendations for the next NDMP (2005-2009) from practical experiences regarding prevention and treatment of drug abuse in the Criminal Justice System.

- The Criminal Justice System must collaborate closely with expert role players and organisations in the community regarding drug abuse because our clients (offenders) come from the community and have to return at some stage to the community. The reintegration process of ex-offenders could benefit greatly from this, especially if the ex-offender can be referred to a suitable support group or self-help group in the community.

- More money should be made available for Prevention and Treatment Programmes, especially in prisons. This could lead to programmes being rolled out for trial awaiting prisoners as well, which make up a large proportion of the prison population, but are normally not included in specific programmes.

- Programmes must be made available in all the eleven languages of our country if we really want to make an impact on society at large, but also on our Criminal Justice Community.

- Prevention and Awareness Programmes should also be part and parcel of school programmes. More emphasis must be placed on the importance of these types of programmes, almost to the same level as the attention the HIV/AIDS campaign is receiving in our country.

- In the final instance we are aware of the fact that the focus on substance abuse can easily be lost given the overwhelming social problems facing South Africa today. We dare not lose our focus – too much is at stake.

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