[redacted]

GAUTENG PROVINCE

DISCUSSION DOCUMENT

Subject: DSD request for additional funding to expand services towards anti-drug and substance abuse

PURPOSE

1. To provide a high-level summary as a basis for GPT and DSD to engage and deliberate on DSD's request for additional funding to expand services towards the fight against drug and substance abuse in Gauteng.

BACKGROUND

2. During the 2016/17 adjustments process, DSD requested GPT to consider allocating additional funding under the GCR Anti-Substance Abuse Social Movement and expansion of services, of which the details were as follows;

KEY INTERVENTION AREA	REQUEST
✓ Media & Social Campaign	R17m
✓ Mobilization for Community Activisms	R25m
✓ Expansion of services (targeting severely affected areas)	R88m
✓ Research & capacity building	R2m
✓ LED (creation of Jobs for youth & recovering addicts – aftercare)	R18m
TOTAL BUDGET REQUESTED	**R150m**

3. After careful consideration by GPT, only R15m was allocated during the November adjustments budget process towards the media and social campaigns as preparatory work for service expansion.

4. Furthermore, due to the importance of the programme, but constrained by fiscal resources, GPT allocated additional funds over the MTEF for expansion of services, as follows; R25m (2016/17); R26.5m (2017/18) and R28m (2018/19).

5. DSD approached GPT on the issue regarding the need for government to intervene and respond to the scourge of drug and substance abuse that is destroying our province. Several meetings were held at HOD level.

6. From these meetings it was resolved that DSD will furnish GPT with the SLA and any other important documents that is part of this matter. Subsequently, GPT received the following; SLA and Business Plan for the Randfontein Life Recovery Center (LRC) as well as a formal memo directed to the HOD: GPT requesting additional funding for the expansion of services in the province.

7. The Facility in question is the same where Gauteng Department of Health had Life Esidimeni in Randfontein, however, GDoH has since moved out and there is no patient therein under the care of Health, all patients were moved to other facilities.

8. The capacity of the facility is 900 beds and DSD has only contracted for 200 beds for the period 1 June 206 to 31 March 2017. This is supported by the SLA. The SLA is a fixed contract (but renewable) of agreement between DSD and LRC, which is effective from 01st June 2016 to 31 March 2017. This is a 10 months contract and has fixed Rand value of R23.3 million.

9. The details in the SLA and the business plan are clear and DSD is safe from a legal point of view. However, although there is room for contract extension but it will be very difficult for DSD to simply exit, mainly based on the demand and nature of service. **The nature of the service being provided will not give DSD any flexibility and immediate viable option on expiry of the contract to simply exit.**

10. This current request for additional funding should be considered in addition to the resources already allocated in the current MTEF. The department has stated in the current submission that R42.5m has been allocated for the social movement campaign, and included in this is the R25m from GPT and R17.5m reprioritized within the baselines by DSD.

11. In the submission, DSD made mention of various strategic partners in this programme, e.g. DCS and GDoH but did not mention how they are contributing in terms of activities and funding, more especially DCS that has programmes in dealing with this problem from a crime prevention and criminal point of view.

DISCUSSIONS

12. The SLA has also clearly stated that should DSD fail to provide the agreed funding, the LRC will simply shut down. This means the facility is being run solely on the basis that DSD will provide funding. The issue the LRC stating that they will go out and seek donation and funding through fundraising does not matter and may not have any effect to the SLA.

13. DSD has indicated that from the day of opening to date, the 200 beds are already occupied and there is need for more beds, but due to limited resources, DSD is not taking any intakes for drug treatment and rehabilitation.

14. There are plans for future expansion of services from treat and rehab to include skills development of the rehabilitated addicts, but this programmes are not yet fully funded.

15. It is observed in the SLA that the LRC has contracted or simply attached a letter from "A re Ageng Social Services" who will receive the funds on behalf of LRC in the current three months, and once the LRC had addressed its own banking issues, funds will then be re-routed to the LRC.

16. I just wonder who the PO will be issued to and what SCM implications this has. But DSD has indicated that this "A re Ageng" is a genuine NPO registered with DSD doing other services, may be they were chosen by LRC based on their relations to hold the funds for them in the meantime.

17. The business plan provides a clear presentation of the nature of services to be rendered, i.e. medical detoxification and rehabilitative interventions for inpatients.

18. In my opinion, given the plight of substance abuse that our communities are facing, the need is real and existent. The business plan acknowledges that in the West Rand there are other treatment and rehab centers, but are not affordable by most of the catchment population, hence the need for "government intervention".

19. While DSD is also offering the same services through other NGOs, such is done via i. GO-owned facilities and other facilities owned by DSD, e.g. Dr F & F Ribeiro in Cullinan.

20. A critical question to ask is whether the NGO model is comparatively effective or DSD should building/acquire its own infrastructure and human capacity. This should be based on a number of variables and factors, e.g., **consistency in demand, funding sustainability and capital cost implications; personnel implications and related costs vs NGO model.**

21. Given the fact that this service will continue for some length into the future, what is the thinking of DSD in terms of funding within the current baseline, should DSD consider extending the contract, **what will be the level of budget escalation at this time of economic and fiscal constraints, as well as what is the thinking of DSD in terms of exiting the contract, i.e. exit clauses?**

22. With this LRC in the West Rand, there is no submission from DSD that says that DSD has done enough analysis and comparative evaluation if this model is the best and is cost-effective. This point raises the question of whether DSD is starting something is either affordable, sustainable or cost-effective?

23. There is no comparative analysis of what it currently cost other related facilities to offer the same services, i.e. the cost per patient of cost per PDE is not provided to justify the total amount to be transferred to the LRC.

24. In the event that the 200 beds are full and limited to the resources, as already is; is DSD going to turn back other demands for such services, **this raises the question of no admittance on the basis that there is no money and the other available beds may not be made available. This should be considered in the context that the general public are aware of the availability of more beds at the same facility and turning the basis that government does not have may raise unwarranted and unintended consequences.**

25. Is it possible for DSD to be able to wash itself away from the increased demand for admittance in that facility, won't this force the hand of government to take more patients, and what will the cost implications be?

26. The business plan clearly states that should government fail to fund the services, the LRC will shut down and discontinue the services, and what that will mean to government is obvious. Lessons may be learnt from the experience that GDoH had during the tenure of Life Esidimeni where there were mentally-ill patients who needed full-time supervision, protection and medical care.

27 In the memo from DSD the request for funding amounts to **R109.2 million**; which is detailed as follows:
   a. Increasing the number of beds in Randfontein from 200 to 900 from the 2017/18 MTEF (R69.3m);
   b. Replication of the Soshanguve Centre for Excellence (1 per region) – (R30m);
      i. JHB North, JHB South, Ekurhuleni, West Rand and Sedibeng.
   c. Creation of 100 inpatient beds in Sedibeng; is this not a duplication?

28. DSD also intends to revitalize the Dr F&F Ribeiro in Cullinan, which is the only state-run treatment facility in the province. Question to ask is whether DSD is able to offer quality and effective services in this facility or not, what are the successes and constraints? Cost implication are yet to be determined.

29. DSD has not provided the estimated costs of this expansionary drive over the MTEF, and has also not demonstrated its internal reprioritization as a first step in resourcing the programme before approaching GPT for additional funding.

CONCLUSIONS

30. There are issues with the SLA that should be clarified, e.g. provision for conditions for exit clauses, budget escalation rates, open-endedness of the SLA, penalty clauses in the event that the LRC is in breach of conditions, indemnity against litigations, etc.

31. Based on service demand, there are only two available options to ensure that the facility if kept open and there is provision of services; i.e. additional funding from GPT and funding from the baseline by DSD. where DSD should furthermore go and do more reprioritization within current baselines to expand to the 900 beds capacity.

32. DSD has not fully considered risk issues when entering into this kind of an agreement. Now that government has committed itself, there is need to mitigate such risk, and that can only be through finding resources to open for more beds. This can be on a phased-in approach of full funding from the 2017 MTEF.

Kind regards;

Rudzani Rasivhetshele
D: Public Finance