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AN EXAMINATION OF SUBSTANCE ABUSE PREVENTION PROGRAMMES AND THEIR IMPACT ON MINORS WHO ARE PRONE TO SUBSTANCE ABUSE IN SOUTH AFRICA.

BY
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DECLARATION

I Precious Ngcobo declare that:

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ABBREVIATIONS

ACRWC: African Charter on the Rights and Welfare of the Child

CDA: Central Drug Authority

CRC: Convention on the Rights of the Child

DARE: Drug Abuse Resistance Education

DoE: Department of Education

DSD: Department of Social Development

EU-Dap: European Drug Addiction Prevention project team

FBO's: Faith Based Organisations

FCP: Family Competence Programme

GDSD: Gauteng Department of Social Development

GDPO: Global Drugs Policy Observatory

HIV/AIDS: Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome

NACADA: National Campaign against Drug Abuse

NDMP: National Drug Master Plan

NFD: Non-Financial Data

NGO's: Non-Governmental Organisations

NIAAA: National Institute on Alcohol Abuse and Alcoholism

NIDA: National Institute on Drug Abuse

POPPETS: Programmes of Primary Prevention through Stories

SACENDU: South African Community Epidemiology Network on Drug Use

SACSSP: South African Council for Social Service Professions

SAMHSA: Substance Abuse and Mental Health Services Administration

SANCA: South African National Council on Alcohol and Drug Dependence

SAPS: South African Police Service

SFP: Strengthening Families Programme

TADA: Teenagers Against Drug Abuse

UK: United Kingdom

US/USA: United States of America

UNODC: United Nations Office on Drugs and Crime

UN: United Nations

WHO: World Health Organisation

YADA: Youth Against Drug Abuse

GLOSSARY

Drugs/Substances-; Encompasses psychoactive or dependence producing drugs which can either be licit or illicit such as but not limited to alcohol, nicotine, over the counter or prescription medicine as well as cannabis, cocaine and heroin (NDMP, 2013-2017).

Minors/Adolescents-; used interchangeably throughout the dissertation referring to persons under the age of 18 years.

Prevention Programme-; A proactive process that enables individuals and communities to face challenges of life's events and changes by creating and reinforcing conditions that promote healthy behaviours and lifestyles through primary (altering the individual and the environment so as to reduce the initial risk of substance use/abuse), secondary (early identification of persons who are at risk of substance abuse and intervening to arrest progress) and tertiary (treatment of the person who has developed substance/drug dependence) prevention methods. Such programmes often encompass educational and psychosocial protective factors which aim to reduce the supply, demand and harm caused by substance abuse (NDMP, 2013-2017).

Substance abuse-; Refers to the misuse or abuse of psychoactive and dependence producing substances that can either be legal or illegal, these substances have the ability to alter brain functioning and create dependence. Such substances can include but not limited to nicotine, alcohol, over the counter or prescription medication, indigenous plants, solvents and inhalants (NDMP, 2013-2017).

CHAPTER ONE
INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The abuse of alcohol and substances among adolescents is a pressing public health challenge in South Africa. Conventional approaches of providing necessary information against the use of illicit substances are largely ineffecftive in preventing or decreasing the substance abuse problem. The abuse of illicit substances and alcohol threatens not only the safety and security within South African communities but the tranquility and development of the country. Hence there is a need to conduct research examining substance abuse prevention programmes and to access their impact on minors who are prone to substance abuse in South Africa. Chapter One of the research undertaken provides the aims, objectives and an overview of this study.

1.2 STATEMENT OF THE RESEARCH PROBLEM

Different substance abuse prevention programmes have been implemented by both government and non-profit organisations in South Africa and much has also been written about the subject. The problem is that there is limited critical analysis on the implementation, impact and outcomes of these programmes. This study therefore seeks to enhance the knowledge on the subject and close this gap in the available literature by doing a study on the examination of some substance abuse prevention programmes and their impact on minors who are prone to substance abuse in South Africa.

1.3 PURPOSE OF THE STUDY

The purpose of this study is to examine the impact and outcomes of several substance abuse prevention programmes and to develop lawful practical solutions and strategies for improving substance abuse prevention programmes in South Africa.

1.4 SIGNIFICANCE OF THE STUDY

The findings of this research are designed to contribute to the improvement of substance abuse prevention programmes implemented among minors in South Africa and to identify the problems that prevent the efficiency and effectiveness of these programmes. The findings will be linked to different relevant statutes dealing with substance abuse prevention programmes in South Africa. The findings of this study will also have an impact on individuals, families, communities and policy makers.

1.5 RESEARCH OBJECTIVES

- The general objective of this research is to critically analyse the implementation, impact and outcomes of several substance abuse prevention programmes implemented among minors in South Africa.

- The specific objective of this paper is to critically discuss how effective these substance abuse prevention programmes are in aligning themselves with the Prevention of and Treatment for Substance Abuse Act No 70 of 2008.

1.6 RESEARCH QUESTIONS

In order for the researcher to address the research problem and to attempt to meet the objectives of this study, the researcher will examine the following questions;

- How certain substance abuse prevention programmes are implemented among minors in South Africa?
- What are the outcomes and impact of these substance abuse prevention programmes?
- To what extent do these substance abuse prevention programmes apply and enforce the relevant legislation?
- How can South African substance abuse prevention programmes be improved?

1.7 METHODOLOGY

The researcher relies on qualitative research and also used comparative literature and sectional studies in regard to the examination of substance abuse prevention programmes and their impact on minors prone to substance abuse in South Africa. In relation to the comparative material, the researcher conducted an extensive desk-based literature search and has also employed library sources. In this regard, the extensive study of comparative literature permitted the researcher to provide the reader with relevant critical evaluations of existing substance abuse prevention programmes implemented among minors in South Africa.

1.8 THEORETICAL FRAMEWORK

The researcher employed the legal realist approach, as well as the historical approach to give the reader a better understanding of law. According to Maxwell (2012), qualitative researchers significantly and indirectly use the realist approach in their methods and suppositions. The legal realist theory is a natural approach to the law and how it is applied in prevention programmes. The realist approach consists of two important features, which are pertinent to qualitative research and these are; epistemology and ontology (Maxwell, 2010). Ontology relates to that which exists, whereas epistemology relates to how human beings obtain information concerning that which exists and, how anything can be understood (Maxwell, 2012). Moreover, both the epistemological and ontological approaches are a collection of fundamental assumptions that manage qualitative research (Maxwell and Mittapalli, 2010). Nonetheless, the epistemological and ontological perspectives are a valid means of conducting qualitative research (Maxwell and Mittapalli, 2010). This study treats the legal realist approach as a method of understanding the implementation, impact and outcomes of substance abuse prevention programmes implemented among minors in South Africa. The legal realist approach makes it easier to understand the different statutes regulating the prevention and treatment of substance abuse in South Africa. Moreover, the legal realist perspective assists the reader in understanding the successes and failures of substance abuse prevention programmes from a legal perspective.

The legal realist perspective also aids the reader to understand how the substance abuse prevention programmes deviate from the legal approach in addressing the abuse of substances. The legal realist perspective facilitates in revealing the legal language of the relevant acts, with regard to the implementation of substance abuse prevention programmes. Unlike positive and natural law theory, the legal realist approach focuses on the question of how laws are amended as well as how laws function in regard to courts, administrative issues or private entities in the community (Dworkins, 1986). In the context of evaluating the relationship between laws and the community by using the legal realist approach, Montesquieu has provided that

> "The whole aim is to show that laws are not born in the void, that they are not the result of positive commands either of God or priest or king; that they are, like everything else in society, the expression of the changing moral habits, beliefs, general attitudes of a particular society, at a particular time, on a particular portion of the earth's surface, played upon by the physical and spiritual influences to which their place and period expose human beings." (Tamanaha, 2013:17)

The exponents of the legal realist theory are fundamentally concerned about sustaining a theory which defines how the laws function (Leiter, 2007). Even though a number of legal realist exponents view laws through the lenses of a predictive theory, their fundamental concern is not about the theoretical aspects of laws, but it is about how laws function and the feasibility of decisions which are closely related to laws (Leiter, 2007). The legal realist theory stipulates that the challenge is not about understanding what a given law denotes, but rather it is about how a particular law exists and operates, and how it is adjusted to address different situations in a changing environment (Ehrlich, 1969). In addition, the legal realist theory states clearly that it is problematic to comprehend how laws are evaded or sidestepped and how laws are successful in circumventing prospective offenders and criminals (Ehrlich, 1969). This further adds weight to the choice of the legal realist theory in lieu of the positive and natural law theory, because the latter does not make use of morality. Moreover, Goldsworthy (2000) asserts that the natural law theory fails to establish lawful obligations in morality, thus, the said failure cancels the legal obligation. This is not to argue that legality depends on morality. According to Hart (1994), a balance must be struck between the demands of law and the interests of morality. Thus, the legal realist theory came into play due to the inability of the natural law theory to give a satisfactory explanation and/or clarity on morality.

Christiano and Sciaraffa (2003) state that everyone including officials and criminals are obliged to comply with the demands of the criminal law and hence such a legal duty is a component of morality, or moral commitment to laws of a given jurisdiction. In addition, the participation of officials in substance abuse prevention programmes is subjective and the abuse of substances by addicts is subjective too. Moreover, the illicit trafficking of drugs by drug traffickers is also subjective. The commitments of all the above parties to their different activities cannot explain a legal obligation, because their actions are subjective and depend on the length of participations (Bratman, 2002).

It is correct to say that the mere presence of well-defined statutes cannot give rise to a legal obligation on the part of the said parties, especially if moral interests are disregarded. Thus, Batman (2002) contends that the three above-mentioned accounts can be rectified by introducing the application of moral precepts as solutions. For the purposes of clarity, the legal realist theory identifies the moral obligations of all participants in given activities with regard to demands of criminal laws (Batman, 2002).

The legal realist theory also underpins the notion that the Constitution of the Republic of South Africa Act 108 of 1996 (hereinafter referred to as the Constitution) and the Criminal Procedure Act 51of 1977, demand the compliance of all parties to the legislation within a given jurisdiction, whether or not such parties consented to abide by the laws of the land (Batman, 2002). Moreover, the preceding assertion is echoed and strengthened by Austin (1998) who states that a legal system prevails in a sovereign state, where laws are continuously abided by the majority of those who live in it and, such inhabitants owe their allegiance to the laws of the land. In addition, Hart (1994) fills in knowledge gaps in the foregoing contention and asserts that persons in a sovereign state not only must obey laws, but they are also restricted by the same laws. The legal realist theory places emphasis on a clear definition(s) of an offence(s) and the overall obedience of people to laws, which is a moral obligation (Green, 1997). Granted the preceding scholarly assertions, it is abundantly explicit that the legal realist approach provides an in-depth understanding about how laws can be understood in terms of this study.

For the purpose of clarity, this study encompasses a comparative section in which certain domestic and international substance abuse prevention programmes are compared and contrasted within different legal jurisdictions. Moreover, the legal realist theory is appropriate for the lay person as well as for the legal fraternity, because it simplifies a contextualised description of international law, which contributes to global problem solving (Alter, 2014). Prior to globalisation, the legal realist theory played a minimal function in the international legal hypothesis and this was because the international law was characterised by relationships between nations and courts were not equipped to accommodate, apply and make sense of it (Shaffer 2014). The legal realist theory is currently more relevant than it was in the previous epochs. The aforesaid contention is evidenced by the following problem solving approach. For example, many problems which were traditionally addressed by using available laws within a given state, can no longer be dealt with by using national laws (Shaffer, 2016). Thus, the globalised world is socially, culturally and economically interconnected and transnational legal rules/laws increasingly permeate domestic legal structures (Shaffer, 2016). In short, individual states do not have monopoly in the sphere of transnational law-making. With reference to this study, the insertion of transnational legal rules into the South African legal system is necessary because such an approach has the potential to strengthen domestic substance abuse prevention programmes implemented among minors in South Africa. According to Lebese, Ramakuela, and Maputle (2014), the addiction to illicit substances by minors in South Africa is a national crisis. Hence, substance abuse prevention programmes are correlated to the victims of illicit substance addiction. The availability of illicit drugs and the addiction to illicit drugs can be addressed by using the realist approach.

The historical approach is also relevant to this study for the following reasons: (a) for comprehending the historical evolution of substance abuse prevention programmes and organisations and (b) for understanding the people and the change in South African statutes with specific reference to the relevant legislation (Brown and Härtel, 2011; Sydow, Schreyögg, and Koch, 2009). Therefore, the historical theory is concerned with revealing the truth and reformulating the past, that is, in regard to the substance abuse prevention programmes implemented among minors (Fulbrook, 2003). By endorsing this school of thought, emphasis was focused on a number of substance abuse prevention programmes implemented among minors in South Africa

1.9 THE CHAPTERS OF THE DISSERTATION

The present chapter serves as an introductory chapter as it describes the research problem, which is a very significant element of the research design. The rationale, objectives, research questions, methodology, a detailed literature review and a synopsis of relevant theories which underpin this study are discussed in this chapter. The other chapters of this dissertation are as follows:

Chapter Two: this chapter will focus on the relevant legislation that will guide and inform this study as well as indicate how the various substance abuse prevention programmes aid the application and enforcement of such legislation.

Chapter Three: this chapter will provide a detailed examination of the various substance abuse prevention programmes that will form the basis for the analysis in this study as well as their implementation and outcomes. The four specific programmes that will be reviewed are Teenagers Against Drug Abuse (TADA), Programmes of Primary Prevention through Stories (POPPETS) and *Ke-Moja*. Their efficacy will be determined mostly by evidence of monitoring and evaluation that has been done on the respective programmes by previous researchers as well as the ability of the programme to meet its intended objectives which for the majority of these programmes, is to curb the abuse of substances.

Chapter Four: this chapter will draw a comparative evaluation of various South African substance abuse prevention programmes and those of other countries so that the reader can see what strategies South Africa can adopt from those countries to improve such programmes.

Chapter Five: this concluding chapter will focus on an analysis of the researcher's findings, discussions and recommendations on how these substance abuse prevention programmes can be further improved in South Africa.

1.10 LITERATURE REVIEW

The abuse of substances amongst minors is a continuous key global challenge, especially in South Africa (Alhyas *et al*., 2015; Chakravarthy, 2013; Kalantarkousheh *et al*., 2014; Dada *et al*., 2014; Setlalentoa, Ryke and Strydom, 2015; Chakravarthy Shah and Lotfipour, 2013; United Nations Office on Drugs and Crime, 2015). "Studies conducted in South Africa indicate that the average age of a first-time substance user is 12 years" (Madu and Matla, 2003 cited in Mohasoa, 2010:22); (Reddy *et al*., 2010 cited in the Department of Social Development, 2013) (hereinafter DSD). The DSD (2013) also reports drug use of children as early as nine years which raises concerns as children are beginning to use and abuse substances at a much younger age. 36% of grade 6 learners were reported to have had experienced pressure to use cannabis and 51% had experienced pressure to drink alcohol (DSD, 2013). Several non-governmental organisations and government departments are continuously formulating methods/programmes for the prevention of substance abuse among minors. Some of the methods include the following: preventing the sale and consumption of substances by minors and; strictly limiting the advertisements of substances by demanding publication of warnings on the containers of alcohol and cigarettes. Alcohol, tobacco and cannabis are cited as the most widely abused substances (DSD, 2013). A study of substance abuse trends found alcohol to be the second most commonly abuse substance, preceded by cannabis among adolescent patients admitted for rehabilitation in Durban, KwaZulu Natal (Parry *et al*., 2004 cited in DSD, 2013:18). Mpanza and Govender (2017) also note the use of substances during ancestral worship ceremonies being considered a "cultural norm", with poor regulation of home-brewed or grown illicit substances also being problematic. Rural adolescents are sometimes introduced to substance usage through traditional ceremonies.

According to (DSD, 2013:21) smoking cigarettes leads to an interest in other hard drugs. More needs to be done to control easy access to tobacco products by young people. Both local or foreign brands must have references to specific relevant statutes included on the exterior of such containers; relevant statutes must be enforced to prevent the consumption of substances in public places (Liquor Act, 2003; Tobacco Product Control Act 1993; Tobacco Products Amendment Bill B24, 2006; World Health Organisation Framework Convention on Tobacco Control, 2003; World Health Organisation, 2013).

According to the United Nations Office on Drugs and Crime UNODC (2016) minors and adolescents in South Africa abuse the following substances: methylated spirit, brandy, beer and cannabis. It has also been documented that minors and adolescents in South Africa abuse a number of other substances such as cocaine, heroin, snuff, glue, ecstasy, crack cocaine, dagga, and tobacco (Mothibi, 2014; Setlalentoa *et al*., 2015). School children in South Africa continue to fall victim to substance abuse despite efforts to implement school based substance abuse prevention programmes. A study by (SACENDU, 2016) in SANCA East London found that 36% of patients admitted in the treatment centres were school learners. Another study by Parry (2006) among Grade 8 learners in Cape Town found that there was a significant association between the use of substances and the learners' school attendance and progress. The chances of repeating a grade were 60% higher for learners who used substances (Parry, 2006). Substance abuse by learners affects their learning abilities and the prospects of them having a progressive future. Furthermore, young people caught is the cycle of substance abuse are also likely to engage in criminal activities which leads to incarceration.

According to Bhana (2007) there is a strong correlation between crime and substance abuse in South Africa. In addition, substance abuse has far reaching negative effects on the South African economy amounting to one percent of the country's GDP or about R8.7 billion per year (Parry, Myers and Thiede, 2003 cited in Bhana, 2007). If government invests more funds in substance abuse prevention strategies today, there will be less damage to salvage in future. It can be argued that substance abuse is the root cause of most social ills facing the South African communities today hence preventing this scourge will reduce some of the ripple effects of substance abuse. HIV/AIDS, domestic violence, child abuse and neglect, violence and injuries motor vehicle accidents are but a few negative incidents related to substance abuse in South Africa (Kalichman *et al*., 2006; Taylor, Dlamini, Kagoro, Jinabhai, and de Vries, 2003; Morojele *et al*., 2006; Morejele, Brook, and Kachieng'a, 2006; Wechsberg, Luseno, Lam, Parry, and Morojele, 2006 cited in Bhana, 2007). It is clear that more needs to be done in terms of substance abuse prevention programmes implemented in schools to ensure that they are more effective. Effective prevention programmes are likely reduce the substance abuse problem which is threatening to cripple the South African economy and its people. Government has recognised that preventing the problem

of substance abuse requires different departments and organisations to work together (Parry, 2006).

The South African National Council on Alcohol and Drug Dependence (SANCA) is one of the organisations that is responsible for rendering substance abuse prevention programmes in schools. The main programmes rendered by SANCA are TADA (Teenagers Against Drug Abuse) and Poppets (Puppet education for pre-school and early school children). They also render life skills education and pupil support programmes for learners (Parry, 2006). While SANCA officials are well trained experts in the area of substance abuse, many officials rendering substance abuse prevention programmes do not have extensive training in the field of substance abuse. For example, teachers and social workers also often have to run substance abuse prevention programmes in schools. The DSD is mandated by the Prevention and Treatment of Substance Abuse Act to implement substance abuse prevention programmes for children (DSD, 2013). These programmes are often implemented by social workers who have to be responsible for running and sustaining these programmes. This is one of the many services that social workers are mandated to deliver which becomes a challenge as social workers are confronted with a backlog of foster care cases and higher than average caseloads. As a result, social workers are not giving substance abuse prevention programmes the time and energy needed for them to be effective and consistent because they are faced with other case-based issues. The message content and leader characteristics are interrelated to producing more or less effective programmes**.** The DSD also requires social workers to report monthly statistics in the form of non-financial data (NFD) upon rendering these programmes, this puts social workers under pressure to deliver quantity over quality without realising what impact this is having on the children.

There is a high possibility that programmes run by social workers may not be as effective as they should be because they do not possess the appropriate training and background. Setlalentoa and Strydom, 2015; Slabbert, 2015 and Galvani, 2015 emphasise the importance of training for social workers to effectively intervene in substance abuse prevention strategies. The authors recognise that social workers do not always possess the relevant skills and training in the field of substance abuse apart from the graduate training they acquire at university. According to (Hansen, 1992 cited in Gottfredson and Wilson, (2003) the training and background of the leader may be

important factors in substance abuse prevention. The DSD should appoint separate social workers who will deal strictly with the implementation and running of substance abuse programmes. These social workers must undergo extensive substance abuse training for at least six months before they can begin working on these programmes. More resources and budget also need to be allocated to invest in these programmes in order for them to be more effective. Often social workers do not have the appropriate resources such as visual aids, pamphlets, handouts etc. to assist them when conducting such programmes. According to Mohasoa, (2010) Adolescents may experiment with substances despite having heard about their negative effects. Visuals can have the power to enhance the substance abuse message being delivered as the children can actually see what damage substances can do to them as opposed to just hearing. Reviews suggest that the important role of the facilitators in reducing substance use (Gottfredson and Wilson 2003).

Most school-based programmes are facilitated by teachers (Gottfredson and Wilson 2003). Unfortunately, like social workers, school teachers themselves also do not possess specialised knowledge or have special training on substance abuse, yet they are also expected in their role as teachers to educate the children on substance abuse this can lead to inconsistent and conflicting substance abuse messages being delivered to the children. What is the intended message being passed on to the children by these programmes, that it is alright to drink when you reach the age of 18 years? Or is the intention to teach them that alcohol is bad for them period no matter how old one is? The issue of consistent messages is an important part of effective substance abuse prevention programmes in South Africa.

There could also be a number of other reasons why these programmes may not be achieving the desired impact such as the contents, delivery mechanism, duration and timing of these programmes (Gottfredson and Wilson 2003). In a study conducted by Gottfredson and Wilson, (2003) it was found that programmes delivered by peers were more effective and had more impact than those delivered by school teachers. TADA is one of the programmes which are peer led and there may be a need to put more focus and efforts on similar peer led programmes to yield more positive results. Learners need to feel that they run and own these programmes and they need to be given more support and resources to make this possible. Gottfredson and Wilson found that peer alone delivery in schools had the highest impact of (0.20) while programmes without had a significantly

smaller impact of (0.5) Gottfredson and Wilson (2003). If peer pressure has been identified as one of the primary factors for minors abusing substances (Mohasoa, 2010) then it is safe to assume that similarly prevention messages coming from the same would yield more positive results/outcomes.

Male learners have also been identified as the gender more prone to substance abuse then their female counterparts (Parry, 1998; Mohasoa, 2010; Miller and Carroll, 2006; SACENDU, 2016; Department of Social Development, 2013). This raises a question of whether or not gender based or gender specific substance abuse prevention programmes would be more beneficial for learners and would produce more positive outcomes. Taylor, Jinabhai, Naidoo, *et al*., 2003 cited in the Department of Social Development, (2013:19) refer to an "earlier study involving 1318 students in grade 10 from 28 high schools in southern KwaZulu Natal, 53% of males and 25% of females reported ever having used alcohol".

A gender-based approach might be needed in substance abuse prevention. According to Mohasoa, (2010:13) "Most high schools encounter problems with males who smoke cigarettes and dagga on the school premises… Some of these males come to school under the influence of liquor". Such incidents may be dangerous because "once these adolescents are under the influence of drugs, they become aggressive and violent towards their parents, educators, other learners, and other members of the community" (Mohasoa, 2010:3). This violent behaviour in turn disrupts teaching and learning. Mohasoa (2010:35) explains:

> "Furthermore, school children who use substances often suffer from impairment of short-term memory and other intellectual faculties, impaired tracking ability in sensory and perceptual functions, preoccupation with acquiring substances, adverse emotional and social development and thus generally impaired classroom performance. Reduced cognitive efficiency leads to poor academic performance, resulting in a decrease in self-esteem and the adolescent may eventually drop out altogether." (Mohasoa, 2010:35)

Many researchers agree that the role of the family especially parents is paramount in the prevention of substance abuse by minors (Van Eeden, 2008; Strader, Collins, and Noe, 2000; Muisener, 1994). Clearly the family can play a key role in preventing substance abuse by their children. Hence more substance abuse prevention programmes should focus on strengthening family relationships so that

in turn the family serves as a strong support system for its children and members have clear facts and information on drugs that they can pass on to their children. It is vital for parents to build open relationships with their children so that the children feel free to share their experiences both pleasant and unpleasant that they may come across at schools. Children will probably be confronted with the temptation to experiment with drugs at some stage of their school life (Van Eeden, 2008). There is a great need to promote substance abuse prevention programmes that strengthen family relationships.

The family, like peers, may be able to achieve what many substance abuse prevention programmes implemented by teachers, social workers and the police, have failed to achieve. According to (Strader, Collins and Noe, 2000) a large number of children lack a sense of connection with their families. Reviving these connections may give children a sense of belonging and they may not feel the pressure to conform to their peers' negative influences. They also recommend programmes that are designed to create parent-child bonds by increasing meaningful engagement between children and their parents to prevent problem behaviors such as substance use and abuse (Strader, Collins and Noe, 2000). Such programmes have the power to achieve major strides in the fight against substance abuse as children spend most of their time at home with their families, and families are often the best role models for their children. Family support usually provides children with security because it helps them to adjust and also increases their chances of developing constructive relationships (Oetting *et al* 1992:106) cited in (Dreyer, 2012: 31). According to Muisener (1994:77):

> "The family is the primary holding environment for supporting the adolescent's development. When a family is functioning as an adequate holding environment, the teenager will experience the continuous safety and support of a firm but flexible family environment, encouragement for appropriate expression of a wide range of feelings, and a clear sense of proactively dealing with issues that arise in family life."

With regards to bonding with the family, researchers report a strong link between a lack of child-parent connection and initiation of drugs (Brook, Lukoff, and Whiteman, 1980; Kandel, Kessler and Margulies, 1978) cited in (Strader, Collins, and Noe, 2000). This invaluable research points us to a different direction that has not been the centre of substance abuse prevention programmes.

Although some programmes like *Ke- Moja* do have a section focusing on parenting skills, not much attention has been given to its implementation which is unfortunate since research strongly links poor parenting skills to substance use and or abuse. Hawkins *et al* (1992:82) cited in (Strader, Collins, and Noe, 2000:15) stress that "Poor parenting practices, high levels of family conflict, and low bonding between parents and children seem to increase the risk of a large variety of adolescent problems, including drug abuse". Parents are often afraid to speak up and ask for help from outsiders when it comes to parenting their children. This is where the DSD can come in to close this gap as that department also recognises the important role played by the family in prevention of substance use or abuse by their children, as evident in the department's stance:

> "The effects of drug use on adolescents and young people inter alia revolve around the family environment. The parental home, as generally the first institution responsible for socialising children appropriately, plays a decisive role in molding and instilling appropriate attitudes and behaviour patterns. Parents should bond, create and maintain an affectionate relationship with their young." (Department of Social Development, 2013:28-29)

According to Muisener (1994) there is a greater chance of children abusing substances or being prone to substance abuse if the family acts a negative influence to a significance degree. Strong positive influences from the family can prevent children from developing substance abuse problems (Muisener, 1994). Substance abuse prevention programmes need to focus more on the family as an agent of change in substance abuse prevention. Parents need to learn positive and meaningful ways to discipline and interact with their children and do away with poor and inconsistent methods.

Positive influences are important, but so is the mitigation of negative parental influences such as substance abusing parents or caregivers. The promotion of substances such as alcohol and tobacco can also have an indirect negative impact on children as it may lead to the breakdown of family structures. When adults have access to alcohol and tobacco it may affect their parenting skills which may lead to hostile behaviours within the home affecting interpersonal relationships within the home and with their children. Substance abusing parents also often have a tendency of neglecting their parental duties thereby limiting their abilities to safeguard their children's best interests and affecting the family's ability to function habitually (Choate, 2015). It may also

convey negative connotations to children that it is acceptable to use these substances (Griffin, Samuolis and Willliams, 2011) and (Choate, 2015).

According to Baxter (2012) older siblings may also find themselves taking on the parental role of their younger siblings due to the parent's inability to perform their parental tasks when intoxicated. This robs the children of their childhood years. When parents refrain from using alcohol, tobacco and other substances their children are less likely to use such substances as well and have the opportunity to grow up in a healthy home environment (Griffin, Samuolis and Willliams, 2011). Parents need to model positive behaviour to set good examples for their children so that their children may become productive adults. Children often model their parent's behaviour hence if such behaviour involves substance abuse by parents then children are likely to follow in the same footsteps (Griffin, Samuolis and Willliams, 2011 and Choate, 2015).

According to Van Eeden (2008) parents can do the following to prevent their children from engaging in risky behaviors such as substance abuse:

1. Encourage open communication within the family;
2. Educate themselves on the facts about drugs;
3. Ensure that they know their child's friends and the places they frequent without creating the impression that they do not trust them;
4. Become involved in their child's life, not just in school activities but also sports and recreational activities;
5. Support their children and encourage self-discipline and a sense of responsibility;
6. Reward positive behavior, but not with large amounts of money;
7. Treat their children with respect.

According to Dreyer (2012) as far as guidance, support and encouragement are concerned, the family remains an important part of the child's life despite the increasing influence of peers. However, the family alone cannot be a solution, the child's peers and school also play an important role that could easily undo the work done by parents. A programme that could bring all these systems to work together might be a breakthrough in substance abuse prevention. For any learner's substance abuse behaviour to be changed, it is important that the young people's social context is

taken into consideration before any intervention is implemented. This includes the learner's parents or guardians (Dreyer, 2012).

While the role of the family/parents remains paramount, the schools and peers also play an important role in influencing the child either negatively or positively. This requires that these systems integrate and work together to achieve plausible results as the substance abuse problem affects all these systems. "Once these adolescents are under the influence of drugs, they become aggressive and violent towards their parents, educators, other learners, and other members of the community" (Mohasoa, 2010: 3). In addition, some male adolescents are arrested by the police because of their involvement in criminal offences such as robbery, house breaking, shoplifting, theft of stock, rape and murder (South African Police Service, 2007) in (Mohasoa, 2010: 3). We need to create a system where the adolescents are free to speak to their parents and teachers about certain issues and concerns and where peers positively influence each other, where parents are actively involved in their child's social and school life and build an atmosphere where these systems actively interact and work together to prevent substance abuse and other related social ills.

1.11 MAIN FINDINGS OF THE LITERATURE REVIEW

The main findings of the literature review highlight that there is a need for:

- More resources and budget allocation for substance abuse prevention strategies;
- Specialised standardised training for all substance abuse facilitators;
- More focus on peer led programmes;
- Gender based prevention programmes;
- Integration of intervention strategies by all stakeholders;
- Reinforcing social, parental and family bonds.

The literature reviewed does not sufficiently evaluate the prevention programmes that have been implemented in South Africa. The gap in the literature extends also to a lack of application of the relevant domestic legislation. Substance abuse is a global phenomenon, yet, there is no comparative study that seeks to ascertain good practices from other jurisdictions. The researcher seeks to address these gaps.

1.12 CONCLUSION

> "Parents, educators, social workers and the police have tried their best to encourage the adolescents to stop using substances through awareness campaigns, but their efforts seem to be ineffective. There is a need for intensive intersectoral intervention strategies to address the substance abuse problem before it escalates even further." (Mohasoa, 2010: 3)

Involving the child's school, family and peers is one way that these systems can combine and together fight this war on substance abuse. Programmes that promote the school, family and peers to all work together have the possibility to produce effective and plausible results since we have identified that all these systems play an important role in the child's life and development. More money and research needs to be invested into the arena of substance abuse prevention programmes to ensure its effectiveness or lack thereof. More money and time needs to be invested into the programmes proven by research, monitoring and evaluation to be more effective in curbing substance abuse among minors in South Africa such as parenting programmes, for example.

> "The key to effective prevention efforts is reinforcing, within every arena, these natural social bonds… between young and old, between siblings, between friends… that give meaning to one's life and a reason for commitment and caring." (Strader, Collins and Noe, 2000:66)

CHAPTER TWO
LEGISLATIVE FRAMEWORK

2.1 INTRODUCTION

This chapter will discuss and analyse the applicable statutes and provisions which guide and inform substance abuse prevention programmes in South Africa. Relevant policy documents will also be discussed. The latter part of the chapter will also examine how these policies are implemented and the impact of substance abuse prevention programmes on minors in South Africa. It is important to note that South Africa is also signatory to the UN Convention on Narcotic Drugs, 1961 regarding the control of illicit substances (Van Nierkerk, 2011). This particular treaty however will not be discussed in detail.

Some of the domestic and international documents that will inform this study are as follows:

1. International and regional law;
2. The Constitution of the Republic of South Africa, 1996;
3. The Children's Act 38 of 2005;
4. The Child Justice Act 75 of 2008;
5. The Prevention of and Treatment for Substance Abuse Act No 70 of 2008;
6. The Drugs and Drug Trafficking Act No. 140 of 1992 (as amended in 2010)
7. The Regulations for Prevention of and Treatment for Substance Abuse, 2013.
8. The National Drug Master Plan (NDMP) 2013-2017.

2.2 LEGAL FRAMEWORK

2.2.1 Brief overview of the international and regional law framework

South Africa is a signatory to the United Nations Convention on the Rights of the Child (CRC) and has incorporated this treaty into its domestic law through the Children's Act. The CRC, in article 33, requires States to "take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and

psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances."

In its General Comment no. 15 (2013) on the right to health articulated in article 24 of the CRC, the Committee on the Rights of the Child has called for provision of information and education for children on health issues such as 'the dangers of alcohol, tobacco and psychoactive substance abuse' (para 59); as well as for prevention of substance abuse (para 62). The Committee further calls on States to "protect children from solvents, alcohol, tobacco and illicit substances, increase the collection of relevant evidence and take appropriate measures to reduce the use of such substances among children", including regulation of the advertising of substances (para 65). The Committee specifically acknowledges the role of parents in early diagnosis and as "the most important protective factor" against "high-risk behaviour" such as substance abuse. Accordingly, the Committee calls on States to "adopt evidence-based interventions to support good parenting, including parenting skills education, support groups and family counselling, in particular for families experiencing children's health and other social challenges" (para 67). In its General Comment on Adolescent Health, the Committee also emphasises the provision of information to adolescents about the use and abuse of substances (para 29).

In its Concluding Observations on South Africa's Second Periodic Report to the Committee, the Committee recommended that the South African state takes measures to reduce drug use, through inter alia provision of "accurate and objective information" and "life skills education" on the prevention of substance abuse (para 48(h).

The African Charter on the Rights and Welfare of the Child in article 28 requires states parties to "take all appropriate measures to protect the child from the use of narcotics and illicit use of psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the production and trafficking of such substances." The other relevant treaties are:

- Single Convention on Narcotic Drugs, 1961; South Africa ratified this convention on the 16th of December 1975. This Convention aims to combat drug abuse by coordinated international action. It seeks to limit the possession, use, trade in, distribution, import,

export, manufacture and production of drugs exclusively to medical and scientific purposes. The Convention combats drug trafficking through international cooperation to deter and discourage drug traffickers which is likely to control the access of illegal substances by minors.

- Convention on Psychotropic Substances, 1971; This Convention establishes an international control system for psychotropic substances. It is designed to control psychoactive drugs such as amphetamine-type stimulants. South Africa ratified this convention on the 27th of January 1972. By doing so South Africa has an obligation to protect the country and all its children against harmful substances.

- United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988; this Convention provides comprehensive measures against money laundering and the diversion of precursor chemicals. It provides for international cooperation through, for example, extradition of drug traffickers, controlled deliveries and transfer of proceedings. South Africa acceded to this treaty on the 14th of December 1998. The accession of this treaty means that South Africa is committed to the fight against substance abuse and to assuring that drug traffickers are caught and arrested.

- The World Health Organization Framework Convention on Tobacco Control; The Convention was developed in response to the globalization of the tobacco epidemic and is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. The Convention represents a milestone for the promotion of public health and provides new legal dimensions for international health cooperation. South Africa acceded to this treaty on the 13th of April 2005.

2.2.2 Constitution of the Republic of South Africa, 1996

Sections 28 of Chapter 2 of the Constitution of the Republic of South Africa, 1996 (hereinafter referred to as the Constitution) provides for a range of rights that are specifically dedicated to children. This right includes a right to basic health care services and social services in section 28

1(c) of the Constitution. The Constitution is the framework of which all other laws and legislation are aligned to and hence can be seen as the cornerstone of all laws regulating the prevention and treatment of harmful substances generally and among minors. Sections 10-12 of the Constitution states that everyone has a right to dignity and such a right must be respected and protected; furthermore, it goes on to say that everyone has a right to life and a right to freedom and security of that person. All these rights enshrined in the Constitution are applicable to all citizens of South Africa including children. Furthermore, these rights are enjoyed equally by all children in addition to the specific children's rights provided in section 28 of the Constitution. A study done by Parry *et al* in patients admitted for rehabilitation in Durban, Kwa-Zulu Natal found alcohol as the second most commonly abused substance after cannabis among adolescent patients (Parry *et al.*, 2004 cited in Department of Social Development, 2013). Evidence has shown repeatedly that alcohol and cigarettes, although very much legal, are also harmful.

The constitutional right to life arguably includes the right to survival and development regulated under international law. Article 6 of the Convention on the Rights of the Child (CRC) 1989, also recognises that every child has an inherent right to life (including survival and development) and that government must ensure by all means possible the survival and development of the child. The rights to life and dignity are compromised when policymakers legalise substances that are proven to cause harm to individuals using them by shortening their life span and hindering the healthy development of children. Abusing substances during the adolescence stage can have marked detrimental effect on the child's development (Kylmänen, 2005 cited in Otingi, 2012). This highlights the importance of prevention strategies that aim to protect children against all harmful substances this includes reviewing policies that legalise substances such as alcohol and tobacco which have the ability to adversely affect child development and survival.

2.2.3 The Children's Act 38 of 2005

The Children's Act provides measures for both prevention of substance abuse; treatment and rehabilitation of addicted children; as well as protection from harm.

2.2.3.1 Treatment:

Section 150(1)(d) of the Children's Act identifies a child that is addicted to a dependence-producing substance and is without any support to obtain treatment for the dependency as a child in need of care and protection. Such status entitles the child to supportive measures.

In its Second Periodic Report on the CRC, the South African government reported that there are eight public treatment centres and 50 private treatment centres, half of which receives state subsidies (para 243). The South African government acknowledged that services targeting the very poor are inadequately subsidised (para 243). Rural areas are most under-resourced when it comes to treatment programmes. Mpanza and Govender (2017) in their study of a rural community in KwaZulu-Natal also highlighted the lack of treatment facilities.

As for prevention, the South African government reported that it uses measures such as "substance-abuse awareness-raising activities" coordinated under the Anti-Substance Abuse Programme of Action and acknowledges the role that the non-governmental sector plays in provision of awareness, prevention and treatment services particularly in relation to "chemical dependence" (paras 237 and 238).

2.2.3.2 Protection:

Section 7(1) of the Children's Act 38 of 2005 talks about the need to protect the child from any physical and psychological harm that may be caused by-

(i) subjecting the child to maltreatment, abuse, neglect, exploitation or degradation or exposing the child to violence or exploitation or other harmful behaviour or-

(ii) exposing the child to maltreatment, abuse, degradation, ill-treatment, violence or harmful behaviour towards another person

The availability of drugs in society directly places children at risk of abuse and neglect. Alcohol is legal hence easily available even though it has the potential to destroy lives and cause chaos not only within families but in society as well subjecting children to violence and abuse within their own homes. Baxter (2012) makes a strong correlation between substance abuse and child abuse. According to Baxter (2012) children's basic needs such as food, health and education may be neglected if the parents are victims of substance abuse. Furthermore, the author notes that children could also be subjected to violence at the hands of a family member who is addicted to drugs (Baxter, 2012). Intoxicated parents may become abusive towards each other and also towards their children. Accordingly, it is submitted that policy makers need to revisit the legalisation of substances such as alcohol and tobacco and work on strengthening prevention strategies to protect children from physical and emotional forms of violence and degradation. It is not enough that there are laws restricting children under the age of 18 from smoking and drinking as the very same adults who are allowed access to such substances can cause direct harm to children as a result of these so called legal substances. Neither is placing high taxes on alcohol and tobacco the only solution (this is discussed below). Adults' free access to alcohol and other substances may subject children to abuse, neglect and degradation hence infringing the child's right to be protected from such.

Apart from being a victim of child abuse, children may also themselves grow up to be victims of substance abuse as a result of being exposed to parents who were abusing drugs in their families (Baxter, 2012). Parental substance abuse hence exacerbates issues of child safety, health and protection (Baxter, 2012). Policies that protect children by prohibiting parents from gaining access to harmful substances will be in the children's best interest as enshrined in section 9 of the Children's Act. If the best interest of children is of paramount importance as specified by section 9 of the Children's Act, then government ought to ensure that children are protected from substance abuse through various strategies and interventions that include policy changes.

2.2.3.3. Prevention:

Section 144 of the Children's Act focuses on the purposes of the prevention and early intervention programmes. Section 144 (1) states that prevention and early intervention programmes must focus on, *inter alia*:

(a) Preserving a child's family structure;

(b) Developing appropriate parenting skills and the capacity of parents and caregivers to safeguard the well-being and best interests of their children, including the promotion of positive, non-violent forms of discipline;

(d) Promoting appropriate interpersonal relationships within the family;

(f) Preventing the neglect, exploitation, abuse or inadequate supervision of children and preventing other failures in the family environment to meet children's needs;

According to section 144 (1) (f) of the Children's Act, parents have a duty to prevent the neglect, exploitation, abuse or inadequate supervision of their children as well as to prevent other failures in the family environment in meeting their children's needs. Substance abusing parents may unintentionally expose their children to abuse, neglect and exploitation. Such parents may also fail in their role of providing adequate parental supervision to their children (Baxter,2012).

Davel and Skelton (2015:12) explain that the Children's Act's "definition of prevention emphasises building the capacity and self-reliance of families to deal with problems relating to the family environment" whilst early intervention appears to be defined broader, relating to "factors that may result in children being harmed or removed into alternative care."

The Children's Act requires the determination of Norms and Standards for Prevention and Early Intervention Programmes (PEIP) (section 147(2)). These Norms and Standards have been issued under regulations for inter alia outreach services, education, information and promotion programmes, therapeutic programmes and family preservation. These particular PEIP do not directly identify provision of substance abuse prevention or treatment programmes and are rather generically framed. The only programmes that mention substance abuse are the diversion programmes which aim to assess children's needs in relation to substance abuse. The Norms and Standards require annual assessment of the programmes, including in relation to the degree to which the programme reached its intended target, receipt of quality services, impact on children,

families and communities, availability and efficient utilization of the programme resources, ability of staff to implement the programme and its sustainability (clause 8 of the General Regulations regarding Children, 2010 (Annexure B: Part IV: National Norms and Standards for Prevention and Early Intervention Programmes). Such annual assessments are not available on the website of the Department of Social Development.

In relation to prohibition, the Children's Act is instructive as it prohibits the sale of alcohol and tobacco to children at places of entertainment (section 140(3)).

2.2.4 The Child Justice Act 75 of 2008

Substance abuse by adolescents often lead to incarceration of minors as they are likely to engage in petty crimes as a result of substance abuse or a means to finance their substance abuse habits. Probation officers (who are social workers by profession) play a crucial role in assessing and providing diversion and mediation services for children in conflict with the law as provided by the Child Justice Act 75 of 2008 (hereinafter referred to as the Child Justice Act). Chapter 5 of the Child Justice Act outlines the duty of the probation officer to assess children as well as the purpose of assessment. Chapter 7 outlines the nature and objectives of a preliminary inquiry and chapter 8 outlines the objectives of diversion amongst other things. The purposes of diversion and victim-offender mediation is to keep minors away from the criminal justice system by avoiding criminal charges or obtaining a criminal record. It also provides an opportunity for restitution to victims of the offences.

2.2.5 The Prevention of and Treatment for Substance Abuse Act 70 of 2008

Chapter 4 of the Prevention of and Treatment for Substance Abuse Act No 70 of 2008 (hereinafter referred to as the Prevention of and Treatment for Substance Abuse Act) gives an outline of the prevention and early intervention services. Section 11 provides a detailed breakdown of provision of prevention and early intervention services by various stakeholders but makes no mention of the type of skills and training that these stakeholders ought to possess. The Act is not specific in terms of the skills and qualifications that are needed by facilitators tasked with implementing these prevention programmes. This is problematic as the skills and qualifications of the facilitator are important in producing quality and effective programmes. As a result, more attention is paid to the content and structure of the prevention programmes and the skills and qualifications of the

facilitator are often overlooked. Often programmes are run by different professionals with different skills and background. This compromises the effectiveness of these programmes as there may be inconsistent views regarding the rollout and implementation of these programmes.

While no special qualifications may be required to conduct prevention programmes, it may be useful for all facilitators from different backgrounds and qualifications, to be exposed to the same training for a certain amount of time. Such training would need to be standardised before any individual can undertake the task of facilitating any substance abuse programmes. This includes peer-led programmes, of which peer leaders will also require exposure to the same training. This will ensure standardisation across all facilitators of substance abuse preventions programmes and ensure that quality and consistent messages are communicated through the programmes. If communication is consistent then it is likely to be more effective. The Prevention of and Treatment for Substance Abuse Act also focuses on prevention, early intervention, treatment and reintegration programmes. Section 8 of the Prevention of and Treatment for Substance Abuse Act mandates the Minister of Social Development in consultation with other departments and organisations to establish integrated programmes for the prevention of substance abuse in South Africa.

Section 9 (2) of the Prevention of and Treatment for Substance Abuse Act states that prevention programmes must focus on the following: -

a) "preserving the family structure of the persons affected by substance abuse and those who are dependent on substances;
b) developing appropriate parenting skills for families at risk;
c) creating awareness and educating the public on the dangers of and consequences of substance abuse;
d) engaging young people in sports, arts and recreational activities and ensuring the productive and constructive use of leisure time."

Section 9 (2) (b) of the Prevention of and Treatment for Substance Abuse Act focuses on the importance of developing appropriate parenting skills for families at risk. As much as policy acknowledges the role of parenting as paramount in curbing the use of substances by minors in South Africa, it is surprising that not many prevention programmes are targeted at families or

parents. Many scholars agree that better parenting can reduce the likelihood of children falling into the cycle of substance abuse (Griffin, Samuolis & Williams, 2010; Kim-Spoon, Farley and Holmes, 2014; Choate, 2015; Jones, 2015; Telzer, Gonzales & Fuligni, 2013; Luk *et al*,2010; Calafat *et al*, 2014); Van Eeden, 2008; Strader, Collins, and Noe, 2000; Muisener, 1994).

Section 9 2 (d) of the Prevention of and Treatment for Substance Abuse Act echoes the desirability of engaging young people in sports, arts and recreational activities and ensuring the productive and constructive use of leisure time by young people. With boredom being one of the most common reasons cited by young people for consuming substances (Morojele, 2010, WHO, 2011 and Chesang, 2013), it is not surprising that legislation would prioritise recreation as one of its substance abuse prevention strategies. It has been suggested that boredom or even fear of boredom is the main reason young people engage in substance abuse. Substance abuse then acts as a satisfying form of recreation among young people (Chesang, 2013). Again this may seem anomalous as recreational activities are relatively uncommon especially in townships and township schools around the country. According to Mohasoa, (2010) an increased availability of recreational facilities may help to deter adolescents from abusing substances by engaging in more constructive activities. The availability of recreational activities will play a central role in keeping young people occupied and away from risky behaviours.

In looking at the harm reduction strategies provided in the Prevention of and Treatment for Substance Abuse Act, what is evident is that there are a number of inconsistencies or contradictions that arise. Alcohol and tobacco are the main substances that threaten communities, yet these very same substances are legalised (Van Niekerk, 2011). Anti-substance abuse communication warns children against all types of harmful substances illicit or not and that includes alcohol and cigarettes as they are known gateway substances to other harmful substances such as cocaine, mandrax, tik and other drugs. According to (Van Niekerk, 2011:80) “South Africa has given much thought and effort to combating the abuse of illicit and legal substances. The Prevention and Treatment for Substance Abuse Act No. 70, 2008 seeks to reduce demand, reduce harm and reduce the supply of illicit substances (including education and raising awareness).” It seems that much more thought needs to be applied to aligning policy to real life situations. Policies that legalise

harmful substances that could possibly affect the survival and development of children should not be condoned. The two most widely used legal substances, alcohol and tobacco, are ranked as the top most harmful substances Van Niekerk (2011). This important information should surely be taken into account in the formulation of substance abuse policies.

2.2.6 The Drugs and Drug Trafficking Act 140 of 1992

The Drugs and Drug Trafficking Act No. 140 of 1992 (hereinafter referred to as the Drugs and Drug Trafficking Act) aims to primarily address the problem of substance use, abuse, manufacturing and supplying in South Africa. It provides a legal framework on the use, possession and dealing of dependence producing substances and how the police can deal with such cases as well as the duty to report certain information to the police. The Drugs and Drug Trafficking Act has been criticised as being harsh and unfair insofar as the sentencing of cannabis users is concerned (Monyakane, 2016). The Act applies a one size fits all approach when sentencing drug traffickers and has thus been boldly criticised by most scholars as highly punitive and they therefore advocate for decriminalisation of cannabis and lesser sentences for cannabis users (Van Niekerk, 2011; Strang, *et al*., 2012; Felingham, et al.,2012; Pienaar and Savic, 2016; Monyakane, 2016). Drug policies in South Africa have historically been dominated by prohibitionist and supply reduction approaches aimed at achieving a drug free society (Otu, 2011; Parry and Myers, 2011). This study highlighted the importance of prevention strategies that aim to protect children against all harmful substances. It provided strong correlations between substance abuse and child abuse including child neglect and degradation. Evidence has shown that access to both legal and illegal substances is not in the best interest of children as it subjects young people to different forms of violence and limits the survival and development of children, indirectly infringing on a number of children's rights. Much more still needs to be done to combat the supply, demand and harm caused by substance abuse this includes the reviewing of certain policies.

2.2.7 The Regulations for Prevention of and Treatment for Substance Abuse, 2013

The Regulations for Prevention of and Treatment for Substance Abuse (hereinafter the Regulations) were designed to facilitate the implementation of the Substance Abuse Act which was passed by parliament on the 24th of June 2008.

Regulation 8 provides the following:

> "Minimum norms and standards for programmes that give effect to prevention [section 6(1)*(a)*]
> (1) Programmes that give effect to prevention of substance abuse must-
> *(a)* at all times be available and accessible to persons affected by substance abuse and to their families;
> *(b)* link service users with resources in order to maximise the use of existing infrastructure;
> *(c)* create developmental opportunities for new capacities that seek to promote resilience and increase ability of service users;
> *(d)* discourage experimental use of substances so that it does not lead to substance abuse;
> *(e)* promote assessment of the prevalence of substance abuse in the community;
> *(f)* educate individuals and communities and raise awareness about the dangers of substance abuse;
> *(g)* build capacity of persons likely to be affected by substance abuse;
> *(h)* promote healthy lifestyles for everyone in the community; and
> *(i)* identify specific groups and communities to be targeted for prevention."

Regulation 8 has played a very important role in guiding the implementation of prevention programmes in South Africa. The majority of prevention programmes implemented among minors in South Africa adhere to these regulations by raising awareness of the dangers on substance abuse and educating individuals and communities about the risks associated with substance abuse. They also discourage experimental use of substances to avoid addiction as well as encourage young people to engage in healthy lifestyles. Although the programmes encourage healthy and alternative lifestyles for young people as per regulation 8 1 (h), it becomes a challenge if there are not many recreational facilities for young people to engage in, as recreational facilities form an important part of promoting healthy lifestyles. Mohasoa (2010) emphasises the availability of recreational facilities as vital for promoting healthy lifestyles among the youth.

Regulation 8(1)(a) is also limited in scope considering substance abuse prevention programmes and services are not always accessible and available for all who need them especially in rural areas. According to the UNODC (2017) rural areas in both industrialised and developing countries often suffer from limited access to substance abuse prevention, treatment and recovery programmes and as a result they face disproportionate difficulties in addressing substance abuse challenges. Generally, substance abuse prevention programmes have at best aligned themselves with the relevant policies and legislation with regards to implementation. It is the duty of policymakers to ensure that such programmes are consistently implemented in both rural and urban areas alike. It

is also their duty to ensure that alternative lifestyles for young people in the form of recreational activities are available and accessible both in rural and urban areas.

2.2.8 The National Drug Master Plan (NDMP) 2013-2017

According to the Department of Social Development (DSD) (2015), the National Drug Master Plan (NDMP) 2013-2017 was designed by the Central Drug Authority (CDA). It has its origins in the Prevention and Treatment of the Drug Dependence Amendment Act No. 20 of 1992 (hereinafter the Prevention and Treatment of the Drug Dependence Amendment Act) as well as in the Prevention of and Treatment for Substance Abuse Act as amended and approved by Parliament. Chapter 4 of the (NDMP) 2013-2017 outlines three main approaches to dealing with the substance abuse problem in South Africa. These approaches are demand reduction, supply reduction and harm reduction. The CDA is responsible for the implementation of the NDMP. The CDA is a statutory body appointed in terms of the Prevention and Treatment of Substance Dependency Act (No. 20 of 1992 as amended (Dreyer, 2012). Apart from establishing the NDMP, amongst other things, the CDA also advises the Minister of Social Development on any matters affecting substance abuse as well as plan, co-ordinate and promote measures for the prevention and combating of substance abuse and the treatment of persons' dependent on them in accordance with the National Drug Master Plan (Dreyer, 2012).

According to NDMP (2013-2017) the CDA is made up of various state departments as well as twelve experts/professionals from the following bodies: universities; delegates from civil society, NGOs and religious institutions; the retail sector and manufacturers; social movement organisations; rehabilitation centers (where drug addicts receive treatment and psychotherapy); qualified and registered counsellors; and regional representatives from the substance abuse forums (DSD, 2015). According to NDMP (2013-2017) the expert members of the CDA are expected to apply their expert knowledge in the field of substance abuse as follows:

- To develop and apply integrated strategies addressing the demand, supply and harm caused by substance abuse;
- To develop policies that address the prevention, treatment, aftercare as well as reintegration of substance abuse victims into society amongst other functions (NDMP, 2013-2017).

Similar to the Prevention of and Treatment for Substance Abuse Act, the NDMP also has better parenting as its number one strategy in the combating of substance abuse. Although better parenting is given the highest priority in the NDMP and the Prevention of and Treatment for Substance Abuse Act there are generally no programmes aimed at families or parents this is inconsistent with the legislation. A recent study by Muchiri and Dos Santos (2018) highlights the vital role of the family in managing adolescent substance abuse, either as risk or protective factors: including parental monitoring, discipline, behavioural control and rewards. The National Drug Master Plan (2013-) also identifies recreation as its second most prioritised substance abuse prevention strategy after better parenting yet recreational facilities in most communities are very scarce. Lebese *et al* (2014) recommends that teenagers in a rural village be encouraged to actively pursue developmental programmes and recreational activities to prevent substance abuse.

Even though the NDMP emphasises that prevention programmes are the most important part of its strategy, it makes a contradicting statement that prevention programmes have a modest effect (Pienaar and Savic, 2016). If proper research was done in a local context before policy formulation takes place, then policy will not focus its attention on a strategy that has 'modest' effects. This strongly suggests that there is a lack of relevant research to inform policy decisions in this respect in South Africa. The depiction of the substance abuse problem as a global issue allows policymakers to rely on evidence formulated by global centres or experts and such evidence may not necessarily be applicable to the South African context (Pienaar and Savic, 2016. This is problematic as it may result in ambiguity and contradictions in the interpretation and implementation of policy. Prevention programmes, when implemented properly, have the potential to produce more than just modest results.

Prevention and early intervention services must be prioritised as primary levels of intervention, followed by rehabilitation, aftercare and reintegration services (Geyer and Lombard, 2014). This means that even the prevention messages have to be clear. This then raises the issue of legalisation of alcohol and cigarettes and decriminalisation of cannabis. It would be logical to legalise and decriminalise substances according to how much harm is caused by those particular substances. According to research by Parry and Myers (2011) it was found that "overall, alcohol was rated as

the most harmful substance, followed by heroin and crack cocaine. Tobacco was ranked the 6th most harmful substance, and cannabis was ranked 8th." (Parry and Myers, 2011:705).

Van Niekerk, (2011:80) states that "discussions based on formal assessment of harm rather than on prejudice and assumptions would enable a more rational debate about the relative risks and harm of drugs." The author further reiterates that the aim of all policies should be to reduce the harm caused by substance abuse. Stages of substance abuse policy making should include thorough research and consultation from the people on the ground. This will ensure that it meets its intended objectives such as of harm reduction. All drugs have the potential to harm but they do so in varying degrees and the creators of substance abuse policies need to take that into consideration in the formulation of policies regulating the control of substances.

Currently there are a number of loopholes that are identified in South African policies. Once policy adopts a clear, evidence-based and unambiguous approach, the prevention messages will also become clearer to children. Policies can be seen as indirectly recreating the problems they are aiming to solve. For example, it is not logical to legalise harmful substances such as alcohol and tobacco yet criminalise the use of cannabis which have been argued to have more or less the same effects (Van Niekerk, 2011). Hence a more evidence-based revised approach is needed for effective harm reduction strategies (Van Niekerk, 2011).

An important policy position is the yearly imposition of taxes on particular substances, for example malt beer and spirits. However, high taxes placed on alcohol and tobacco to discourage use of these substances can have adverse effects as people will continue to purchase such at the cost of neglecting their family's financial responsibilities, this will impact more negatively on already impoverished households.

Policy development around illegal substances is seen as contradictory as many policies exist but so little is done in practice to ensure these policies are effectively implemented. Parry & Myers, (2011) argue that the challenge is the lack of leadership on drug related issues as no single authority is responsible for the implementation of policies or held accountable for the policy failures and

successes. This task was originally assigned to the CDA but they have been unable to effectively carry it out (Parry and Myers, 2011).

2.3 CONCLUSION

This chapter has discussed and analysed the applicable statutes and provisions which guide and inform substance abuse prevention programmes in South Africa. The chapter has also discussed relevant policy documents and examined how these policies are implemented as well as their impact on substance abuse prevention programmes implemented among minors in South Africa. While in principle, programmes have been aligned with all relevant policy and legislation, in reality some of these programmes appear to be inconsistent with the laws. For example, the lack of recreational facilities which is emphasised by the prevention programmes and policies is one of the key prevention strategies that may prevent youth from abusing substances.

It is obvious that more research still needs to be done to assist in more realistic and evidence based localised policy formulations. The NDMP's acknowledgment of a lack of research in the arena of substance abuse is consistent with observations drawn by various scholars that there is in fact a lack of funding for such research in South Africa (Pienaar and Savic, 2016). Government needs to invest more funds in substance abuse research in South Africa if any significant progress is to be made in the prevention of substance abuse. The cost of the consequences of substance abuse in the economy is far more devastating than what it will cost government to invest in prevention programmes and strategies. According to (Parry, Myers and Thiede, 2003 cited in Bhana, 2007):

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

Hence investing in prevention programmes will have positive outcomes for the country's economy in the long run as substance abuse is slowly crippling the country's economy.

Given the limited research available on substance abuse prevention strategies, policymakers ought to be more careful in their policy proposals and assertions (Pienaar and Savic, 2016). There is a strong need for an evidence-based policy framework. This chapter has revealed that there is a lack of research and evidence to inform the formulation of drug policies in South Africa. It is also of vital importance that the people who are directly affected by these policies are consulted during the stage of policy formulation process going forward, in fact child and adolescent participation in policy formulation and law reform is imperative. It is further necessary to bear in mind that the substance abuse problem exists amidst other social ills such as poverty, unemployment and HIV/AIDS, hence it cannot be tackled in isolation of these issues. Ongoing monitoring and evaluation of these policies is highly necessary to ensure their effectiveness or lack thereof.

CHAPTER THREE
SUBSTANCE ABUSE PREVENTION PROGRAMMES IN SOUTH AFRICA

3.1 INTRODUCTION

The Prevention of and Treatment for Substance Abuse Act clearly states that "the purpose of prevention programmes is to prevent a person from using or continuing to use substances that may lead to abuse or result in dependence" section 9(1). In line with this legislation, a number of community based and non-governmental organisations have emerged to prevent abuse and implement substance abuse prevention programmes in South Africa. The Department of Social Development (DSD) (2006) has formed partnerships with various non- government organisations that deal with substance abuse, of which the South African National Council on Alcohol and Drug Dependence (SANCA) is the most important. Faith-based organisations and community-based organisations are also key role players. Most of these organisations such as SANCA for example are subsidised and monitored by the Department of Social Development (Dreyer, 2012:36).

SANCA runs programmes such as TADA (Teenagers Against Drug Abuse); YADA (Youth Against Drug Abuse); Poppets (Puppet education for pre-school and early school children); and Life Skills Education and Pupil Support programmes (Parry, 2006). Although these programmes are supposedly successful they have not yet been formally evaluated (Parry, 1998). "It is indisputable that prevention is more affordable than treatment, and that it also has the potential to prevent a myriad of drug-related problems" (Goliath and Pretorius, 2016: 113). Chapter three will provide a detailed examination of the different substance abuse prevention programmes that will form the analysis of this study as well as their implementation and outcomes.

Mhlongo (2005:34) cited in Dreyer, (2012:22) states that "the progress of other learners may be impeded when a number of learners in a class abuse substances or are absent from school because of substance abuse." They further concur that the continued abuse of substances destroys the abuser's ability to think logically and rationally. Substance abuse can also disrupt the entire school by negatively affecting the learner's academic performance as well as the relationship between learners and their peers as well as with their school teachers. It also has a negative impact on the

adolescent's social life as the young person may engage in criminal activities such as stealing and illegal substance possession. This paints a clear picture of the importance of effective school based substance abuse prevention programmes. Below are some of the substance abuse prevention programmes implemented among school learners primarily by SANCA, DSD and other non-governmental organisations which will be evaluated in this chapter. These programmes are Teenagers Against Drug Abuse (TADA), Programmes of Primary Prevention through Stories (POPPETS) and *Ke-Moja*.

3.2 TEENAGERS AGAINST DRUG ABUSE (TADA)

According to Mattebo and Nord (2010), the TADA programme was initiated by Adele Searle in August 1986. Searle had a personal interest in the programmes in that she was conducting campaigns against substance abuse and was also a mother of a recovering drug addict. During one of her campaigns she addressed Durban Girls College, which led to an establishment of an anti-substance abuse group in the school. This group was both established and maintained by the school learners themselves. SANCA provided the learners with substance abuse training which led to a number of anti-substance abuse campaigns and eventually led to the forming of TADA which has developed into a school-based substance abuse prevention programme that is implemented by SANCA in almost every province in South Africa (SANCA, 2008).

TADA is a peer led programme as it is run by other learners in the school. Peers are more influential in choices taken by adolescents about risk as they are the primary socialising agents during adolescence (Goliath and Pretorius, 2016). TADA can be classified as a primary prevention programme as it aims to prevent the onset of substance abuse before it actually happens (Social Development, 2008). According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) This type of programme can be also classified as a universal programme as it is aimed at reaching the general population.

The TADA programmes aims to prevent substance use among adolescents by forming peer-led groups in schools encouraging teenagers to make positive life decisions such as abstinence from drugs. It is based on the belief that teenagers understand the issues facing other teenagers better

than adults hence are better equipped to deal with those issues. The teenagers act as positive role models for other teenagers by living a healthy drug free lifestyle (SANCA, 2008) cited in (Mattebo and Nord, 2010). The TADA programme is run by teenagers which creates a great sense of responsibility as well. SANCA facilitates the programmes and makes sure that the teenagers receive the necessary training and support they need to run the TADA groups (Parry, 1998). According to Parry (1998: 13) "Peer-led programmes may be an effective mechanism for influencing adolescent norms and self-identity."

While the TADA programme may have many benefits there are also a few challenges that come with running peer-led programmes such as TADA. According to Goliath and Pretorius, 2016: 124) "Adolescents who maintain good relations with positive peers also enjoy positive relationships with their parents and/or siblings". As much as the programme is peer-led, involving parents of these learners may strengthen or assist in making the programme more effective as several researchers have stressed the paramount role of parents or families in substance abuse prevention (Griffin, Samuolis and Williams, 2010; Kim-Spoon, Farley and Holmes, 2014; Choate, 2015; Jones, 2015; Telzer, Gonzales and Fuligni, 2013; Luk *et al*,2010; Calafat *et al*, 2014). Peer-led programmes such as TADA may be difficult to maintain as the peer leaders may change from one school to another, e.g. from primary to high school and new peer leaders may need to be continuously trained. Kim, Zane and Hong (2002) cited in Goliath and Pretorius (2016) classify the adolescent stage as a time of turbulence and identity confusion. This identity confusion is likely to make TADA peer leader's roles inconsistent as they may easily be influenced by other peers who may be involved in risky behaviours such as substance abuse. According to Bester (2011) cited in Goliath and Pretorius (2016) adolescents may overestimate their abilities and responsibilities and underestimate their susceptibility to risk. TADA peer leaders like any other peers may experience similar dilemmas which are likely to negatively influence their roles as peer leaders and at worse, fail to fulfil their TADA roles and responsibilities.

3.3 PROGRAMMES OF PRIMARY PREVENTION THROUGH STORIES (POPPETS)

Programmes of Primary Prevention through Stories (POPPETS) are aimed at pre-primary and early primary school children mainly aged between five to nine years. Puppets, stories and various games are used to educate the children on different substances and information is provided on substance abuse as well as skills training to enhance self-esteem and increased resistance to peer pressure (Parry, 1998; Dreyer, 2012). POPPETS can also be classified as a primary prevention programme as its main focus is to prevent these pre-primary and early primary school children from using substances later on in their lives (Social Development, 2008). "Prevention is a pro-active process of planned change which leads to a new condition that is relatively free of the symptoms one wishes to prevent" and POPPETS aims to create such change. POPPETS is also a universal programme aimed at reaching out to general populations (NIAAA).

Although it is preferable to teach children while they are still young, a common criticism of programmes targeting primary school children is that these learners are not yet at risk of abusing substances therefore it is hard to immediately determine the effectiveness of the programme (Gottfredson and Wilson 2003). Gottfredson and Wilson reviewed 94 programmes in the United States. According to Gottfredson and Wilson (2003), it is suggested that long term follow-ups are essential and will determine the effectiveness of such programmes in the long term. A study by the same researchers found that programmes targeting middle school aged children (11-14 years) are slightly more effective than those targeting primary school aged (5-11years) or senior high school (14-16 years), as these primary school learners are still very young.

(Evans, 1999) and (Gottfredson and Wilson, 2003) are of the view that although selective programmes are generally costlier, selective prevention programmes are likely to be more effective and efficient than universal programmes as they target populations already at risk of substance abuse related problems. The authors argue that programmes targeting higher risk populations will be more beneficial than programmes aimed at the general population. This calls for a shift away from a blanket or universal approach and a more focused approach to substance abuse prevention programmes that are designed for specific target groups that they are intended for.

3.4 KE MOJA

Ke Moja is a substance abuse prevention programme which means 'I am fine without drugs' (Hendricks, 2010). *Ke Moja* is an invention of the Department of Social Development and, it aims to prevent substance abuse amongst the youth (Hendricks, 2010). The South African Government Information (2007) reported that the youth programme *Ke Moja* is intended to uplift young people's confidence so that they can easily resist peer pressure. The programme empowers teachers, parents and school governing bodies to identify young people with substance abuse problems so that they can receive early intervention services (Dreyer, 2012). The *Ke Moja* programme consists of trained employees and non-expert counselors, as well as community health centre managers (Hendricks, 2010). The *Ke Moja* programme can be classified as an educational programme. According to Stoker (1997) educational programmes are meant to transmit information by challenging attitudes and maybe some exploration of life skills. Stoker (1997) submits that while education on drugs will not necessarily prevent substance abuse, it will educate. Although *Ke Moja* is an educational programme, its primary aim is to educate in order to prevent hence it can be classified as a preventative education programme on substance abuse (Social Development, 2008).

According to Hendricks (2010), *Ke Moja* concentrates on the following: (a) real life circumstances and experiences; and, (b) skills acquisitions, so that the youths and ex-drug addicts can become employable. The DSD (2008) has revealed the following successes of *Ke Moja*:

(i) the *Ke Moja* programme has positively influenced learners, because it has improved their knowledge about the dangers of drugs and factors that contribute to the abuse of drugs;

(ii) learners have clearly changed their behaviours because they report substance abuse activities to educators and principals;

(iii) learners have shared the message about *Ke Moja* with their peers and relatives;

(iv) principals, guardians/parents and teachers increased their awareness about the bad adverse effects of substances;

(v) *Ke Moja* is relevant to learners because substance abuse is widespread in their own neigbourhoods, taverns, schools and homes; and

(vi) learners are able to identify with persons who facilitate the implementation of *Ke Moja*, because they reside together in the same communities and this makes it easier to accept the programme.

Chames, Norushe, and Wessels (2009) emphasize that *Ke Moja* lacks tangible successes and recommend the following in order for the programme to become more effective:

1) Quality as opposed to quantity of the programmes must be rendered so as to make sure that there is a suitable ratio of schools to capability of the implementing institution. For sustainability and consistency each school should have their own facilitator allocated per school or at most two or three schools per facilitator;
2) There ought to be formidable project management systems which encompass correct planning, control and assessments. Regular monitoring and evaluation of the programmes is recommended to ensure programmes are effectively implemented and make the necessary improvements;
3) There must be a strong bond between the DSD and the Department of Education (DoE) and, DoE circuit officials must be proactive. It would even be of great benefit if the DoE employed their own facilitators who will be school based. This will ensure greater results as currently it is the task of DSD and NGO's to facilitate such programmes in schools. With school based substance abuse facilitators, it will allow DSD and NGO's to focus more attention on out of school youth and those children who may have dropped out of school due to drugs;
4) *Ke Moja* must be incorporated into the curriculum and school environment (e.g. extra-school activities or sports lessons). One hour that is allocated to facilitators is simply not enough neither is the Life Orientation (LO) period on its own;
5) Highly qualified and suitably chosen persons are required to facilitate the implementation of *Ke Moja.* Currently not much emphasis is placed on the qualifications or training of the facilitator. For example, the researcher never received any formal training in *Ke Moja* yet had to coordinate and facilitate the programme and learn on the job. Formal training of the facilitator will ensure that accurate information is dispensed to young people and will equip the facilitator to professionally handle all questions that may arise.

6) Further, an enabling environment is necessary which includes a mutual relationship with educators and parents. This includes having the necessary resources needed to facilitate the programme and successfully execute all the activities set out in the training manuals. This is currently always a challenge due to lack of resources (Chames, Norushe and Wessels, 2009).

Ke Moja is implemented by different facilitators and professionals whom do not all receive appropriate and or uniform training to conduct such programmes. It has been argued that the training and background of the facilitator may even be more important than the contents of the message itself (Gottfredson and Wilson 2003). This is problematic as the message portrayed to learners may be contradictory and ambiguous. For example, some facilitators may be teaching learners to abstain from harmful substances while some may be simply delaying the abuse of susbtances among minors until they reach the age of 18 years. "There is no national regulating legislation to oversee the training, qualifications and competencies of prevention service providers. There are also no minimum norms or standards to serve as guides for any prevention interventions" (Burnhams *et al*., 2009) cited in (Puljević and Learmonth, 2014).

For effectiveness, uniformity and stability, it would be logical to have stable service providers and or facilitators implementing not just *Ke Moja* but other substance abuse prevention programmes. These facilitators must be trained by the same service provider for an equal period of time and must have no other tasks either than administering, implementing, facilitating and monitoring such programmes on a full time basis. Parry (2006:34) identifies the rural articulation gap: "A recent evaluation found that while there were a number of positive responses to the content, it's effectiveness was somewhat limited to urban areas". It is abundantly clear that *Ke Moja* is not flawless as already stated above. Chames, Norushe, and Wessels (2009) suggest numerous recommendations as solutions to the challenges of *K*e *Moja*. Such suggestions will need to be thoroughly evaluated to determine their effectiveness in such programmes.

The duration and timing of substance abuse prevention programmes may be important determinants of the outcome of these programmes (Gottfredson and Wilson 2003). The time allocated by the schools to facilitators for implementing the *Ke Moja* programme is insufficient,

often this will be the Life Orientation (L.O) period which is an hour maximum. The content of the *Ke Moja* manuals and modules as well as the activities therein cannot be implemented in an hour or less hence the time constraints issue may render the programme ineffective. Burnhams *et al.,* (2009 cited in Puljević and Learmonth (2014) recognise long-term prevention programmes as important for effective substance abuse prevention rather than once-off interventions. Due to the issue of time constraints, programmes such as *Ke Moja* end up being implemented as once off programmes. The Department of Education (hereinafter DOE), must as part of their school curriculum incorporate prevention programmes such as TADA, POPPETS and *Ke Moja* this will also ensure sustainability of these programmes as many programmes fail due to inconsistency.

The issue of quantity over quality is an important factor in determining the effectiveness of the proramme. More focus should be paid on extending the length of time allocated in implementing each programme instead of focusing on reaching more children and young people. This will ensure that quality programmes are implemented which are likely to be more effective. In the 2012-2013 Annual Report from the Gauteng Department of Social Development (GDSD) reported that 44184 school going children and youth had been reached through the *Ke Moja* substance abuse prevention programme. "The GDSD exceeded its target by 18214 due to an intensified roll out of the programme which yielded an increase in the number of learners attending *Ke Moja* events" (Thobeka, Priscalia, and Nkosiyazi, 2017: 96). The number of children and youth assisted through the *Ke Moja* substance abuse prevention programme does not reflect to the effectiveness of the programme in itself. Even though the implementation may be going well, it does not necessarily mean that it is effective. If this amounted to effectiveness, then the number of minors prone to substance abuse should be decreasing instead of increasing.

Again there is the issue of uniformity in the implementation and facilitation of the *Ke Moja* programme generally and across provinces. In Gauteng, 215 master trainers were trained and are responsible for training coaches in different regions within the Gauteng province. In addition, 604 Ke Moja coaches were also trained to assist in the implementation of the *Ke Moja* programme (Thobeka, Priscalia, and Nkosiyazi, 2017). In respect of the programmes, the facilitators work hand in hand with social workers in identifying minors prone to substance abuse or have relatives that experiencing similar problems. Social workers provide counselling services to the individual

and family to ascertain whether they are to be referred to appropriate rehabilitation centres (Thobeka, Priscalia, and Nkosiyazi, 2017). In addition to counselling and referrals to rehabilitation centres, in KZN the social workers are also expected to implement and facilitate the *Ke Moja* and other substance abuse prevention programmes. Apart from SANCA who have specially trained paid facilitators to do the job, other smaller NGO's do not have the funds and capacity to employ and train such facilitators. Thobeka *et al*., explain that "Although learners are taught about the consequences of substance abuse, there is no module which covers how they can avoid being involved in drug use because there are a number of factors which contribute to young people abusing substances" (Thobeka, Priscalia, and Nkosiyazi, 2017: 94). This supports the contention that the *Ke Moja* manuals and modules themselves need to be revised and improved. The content of the manuals focuses mainly on substance abuse information which includes definition, classification and effects of drugs; life skills information; which includes stress management, conflict management and assertiveness; a sexuality section which focuses mainly on HIV/AIDS information and a career guidance section. The *Ke-Moja* manuals are divided into five:

1. Facilitator's manual
2. Holiday programme manual
3. Parents and caregiver's manual
4. Peer trainer guidance manual
5. Puppet Show manual

It bears reiteration that prevention is not sufficiently covered in the manuals.

3.5 THE IMPLEMENTATION OF PROGRAMMES AND APPLICABLE LEGISLATION

As discussed in chapter 2, section 9 2 (b) of the Prevention of and Treatment for Substance Abuse Act clearly states that prevention programmes must focus on "developing appropriate parenting skills for families at risk." Currently there is no specific programme in South Africa targeting or aimed at parents and families. Although some substance abuse prevention programmes such as *Ke Moja* include a section on parenting skills in one of their manuals, it is not a separate programme on its own but rather part of the broader *Ke Moja* programme. Both the National Drug Master Plan (NDMP) and the Prevention of and Treatment for Substance Abuse Act prioritise better parenting as the primary approach to the substance abuse problem in South Africa. Strengthening family relationships also improves communication between parents and children and does more than prevent children from experimenting with substances. If children have a good sense of belonging at home, they will have no pressure to try and fit in with their peers by engaging in risky behaviours. "Feeling positively attached to one's family and parents can serve to protect youth from drug use" (Brounstein and Zweig, 1999) cited in (King, Wagner and Hedrick, 2002:71). Such a programme could also mean that parents spend more time with their children so as to strengthen family bonds.

(Evans and Mallick, 1997) submit that parental involvement is a potential force for positive change within an overall strategy for encouraging children and young people to adopt healthy life styles and develop risk free social habits. Realistically, it is often not feasible to conduct such programmes among parents or families, primarily because parents are often at work during the day and hence not available to attend such programmes. Nonetheless, not much effort is being made by policy makers to ensure that such programmes also reach parents. This can be seen as a breach of section 9 2 (f) of the Prevention of and Treatment for Substance Abuse Act which states that programmes must focus on "enabling parents and families to recognise the early warning signs with regard to substance use and equipping them with information on appropriate responses and available services".

According to Evans and Mallick (1997) parents have an important role to play in drug education but to effectively play their part, parents require appropriate knowledge and education on drug

issues as well as access to relevant resources. Furthermore, they require communication skills in addressing sensitive issues. If there is a lack of programmes aimed at equipping parents and families with such information, then they are not being empowered to adequately assist minors prone to substance abuse in South Africa. Evans and Mallick, (1997) further submit that it is important to be aware of the kind of support and knowledge parents require in order to be actively involved in drug prevention strategies. Parents may become frustrated when faced with a substance abusing child, to the extent that parents may start to fight amongst themselves because they cannot agree on how best to handle the substance abusing child. More research and funding is needed to develop and sustain such a programme. Compensation and incentives such as refreshments, transportation and child care facilities could also be offered to parents as motivation for them to participate after work or in the evenings. (Evans and Mallick, 1997) suggest that appropriate training and support can assist parents to become more effective in helping their children resist substance use/abuse.

Section 9(2)(d) of the Prevention of and Treatment for Substance Abuse Act clearly states that prevention programmes must focus on "engaging young people in sports, arts and recreational activities and ensuring the productive and constructive use of leisure time." However, sports and recreation is a rare sight in underprivileged schools and rural areas and so is the implementation of anti-substance abuse programmes. A study done by Puljević and Learmonth (2014) among local health trainers in Cape Town's peri-urban settlements found that there was a lack of safe recreational spaces for the township-based youth (Puljević and Learmonth, 2014). One of the health trainers quoted in (Puljević and Learmonth, 2014:191) stated the following: "The children are bored; they are just there on the streets".

In principle as per section 9(2)(d) the anti-substance abuse campaigns encourage learners and young people to engage in sports and recreation in order to keep them entertained and away from drugs. In reality this is not happening because there is a lack of sports and recreational activities in most rural and township schools and communities hence this favours only a privileged few. According to (Puljević and Learmonth, 2014) most peri-urban structures lack open spaces and infrastructure for recreational and relaxation purposes. Hence, boredom and idleness is the number one reason reported by the majority of young people for engaging in substances. engaging in drugs

(Morojele, 2010 and WHO, 2011). The message is inconsistent if young people are being encouraged to engage in sports and recreation but there are no sports and recreational facilities at their disposal. Both policy and prevention programmes need to be aligned for successful implementation of these programmes in both rural and urban areas alike. Policies need to be actionable and persons or organisations are required to be held accountable for the failure of these programmes.

Chapter 7 of the National Drug Master Plan (NDMP) (2013-2017) outlines the roles and responsibilities of different departments/institutions in the fight against substance abuse. The NDMP emphasizes the importance of integration between various government departments, NGO's, FBO's and civil society in the scourge against substance abuse. It acknowledges the importance of these various bodies working together to combat the fight against substance abuse but does nothing to ensure that in reality this integration of various bodies and organizations actually takes place. The NDMP sets outlines the role of various government departments at national and provincial level in fighting the scourge of substance abuse. It also recognises the significant contribution that can be made by other stakeholders in the country (NDMP, 2013-2017). Without such an integration substance abuse prevention programmes will have very little impact.

In the foreword to the NDMP, the Minister of Social Development acknowledged that the substance abuse problem in South Africa is everybody's problem because it goes beyond the individual, destroying families and communities in the process. Substance abuse is the root of most social ills in our communities such as HIV/AIDS, teenage pregnancies, crime, and even the breakdown of families as substance abuse puts so much strain in the family (Pienaar and Savic, 2016). As for the link between substance abuse and HIV (and Sexually Transmitted Infections) a study by Bana *et al* (2010) indicated that substance abuse is significantly associated with mulitiple sexual partners; with increased sexual activity and violent behaviour correlated to drug use; as well as higher risk of HIV infection. Karim (2016: 547) explains the co-morbidity of substance abuse and mental health; as well as increased risk for sexual activity related incidences such as pregnancy and HIV:

> "[M]any adolescents with mental health illnesses also experience poorer academic performance, higher rates of suicide, violence, substance abuse, pregnancy and psychopathology with ageing. In addition to an increased risk of mental health problems, high rates of alcohol dependence and the early initiation of, or participation in, binge drinking may increase the risk of negative sexual health outcomes by increasing the chances of unwanted pregnancy, risky sexual practices, and gender-based violence. In the context of sub- Saharan Africa, where HIV rates remain high, particularly among young women, mental health and substances use disorders could play a mediating role in further enhancing the risk of HIV infection in this already vulnerable group."

The South African Police Service (SAPS) found that substance abuse accounts for 60% of the all the crime in South Africa (Tshitangano and Tosin, 2016). If more resources are pulled together much more can be achieved with successful monitoring and implementation. The prevention programmes with all the emphasis placed on them by both the NDMP and the Prevention of and Treatment for Substance Abuse Act, are not a solution on their own, better coordination is needed.

3.6 THE ROLE OF THE SOCIAL WORKER IN PREVENTION PROGRAMMES

Social workers play an important role working with individuals, families and communities indirectly or directly affected by substance abuse. They also have a duty to protect young people and the community in general against substance abuse. (Setlalentoa and Strydom, 2015; Slabbert, 2015 and Galvani, 2015) note the many differing roles that social workers play in working with client systems affected by substance abuse. Social workers often have to deal with children who have been neglected, abused or abandoned by substance abusing parents. The neglect and abuse of children as a result of parental substance abuse is problematic as it results in emotional, physical and educational problems being faced by the kids (Zawaira, 2009 cited in Setlalentoa and Strydom, 2015). In addition, social workers also have to work with young people in conflict with the law as a result of substance abuse crimes. They also work with domestic abuse victims who have been abused as a result of substance abuse.

Furthermore, substance abuse is closely linked to poverty as many families use the little income they have (which is usually in the form of social grants) to buy alcohol and other substances (Setlalentoa and Strydom, 2015). This according to these authors aggravates poverty and social workers often have to intervene with poverty alleviation methods in the form of food vouchers or

food parcels. Sometimes the buying of substances by members of the family is non voluntary which presents another scenario for the social workers to intervene where elderly family members are forced by the adolescents to feed their drug habits. Substance abuse seems to be the cornerstone of most social ills burdening the communities. It is clear that social workers bear the immense responsibility of preventing substance abuse in communities and rendering effective substance abuse prevention programmes among young people in order to reverse or decrease the ripple effects of substance abuse in communities. Social workers often intervene at three different levels in the prevention of substance abuse. Firstly, at the primary prevention level where they have to alter the individual and the environment to reduce the onset of substance abuse, this includes changing the social norms and values in any given society. Secondly, social workers have to intervene at a secondary level where they identify individuals and communities at a high risk of substance abuse and render interventions to minimize the use of substances whilst in the early stages before any real harm or damage is caused to the individual or society. Then lastly social workers intervene at a tertiary level where basically they have to control the damage done by the drugs/substances through various treatment measures aimed at minimising the suffering caused by substance abuse. Whilst primary prevention measures are generally aimed at universal populations, secondary and tertiary measures are aimed at selected or at risk populations. According to Dance and Galvani 2014; Galvani *et al*. 2011, Hutchinson *et al*. 2013, Loughran *et al*. 2010 cited in Galvani, 2015 social workers are not always clear what they should be doing or what their role is in relation to substance abuse interventions as their knowledge of substance abuse is often very limited. According to these authors this limited knowledge can affect their confidence levels as well which affects the quality of work produced.

In order to provide effective substance abuse prevention programmes, Setlalentoa and Strydom, 2015; Slabbert, 2015 and Galvani, 2015 note that social workers require proper training and skills in the field of substance abuse prevention. The authors assert that social workers require specialised knowledge and training to render effective substance abuse prevention interventions. Proper training and skills will provide social workers with much needed clarity to effectively render quality services to individuals, families, couples and communities affected by substance abuse, furthermore this will assist social workers to render holistic substance abuse prevention strategies to assist not only young people but all members of the community.

3.7 CONCLUSION

It is unfortunate that programmes have generally become quantity over quality driven, that is, more programmes are being implemented in a variety of schools with less time to really focus on providing in-depth quality programmes over a longer period of time. Extending the duration of effective programmes would definitely produce positive results (Gottfredson and Wilson 2003). Skills and qualifications of the facilitator cannot be overlooked as they determine the quality of the programmes implemented. Hence the training of social workers and other service providers in the field of substance abuse is important. Different programmes should be aimed at different target groups. It cannot be assumed that programmes that have shown to be effective in general populations will also be as effective with young people who have already started experimenting with substances (Gottfredson and Wilson 2003). (Gottfredson and Wilson 2003) argue that with high risk populations, cognitive behaviourally based preventions programmes tend to be more effective than when applied to general populations.

Programmes targeting specific gender groups may also prove to be more effective as research points to more male then female learners being prone to substance abuse. Male learners are obviously at higher risk of abusing substances than their female counterparts. A study conducted by Parry, (1998) focused on school-going children found that more males than females were prone to substance abuse (Parry, 1998). Interventions should be designed for the particular target group they are meant to reach, that is, "generic programmes may not be effective" (Parry, 1998:13). The importance of assessing and monitoring cannot be undermined. If various institutions and stakeholders work together positive outcomes can be achieved. From the above information it is clear that government and other organisations need to revisit their methods and re-examine the relevance and effectiveness of the substance abuse prevention programmes implemented among minors. The role of the family and parental involvement in substance abuse prevention among minors is crucial. Moreover, the availability of sports and recreational facilities play a crucial role in keeping young people busy and away from risky behaviours such as substance abuse. Family/Parental involvement as well as sports and recreational facilities are key prevention factors for preventing the abuse of substances among minors in South Africa.

CHAPTER FOUR
AN EXAMINATION OF SUBSTANCE ABUSE PREVENTION PROGRAMMES AND STRATEGIES APPLIED IN OTHER JURISDICTIONS

4.1 INTRODUCTION

While it is important to draw on the local context when implementing substance abuse policies and programmes, much can be learned from drawing on international practices as well. This chapter will firstly examine and secondly make comparisons of some programmes that have been implemented in Africa, Europe and the United States so that South Africa can learn from the successes and learn from failures of these programmes in other countries. It draws on the strategies of developing African countries such as Zimbabwe and Kenya. The chapter also examines a number of strategies and programmes of more developed countries, specifically the United States of America (USA) and other countries i.e. United Kingdom (UK), Spain and Germany that have adopted similar programmes. Drawing on the experiences of the implementation of these programmes in other jurisdictions and what has worked in other countries may assist South Africa to find more effective strategies.

Adolescence is a stage where most young people will experiment with substances such as alcohol because it is a vulnerable stage associated with more psychological, physical and social changes. Consequences of alcohol abuse among adolescents include brain damage, poor academic performance, risky sexual behaviours, violence and injuries hence prevention programmes are very crucial during the adolescent stage. (Gmel, Rehm, and Kuntsche, 2003; Perkins, 2002 cited in de Looze *et al*: 2014). Effective prevention strategies have also been proven to be more cost effective than treatment as more costs are involved in substance abuse treatment and rehabilitation in comparison to prevention strategies (Sloboda and Bukoski, 2006 cited in Ronoh, 2014). Adolescent substance abuse has been a concern for many years worldwide but recently adolescent substance use and risky consumption patterns have been reported to be on the rise in the last five years in Europe and the USA (Kumpfer, 2014). Adversely African countries have also been affected by the substance abuse epidemic (Nhapi and Mathende, 2016).

4.2 AN AFRICAN PERSPECTIVE

According to the African Union Plan for Action on Drug Control and Crime prevention (2011) cited in Nhapi and Mathende (2016), the substance abuse problem in Africa is increasing and poverty is the basis of the problem. Moreover, children are more prone to poverty because they are more vulnerable than their adult counterparts (Nhapi and Mathende, 2016). Although there are substance abuse prevalence studies on the continent (Kanyoni *et al* (2015) on Rwanda; Otieno and Ofulla (2009) on Kenya; Okoza and Aluende (2009) on Nigeria; Reddy *et al* (2002) on South Africa; Adu-Mireku (2003); Doku *et al* (2012) on Ghana), there is no literature on prevention programmes or evaluation or assessment of their efficacy.

This section will draw on the gaps for programmes and strategies employed in two African countries, Zimbabwe and Kenya.

4.2.1 Zimbabwe

According to the Global Drugs Policy Observatory GDPO (2014) young people in Zimbabwe may engage in substance abuse to escape from poverty (Nhapi and Mathende, 2016). Hence there is a need for more comprehensive substance abuse prevention strategies aimed at children especially in Africa.

For Zimbabwe the period after independence also contributed to heightening the substance abuse problem. (Nhapi and Mathende, 2016) report an increase of substance abuse among adolescents immediately after the country gained independence as schools opened gates for all the young people who were in the liberation struggle and once used drugs as a coping mechanism (Tshabalala *et al*, 2015) (Nhapi and Mathende, 2016). According to the Zimbabwe Youth Investment Case Study (2016) and Bhebhe, Bhebhe and Bhebhe (2016) youth unemployment and idleness is one of the leading risk factors of substance abuse among young people in Zimbabwe today. The Zimbabwe Youth Investment Case Study (2016) has reported that Zimbabwe has no recognised programmes to deal with the drug problem and information on drug rehabilitation for the youth in the country is scarce. 65% of young people in Zimbabwe suffer from substance abuse related

mental problems (Nhapi and Mathende, 2016). This is problematic as majority of the country's youth is at risk. The future of any country lies in the hands of its youth and hence government needs to have effective substance abuse prevention strategies in place to protect its young people from the scourge of substance abuse. Currently the Zimbabwean government is doing very little in the prevention of substance abuse. The legislation on substance abuse in Zimbabwe fails to address crucial aspects in substance abuse prevention, the same can be said about Zimbabwe's education system.

> "Zimbabwe's legislation on drugs and substances is fragmented. The main legislation being the Medicines and Allied Substances Control Act (Chapter 15:02) which prohibits the production, supply or distribution of illegal drugs. The aim of the legislation is on supply reduction, but casts a blind eye on demand and harm reduction." (Nhapi and Mathende, 2016:136)

According to Tshabalala et al, 2015 research shows that learners who are involved in substance abuse often display aggressive behaviour in schools including theft, they fail to adhere to school rules and regulation as well as fail to produce satisfactory academic achievements. Such actions cannot produce productive adults in the future. Despite all these consequences of substance abuse the Zimbabwean schools seem to turn a blind eye to the problem of substance abuse in their schools and nothing is being done in terms of prevention. Tshabalala *et al*, 2015 note that; - teachers appear to be unaware or unconcerned about the extent of the substance abuse problem in their school. The lack of recorded substance abuse prevention programmes implemented in Zimbabwean schools is evidence that the education system is not doing enough in the field of substance abuse prevention within their schools. In the meantime, more and more learners are being exposed to substance abuse yet the government and civil organisations are not doing enough to curb this scourge. In Zimbabwe, the media also has the power to fight the scourge of substance abuse but unfortunately the media space in Zimbabwe is not free so it becomes difficult for media personnel to blow the whistle against dominant leaders involved in drug trade (Nhapi and Mathende, 2016). This tends to perpetuate the scourge of substance abuse in the country even further as drug criminals are seldom exposed and criminalised.

From the above it is clear that Zimbabwe still has a long way to go in preventing substance abuse within their schools and in society at large. The government of Zimbabwe needs to create

institutional mechanisms that can effectively deal with substance abuse, such mechanisms need to involve the affected communities and young people (Nhapi and Mathende, 2016). The lack of drug information and substance abuse prevention programmes (Zimbabwe Youth Investment Case Study, 2016) in Zimbabwe, is evidence that Zimbabwe has no real mechanisms in place to deal with the substance abuse problem among the youth in the country. Moreover, the lack of prevention and early intervention services in Zimbabwe is also putting young people at risk of other social ills such as mental health disorders, alcoholism, prostitution, unwanted pregnancies, rape and sexual violence (Zimbabwe Youth Investment Case Study, 2016).

4.2.2 Kenya

Studies carried out in Kenya report a strong link between substance abuse and the breakdown of family values with children as young as 10 years abusing substances (NACADA, 2010) cited in (Otingi, 2012). Broken homes in Kenya are increasing the number of adolescents involved in substance abuse (Chesang, 2013). Families are the sites that groom and equip children with moral values. The breakdown of families inevitably leads children to abusing substances when these structures are broken down. In Kenya adolescents have the highest substance abuse prevalence which can be linked to the immediate social environment in which they grow up (Otingi, 2012). Research shows that 50% of learners had experimented with drugs in Nairobi alone (Chesang, 2013). Adolescents substance abuse affects their ability to make informed and sound decisions about their life and future which not only affects themselves and their families but has vast impact on the entire nation as well as children represent the future of any nation (Otingi, 2012). When children fail to reach their full potential and grow up to become productive adults, the economy of the country is also affected as it puts pressure on the economic system (Otingi, 2012).

The Kenyan government has introduced different strategies and interventions to deal with the substance abuse problem in the country at a national, provincial and local level. At a national level, the government has banned smoking in public spaces and declared many government and private building as smoke free zones (NACADA, 2006 cited in Otingi, 2012). The government has also banned the brewing of indigenous alcoholic beverages such as ‘changaa’ and ‘kumi-kumi’ as children especially from rural areas were reported to be more likely to fall victim to this

homebrewed drink (NACADA, 2016 and Otingi, 2012). Recognising the seriousness of the substance abuse problem in Kenya, the government also introduced the National Campaign against Drug Abuse (NACADA) early in 2001 (Otingi, 2012). This organisation is mandated to create public education campaigns aimed at curbing adolescent substance abuse (Otingi, 2012).

At the school level, the Kenyan Minister of Education has integrated substance abuse education into the school curricula. At the primary school level, substance abuse education has been incorporated into the Social Studies class and in secondary schools it has been incorporated into Religious Studies class (Otingi, 2012). The Minister of Education has also highlighted the importance of training in substance abuse education by all teachers and heads of schools (Otingi, 2012). These inclusions encourage teachers to be capacitated on substance abuse related issues which will also assist them to identify and refer learners prone to substance abuse in their schools for appropriate assistance.

Educational institutions such as secondary schools, colleges and universities in Kenya have joined forces to fight the scourge of drugs through peer education programmes. The aim of these peer education programmes is to reduce substance abuse and its related social ills (Otingi, 2012). Students are trained through peer outreach programmes to reach out and spread positive messages as well as promote responsible behavior among their peers (Otingi, 2012). Several authors acknowledge the importance of targeting young people in primary and high schools through substance abuse prevention services (Atwoli *et al*., 2011; NACADAA, 2007; NACADAA, 2010a; Ndetei *et al*., 2010; Otieno and Ofulla, 2009 cited in Kimunya, 2012). According to Kimunya, 2012 such platforms have the ability to equip young people with social skills and coping skills to enable them to resist peer pressure and other negative influences that might lead to adolescent substance abuse.

The involvement of colleges and universities in substance abuse peer education programmes is one of the initiatives that South Africa can adopt from Kenya. In South Africa tertiary students are often not the main focus of substance abuse prevention programmes as the focus is mainly on primary and secondary school learners. In addition, churches in Kenya have also been playing an active role in the fight against substance abuse by creating treatment and rehabilitation centres that

aim to raise awareness on substance abuse and bring about spiritual and physical healing to those affected by drugs (Githinji, 2004 cited in Otingi, 2012). The church believes that is has a biblical obligation to assist on the war against substance abuse and its related social ills (Otingi, 2012). The involvement of the church in the fight against substance abuse is important as religious organisations form an important part of the social environment in which young people grow up, hence have the power to make a significant impact in society. Moreover, society often holds the church in high esteem.

While different strategies and activities are crucial in substance abuse prevention interventions in the African context, Kimunya and Chesang emphasise the role of parents and families as paramount in the upbringing and socialisation of adolescents Kimunya, 2012 and Chesang, 2013. Families are the basic building blocks of any society and play a crucial role in ensuring that children grow up in a loving environment which promotes positive moral values (Kimunya, 2012). The author further asserts that substance abuse prevention programmes in Kenya need to ensure the active participation and involvement of parents and community members at large. Furthermore, the Kenyan culture values the interdependence and interconnectedness of families and communities (Igboin, 2011 cited in Kimunya, 2012). Chesang asserts that parents themselves need to be capacitated with drug information and parenting skills to assist them to be positive role models to their children and instil in them good values (Chesang, 2013). These skills will also assist parents to assist their children to resist peer pressure to use drugs and other substances, as well as be able to spot early signs and symptoms of substance use in their children.

The problem of substance abuse should not be left to a few individuals and institutions but every individual, institution and organisation should participate in the reduction and control of substance abuse in society. Kenya can be applauded by the co-operative efforts made by the government, various organisations schools, universities and the church amongst others in playing their parts in prevention efforts aimed at assisting young people prone to substance abuse in the country. The eradication of substance abuse requires the integration of all stakeholders (Otingi,2012:32). The active involvement of universities and colleges in substance abuse prevention programmes in Kenya can be seen as a positive move which is likely to produce effective outcomes. University is

a time when most adolescents move away from their parent's care and gain more autonomy over their own lives hence they require more guidance.

Whilst recognising the importance of stakeholder cooperation, Kenya also recognises the involvement of parents and families as crucial in the implementation and effectiveness of any substance abuse prevention programme. Indeed, Kenya may have much to improve in eradicating the substance abuse problem in the country but their efforts so far are seemingly on the right path. From the above, it is evident that reducing substance abuse has been an important task of the Kenyan government at national and local level for many years (Otingi, 2012).

4.3 AN AMERICAN PERSPECTIVE

The United States ranks first in lifetime use of three substances- cocaine, cannabis, and tobacco - and is in sixth place for alcohol use in a survey conducted by the World Health Organization among 17 nations (Kumpfer, 2014). This clearly indicates the extent which the US is affected by the substance abuse problem and the need for the country to develop effective substance abuse prevention strategies. Drug Abuse Resistance Education (D.A.R.E) and Strengthening Families Programme (SFP) are only two of the many substance abuse prevention programmes that are implemented in the United States (US). For the purposes of this paper only the above two programmes will be examined in the US context.

4.3.1 Drug Abuse Resistance Education (D.A.R.E)

Drug Abuse Resistance Education D.A.R.E. is an American anti substance abuse prevention programme that was developed in 1983 by the Los Angeles Police Department and the Los Angeles Unified School District (Birkeland, Murphy-Graham and Weiss, 2005). It is the most popular school-based drug abuse prevention programme in the U.S targeting children of school going age. It's core curriculum focuses mainly on resistance, skills training and self-esteem building. General information in respect of different substances also forms part of the content. In 2001 D.A.R.E. was already implemented by 80% of American schools (Birkeland, Murphy-Graham and Weiss, 2005). The D.A.R.E. programme is very similar to the South African *Ke-*

Moja programme which has been discussed in detail in chapter three. Evaluations of the D.A.R.E programme across a variety of contexts have on several occasions found the programme to be ineffective in reducing substance use among adolescents (West and O'Neil, 2004 and Birkeland, Murphy-Graham and Weiss, 2005). The effects of the D.A.R.E. programme are said to be short-lived as they fade away over time and it becomes difficult to distinguish between learners who have been exposed to the programme and those who have never been exposed to the programme. This is surprising considering the exorbitant amount of three quarters of a billion dollars' expenditure spent on the programme annually (West and O'Neil, 2004).

It is unfortunate that despite findings indicating that the D.A.R.E. programme was ineffective and policy makers being aware of these evaluations, it has continued to be widely used in American schools. Only recently have some improvements been made to the programme based on the evaluations which was a step in the rights direction (West and O'Neil, 2004). Perhaps one of the downfalls of the programme is that American schools and decision makers have become so attached to the programme over the years that they seem to have become complacent.

Another challenge with the D.A.R.E. programme is that not enough time is allocated for its implementation (1 hour weekly) this may be one of the reasons why the programme has proven ineffective over the years. More time needs to be allocated to the implementation of the programme. One suggestion could be incorporating the programme within the school's daily curriculum.

4.3.2 Strengthening Families Programme (SFP)

The Strengthening Families Programme (SFP) was originally developed by Dr Karol Kumpfer from the University of Utah, USA in the early 1980's. This was made possible with a grant from the National Institute on Drug Abuse (NIDA) (Kumpfer, 2014). SFP is a highly structured family skills training programme conducted between 7-14 weeks. It is a multifamily group setup comprising of three to four gender-balanced and culturally sensitive group leaders and a coordinator (Kumpfer, 2014). The programme primarily involved school children between the ages of six to eleven years and their families. The programme is in the form of 14 family training

sessions using family systems and cognitive behavioural approaches to increase resilience and reduce risk factors. It also seeks to improve family relationships, parenting skills, and young people's social and life skills. Although the SFP programme has proven to be more effective than other substance abuse prevention programmes (Kumpfer, 2014), it is however, time consuming and very costly as different strategies are used to recruit and retain families participating in the programme. In the US families are offered incentives such as transportation, dinner, babysitting, and incentives for homework completion and graduation parties (Kumpfer, 2014). While these may be good recruitment and retention strategies, they tend to be very costly.

The SFP programme has since evolved over time to include age and cultural changes (Kumpfer, 2014). Recently, a new 10 session version of the SFP programme have been developed for 7-17-year-old age groups that comes in DVD that can be easily used at home which has been met with positive evaluations compared to the earlier version. (Kumpfer, 2014:14). This latter version has been met with positive outcomes because even families who are unable to physically participate in these programmes can easily be reached through the DVD's (Kumpfer, 2014). Having access to the DVD is also cost time and cost effective as families can watch the DVD and participate in the activities at a time that suits them, no incentives needed. Parental monitoring and supervision have been cited by several authors/ researchers as critical for substance abuse prevention among minors. These are some of the advantages of the SFP and its important role in strengthening families and grooming children to also be better parents of tomorrow by modelling the good parenting values instilled by their parents.

> "SFP's effectiveness is attributed to the fact that the whole family attends each week thus changing the total family system. In the first hour, the children and parents attend their own classes with two gender-balanced group leaders. Children are trained in social and emotion-regulation skills, peer resistance skills, problem solving, effective communication, while parents receive training in 'attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting' (Kumpfer, 2002). Both learn about the importance of family play and togetherness time, effective family communications, and family meetings to enhance organization and reduce stress and conflict which practiced together in the second hour." (Kumpfer, 2014:14-15)

4.4 A EUROPEAN PERSPECTIVE

The next section explores programmes and strategies in three particular countries, Spain, Germany and the United Kingdom.

4.4.1 Spain: Family Competence Programme (FCP)

The American programme, SFP, discussed above, has been adopted in the UK, Germany and Spain, with the latter renaming it the Family Competence Programme (FCP). The programme was developed to reduce the influence of family risk factors and strengthen protection factors by increasing the children's resilience to substance abuse and other social ills. The programme also aims to equip parents with the proper parenting skills and train them to face the challenges of modern family dynamics as well as improve their relationship with their children (Orte *et al*., 2015). The US SFP is considered to be effective in preventing drug use and other behaviour problems (Foxcroft *et al*., 2002; Foxcroft and Tsertsvadze, 2011), in both the general population as well as high-risk groups (Kumpfer *et al*., 2010; Bröning *et al*., 2012).

An evaluation of the Spanish FCP found it to be highly effective and upon completion of the programme participants displayed low conflict levels, positive parenting, good relationships, family cohesion and increase in values (Orte *et al*., 2015). Significant improvements were observed after successful completion of the FCP. According to Orte *et al*., (2015) a considerable psychosocial maturing was observed in children over a two-year period. The implementation of the Spanish FCP has proven to have considerable positive results in the medium and long term for families with social and educational challenges that are receiving care agency services. Orte *et al*, (2015: 117) explain that: "The duration of the effects is consistent with the model from which the programme was developed and confirms the FCP's usefulness for the great majority of established objectives in the short, medium and long term regarding its adapted application to the Spanish population". The researcher is of the view that such a programme needs to be broadened to include important elements such as role play and peer-led activities which are important in programmes aimed at educating young people.

4.4.2 Germany: *Familien Stärken*

According to (Bröning *et al*., 2014) the German health care system lacked a family- based prevention approach. They therefore adopted *Familien Stärken* as the German adaptation of the American SFP. Cultural adaptations were made to suit the German culture. The programme is manual based and consists of seven weekly sessions plus four booster sessions conducted. The booster sessions are conducted every four-six months after the last session. The programme is tailored to address children, parents and family needs. It aims to reduce the risk of substance abuse disorders and other risk behaviours among children and young people. Bröning *et al*., (2014: 3) explain that "Youth modules aim at improving youth's self-efficacy and their ability to cope with stress and peer pressure. Parent modules encourage caregivers to reflect on their parenting style, to develop a more consistent form of parenting ("using love and limits") and to express positive affect more openly". The programme strengthens family communication and cohesiveness and encourages parents to reflect on their parenting style (Bröning *et al*., 2014).

As a recruitment and retention strategy for participating in the *Familien Stärken* programme, families are invited for a complementary meal after each programme meeting. The meal is either served by external caterers or affiliated restaurants. Child care services are also offered for families who have smaller children that they cannot leave alone at home. As an additional incentive, families also receive a voucher worth € 15 after each session which is equivalent to roughly R217, 57 in South African currency. The agencies decide what kind of vouchers they offer to participants, examples are cinema or swimming baths vouchers (Bröning *et al*., 2014). Such lavish incentives raise the question of the programmes' sustainability in the long term. Although it is with good intentions, the programme may appear to be 'buying' participants which may tarnish the whole image of the programme. It is also highly unlikely that the programme will be sustained if such incentives were to be withdrawn in future. It could be argued that such funds could be better used for community upliftment projects which are also crucial in the fight against substance abuse.

4.4.3 United Kingdom: Strengthening Families Programme (SFP)

The Strengthening Families Programme (SFP) has been recently culturally adapted in the United Kingdom (UK) and has sparked much interest amongst policy makers. SFP has been adapted as part of the UK Government's Family Intervention Projects in some parts of England known as having high risk families (Segrott *et al.*, 2014). "An evaluation of the programme's implementation in Barnsley England, highlighted the need for some cultural adaptation and consideration of the best approach with regards to universal or high-risk targeting" (Segrott *et al.*, 2014:3). Those cultural adaptations have since been completed and the programme has been considered effective in the UK context. Risky behaviour such as substance abuse among the youth lead to antisocial behaviour such as crime, poor education, teenage pregnancy, social exclusion by young people and has a negative impact on the UK economy (Segrott *et al.*, 2014).

The introduction and implementation of the SFP in the UK was with the hope that it will help address all these social ills and risk behaviours that affect young people in the UK. Segrott, *et al*., (2014) acknowledge that the majority of parenting and family interventions were developed in the United States (US) hence it does not mean that if such programmes are successful in the US it will automatically be successful in other countries and cultural contexts as well. Prevention interventions when applied to new countries may require some cultural adaptations (Segrott *et al.*, 2014). The UK has successfully managed to incorporate the SFP into their cultural context. During the trial period of the SFP the UK used a number of strategies to retain young people and parents in the programme such as offering incentives in the form of vouchers and prize draws (Segrott *et al*., 2014). While offering incentives may be good, it can also be problematic by creating a dependence on these incentives of which, when withdrawn very little or no families might have an interest in the programme. Moreover, the incentives may be the only reason while some families may be participating in the programme at all.

4.5 BENEFITS AND POSSIBLE ADAPTATIONS AND IMPLEMENTATION IN THE SOUTH AFRICAN CONTEXT

When adapted for different cultures, the SFP's effectiveness has also been demonstrated in various countries (Kumpfer *et al*., 2012) and (Orte *et al*., 2015:102). South African policies and legislation recognise the importance of families and the role of parents in minimising the risk of adolescent substance abuse and other problem behaviors that make minors prone to substance abuse. Both the National Drug Master Plan (NDMP) and the Prevention of and Treatment for Substance Abuse Act No. 70 of 2008 (which have been examined in chapter 2) prioritise parenting skills and better parenting as their primary prevention strategy in curbing substance abuse among minors in South Africa. Studies from other countries have shown that family based substance abuse prevention programmes have been widely adopted because they have proven to be more effective across all cultural contexts. Several authors are of the opinion that better parenting can reduce the likelihood of minors being prone to substance abuse (Griffin, Samuolis and Williams, 2010; Kim-Spoon, Farley and Holmes, 2014; Jones, 2015; Telzer, Gonzales and Fuligni, 2013; Luk *et al*.,2010).

Kumpfer advocates for family interventions:

> "Family interventions have been shown to be the most effective prevention and treatment interventions for adolescent substance abuse and other negative developmental outcomes. They are also cost beneficial, because the family members learn and practice new skills to improve their interactions to have long-term sustainable impact on positive youth developmental outcomes." (Kumpfer, 2014: 1)

SFP opens opportunities for better communication between children and their parents, hence children will feel free to come to their parents if they might have experienced any peer pressure to experiment with substances making minors less prone to substance abuse. Moreover, they may also feel more at ease to discuss any drug related questions they may be curious about with their parents and parents will be equipped with enough knowledge to be able to answer such questions.

We live in a global community where information is shared by a click of a button and unfortunately new drugs are trending just as fast. According to (Yach and Bettcher, 2000 cited in Bhana, 2007:16) "globalisation has also played a role in proliferating the liberalisation and penetration of

tobacco, alcohol and drug use into relative untapped markets." A relatively new drug on the market known as a 'zombie drug' or *flakka* that has been recently introduced in South Africa. This new deadly drug *flakka* that entered Europe, USA and Japan at an alarming rate about six years ago and has recently hit the South African streets. Side effects of this dangerous drug are reported to cause intoxications, seizures, extreme paranoia and even death (Katselou *et al*., 2016). Families need to be made aware of this so that they can become more resilient and better equipped to confront such challenges that threaten the future of young people in South Africa in a global world. Positive family relationships have been identified as a key protective factor against young people's misuse of substances such as alcohol and tobacco (Segrott *et al*., 2014). Prevention interventions which promote family values and positive family relationships therefore have the potential to make a significant impact on the health, wellbeing and future of adolescents (Segrott *et al*., 2014).

Parents are spending less time with their children because of the worldwide economic crisis that has resulted in them working more hours, leaving parents with little time to spend with their children. Even simple tasks like sharing family meals have declined which has a negative impact on the lives of adolescents as they no longer feel that sense of belonging which was traditionally provided by the family (Kumpfer, 2014). This apparent search for a sense of belonging outside the home may expose young people to risky behaviours such as substance abuse (Kumpfer, 2014). With parents working long hours and most young people moving away from home to learning institutions, parents can no longer provide the appropriate guidance and discipline to their children like they should (Chesang, 2013). This decline in parental care leaves young people with little guidance and supervision which often places them at the risk of substance abuse and other problem behaviours.

Programmes that strengthen families provide parenting skills that can assist parents to set strict rules and guidelines on aspects such as discipline methods, pocket money (allowance) as well as introducing curfews if they want their children to grow up to be productive adults. Consistent parenting is very important hence both parents need to agree on effective ways of raising their children. Programmes that strengthen families are of utmost important as both parents can attend and learn about appropriate parenting skills together and at the same time strengthen their own (husband/wife/partner) bonds as well as bonds with their children. When parenting methods are

more consistent, there will be less conflict within the family structure itself and between the parents. Kumpfer therefore maintains that there is strong evidence suggesting that family-based skills training programmes often result in positive outcomes among participants (Kumpfer, 2014).

What is noteworthy about family-based prevention programmes is that they not only benefit one or certain members of the family but the whole family including extended family members all at once. They also tackle a lot of other issues apart from the substance abuse problem. Kumpfer (2014) asserts that family-based programmes have a good impact on both the child and the parent as it promotes positive family relationships. He therefore maintains that such positive family relationships impact positively on the parent's productivity at work and the child's productivity at school. Healthy family life also impacts on good mental and physical functioning of the family members and their ability to reach their desired goals (Kumpfer, 2014). Family-based prevention programmes enhance positive outcomes by providing education and skills training to young people. It promotes positive youth development by teaching parents positive parenting skills and reinforcing factors that promote the parent/child bond, communication skills as well as effective parental supervision and discipline (Kumpfer, 2014). The advantage of family-based prevention programmes is that they are community based which fosters respect for cultural values as they take place in a familiar household environment. At the same time, they offer good opportunities for families to bond and socialise.

Studies have shown that parents who possess positive parenting skills tend to have children who are independent, sociable, cooperative and self-confident (Griffin, Samuolis and Williams, 2010; Kim-Spoon, Farley and Holmes, 2014; Kumpfer, 2014; Jones, 2015; Telzer, Gonzales and Fuligni, 2013; Luk *et al*.,2010). These aspects of positive parenting include positive discipline methods, positive response to their children's needs and involving their children in setting family rules (Orte *et al*., 2015). Conversely parents that display negative parenting styles such as lack of affection and support for their children tend to have children with emotional and behavioural disorders such as aggression, depression and anxiety (Orte, *et al*., 2015). Evaluations of the SFP have consistently demonstrated favourable results in reducing substance use or abuse among young people. Young people participating in the programme have displayed lower average use of alcohol and tobacco and parents participating in the programme displayed better parenting skills, more effective

communication skills and better parental supervision (Bröning *et al*., 2014). SFP can be can be classified as a model programme in comparison with other substance abuse prevention programmes in the US (Orte *et al*., 2015). This is supported by Orte *et al*, who explains that the SFP was classified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a model programme.

From the above submissions it is clear that family-based prevention programmes such as FSP (US and UK), FCP (Spain) and *Familien Stärken* (Germany), have been proven to have more effective outcomes and hence have gained more momentum in several countries than other programmes such as D.A.R.E. Family-based prevention programmes like SFP are highly recommended for the South African context provided that certain aspects are improved.

4.6 CONCLUSION

This chapter has examined some of the substance abuse prevention strategies that have been implemented in some of the African countries such as Zimbabwe and Kenya. It has also drawn on international family-based prevention programmes that have been found to be effective in the US and in European countries (UK, Spain and Germany) and highlighted some of the advantages of such programmes and how such programmes can be effective in minimising substance abuse among minors. Although the socio-economic situation of American and European families are different to those in Africa, specifically South Africa, the decline in family or parental care has been found throughout this research as a problem affecting the American, European and South African contexts alike. This decline in family or parental care has been argued throughout this research as one of the main reasons for adolescent substance abuse. Hence this research has recommended the adoption of family-based prevention programmes in the South African context, similarly to those adopted in America and Europe. The South African economic and cultural context will of course have to be taken into consideration to effectively inform the future development of the programme in South Africa. This position is supported by Ronoh (2014) who provides that cultural sensitivity is an important aspect to consider when formulating and or implementing prevention programmes. Programmes need to be culturally relevant to the intended participants (Ronoh, 2014).

Although there are vast differences between prevention strategies implemented by the developing and developed countries, two common factors are emphasised by the authors throughout the African, US and European literature. One is the important role that parents and families can play in effective substance abuse prevention programmes and strategies across all spheres whether it is Africa, the US or Europe. Second, is the importance of integration and cooperation of various stakeholders, organisations and institutions across all spheres of society in fighting the scourge of substance abuse and ensuring effective implementation of substance abuse prevention programmes and strategies. As seen throughout this chapter these are crucial aspects to ensure the protection of adolescents from the harmful effects of substance abuse which threatens their future.

The African countries surveyed showed a different level of commitment to substance abuse prevention programmes compared to the European and American counterparts. Whilst lessons can be learnt from the programmes on other continents with a proven track record, we need to find solutions for causes of abuse that are contextual to Africa, such as the high level of unemployment of youth and adults. Parry and Myers (2011) suggest that drug policies need to be evidence-based and also draw from the experiences of other countries. This will require consultation and active participation of community members and the young people at which the programmes are aimed.

It is clear that much can be learned from research and experience, hence trial programmes would be an effective means to test the viability of such a programme in South Africa. Careful monitoring and evaluation will reveal any shortcomings that the programme might encounter in a South African context. Segrott *et al.*, 2014 asserts that thorough evaluations are needed before any programmes can be adapted and implemented in a different setting. Every prevention programmme has its advantages and disadvantages regardless of the target population or intervention strategy used (Kumpfer, 2014). According to Kumpfer, 2014 the SFP has proven to be effective in both efficacy trials and real world situations. Family based programmes have also proven to be both successful and cost effective in the long term. Although there may be cost implications associated with any intervention strategy, the biggest mistake would not be preventing what can be prevented (Kumpfer, 2014).

CHAPTER FIVE
RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

The findings of this study highlight a few issues that that need to be addressed in order to improve substance abuse prevention programmes implemented among minors in South Africa. This concluding chapter will focus on the analysis of findings, limitations of this study and recommendations on how the substance abuse prevention programmes implemented among minor in South Africa can be further improved.

5.2 FINDINGS

The findings in this research have emphasised the importance of integration in substance abuse prevention strategies. All stakeholders within communities need to work together to prevent the problem of substance abuse from escalating. Programmes that involve the participation of parents, the school and the young people concerned are likely to produce effective results. The key to effective prevention strategies is to reinforce the natural social bonds that exist between young people and their families, friends and peers as such bonds give adolescents a sense of belonging and purpose (Strader, Collins, and Noe, 2000). Van Niekerk asserts that in order to effectively deal with the substance abuse problem it is important to first acknowledge that drugs have always been a part of human history (Van Niekerk, 2011). The lack of research and funds in the field of substance abuse prevention continues to be problematic. This study has revealed that there is a lack of research/evidence to inform the formulation of drug policies in South Africa hence a more evidence-based approach to substance abuse prevention is required. Good practices from African neighbours is difficult to obtain due to a dearth of literature on prevention programmes or policies. Dealing with the substance abuse problem requires that policies also adequately address other social ills such as poverty, unemployment and HIV/AIDS as the substance abuse problem does not exist in isolation.

The findings have also indicated that for the production of quality programmes, it is important that facilitators possess the appropriate skills and training for implementing substance abuse prevention programmes. The duration of programmes was also found as an important determinant in producing effective programmes.

The findings in chapter three also suggest that selective programmes targeting certain groups are likely to be more effective than programmes targeting general populations. Prevention strategies should be designed for specific groups they intend to target, for example in terms of gender, age race etc.

The finding in chapter three indicates the role of recreational facilities as being crucial in keeping young people away from drugs. Boredom and idleness are one of the reasons identified in this research for young people engaging in drugs, hence the availability of such in both rural and urban areas will ensure that young people are kept busy in constructive ways.

Drawing from international experiences and strategies, as indicated in chapter four has revealed that in Europe and the US the programmes found to be more effective in trial studies are the family-based prevention programmes. Substance abuse prevention strategies in African countries reflect that these countries are still in their developing stages, hence their substance abuse prevention strategies require many developments compared to industrialised countries. However, family-based prevention strategies are echoed throughout Europe, US and Africa. Families have also been found to be key elements in the prevention of substance abuse among minors as they not only give adolescents a sense of belonging and self-worth, but they also help them in their journey towards self-actualization. Moreover, families provide a good value base for young people.

5.3 LIMITATIONS OF THE STUDY

This study was based on desktop research; more in-depth qualitative research is needed to delve deeper into the examination of substance abuse prevention programmes and its impact on minors who are prone to substance abuse in South Africa.

This study focused mainly on substance abuse prevention programmes implemented among minors in schools. Programmes implemented among minors who do not attend school (school dropouts) were not included which limited the findings of this study. Hence more knowledge on programmes implemented outside of the schools could also prove useful.

The bulk of the research on substance abuse prevention programmes is based on urban areas there is very little knowledge on substance abuse prevention programmes implemented in rural areas which is very limiting.

This study has also analysed substance abuse prevention programmes from the American and European context which is totally different from the South African context both culturally and economically. Hence reasons for young people abusing drugs across these different cultural and socio-economic contexts may differ.

Despite its limitations, the study has assisted in identifying gaps in substance abuse prevention programmes implemented among minors in South Africa which may assist policy makers in developing effective evidence-based substance abuse prevention programmes in the future and also help to improve the current programmes rendering them more effective in curbing the use of substances among minors in South Africa.

5.4 RECOMMENDATIONS

- This study suggests that there is a need for further research to be undertaken with regard to the role of parental support and involvement in substance abuse prevention programmes implemented among minors prone to substance abuse in South Africa. Strategies aimed at strengthening parent-child relationships should also be put in place as strengthening these relations may ensure that fewer minors are susceptible to substance abuse. This is because most research points to families as paramount in the struggle against adolescence substance abuse.

- Chapter 4 of this research has identified families as key protective factors against adolescent substance abuse and hence family based prevention programmes are strongly recommended within the South African context. However, the importance of community programmes cannot be overlooked.

- In addition, this study calls for regular monitoring and evaluation of all substance abuse prevention programmes implemented among minors to ensure their impact and effectiveness in curbing substance abuse behaviour among minors in the country.

- As discussed in chapter 3 and 4, it is also recommended that more research is required to focus on substance abuse prevention programmes implemented outside of the schools as well aimed at reaching minors out of schools. More focus should also be paid to substance abuse prevention programmes in rural areas. More in depth qualitative research involving research participants is recommended to get a more detailed analysis of the impact and outcomes of substance abuse prevention programmes implemented among minors prone to substance abuse in South Africa.

- As discussed in chapter 2, substance abuse policies should ensure that all substance abuse prevention programmes implemented among minors are evidence-based and in line with all relevant legislation. Policy makers should appoint a body to ensure the smooth running and effectiveness of these programmes as well as be accountable for such programmes.

- Uniform/standardized training and capacitation of all facilitators of substance abuse prevention programmes is recommended to ensure accuracy and standardisation of information disseminated. This includes the training of social workers.

- It is also suggested that government should invest more funds in building recreational facilities especially in townships and rural communities. The availability of recreational facilities will keep young people occupied in constructive ways which will steer them away from drugs and other risky activities. Isibindi safe parks (if implemented well) can to a certain extent play an important role in remedying this situation. The availability of

recreational facilities is one of the key factors identified in this research as an effective strategy for curbing substance abuse among minors. This is explained in detail in chapter 4. Overall, more funds need to be invested into substance abuse prevention strategies and research in South Africa.

- The substance abuse problem affects all members of the community equally regardless of class, gender, race and social standing. Hence the integration of all stakeholders, government departments, community and religious based organisations as well as civil society is recommended for controlling the existing abuse of drugs in society.

5.5 CONCLUSION

All young people need to be able to make healthy and responsible choices when it comes to substance use and abuse, prevention programmes when implemented effectively have the power to shape the kind of decisions young people make regarding substance use and abuse. It is therefore important that all programmes are continuously monitored and evaluated to measure the impact and outcomes of these programmes and to also determine their effectiveness. The purpose of this research has been to provide a framework for effective substance abuse prevention programmes implemented among adolescents in South Africa. While there is no single strategy or framework for effective prevention programmes that can be adopted, this study has outlined some of the best practice models that can make for effective prevention programmes. Parental involvement, availability of recreational facilities, integration of stakeholders, training and skills of facilitators, duration of programmes, types of programmes are some of the factors identified in this study as important determinants for effective substance abuse prevention. On-going evaluation of current policies and intervention strategies is also very important to the success of effective substance abuse prevention programmes.

BIBLIOGRAPHY

Primary Sources:

International and regional law:

African Charter on the Rights and Welfare of the Child (ACRWC)

United Nations Convention on the Rights of the Child (CRC)

Committee on the Rights of the Child General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) 17 April 2013 CRC/C/GC/15

Constitution:

Constitution of the Republic of South Africa, 1996.

Legislation:

Children's Act 38 of 2005

Drugs and Drug Trafficking Act 140 of 1992

Prevention of and Treatment for Drug Dependency Act 20 of 1992

Prevention of and Treatment for Substance Abuse Act 70 of 2008

Tobacco Product Control Act 1993

Policy:

DSD (2013). National Drug Master Plan 2013–2017. Pretoria: Government Printers.

Sector Regulations or Guidelines:

South African Council for Social Service Professions: Policy Guidelines for Course of Conduct, Code of Ethics and the Rules for Social Workers.

Regulations for Prevention of and Treatment for Substance Abuse, 2013

Regulations for the registrations of liquor manufacturers and distributors, and related matters arising under Liquor Act 59 of 2003. (2004). Government Gazette No. 26689, Republic of South Africa.

Secondary Sources:

Books and Chapters in Books:

Alter, K. (2014). *The New Terrain of International Law: Courts, Politics, Rights*. Princeton University Press.

Chakravarthy S.R. (2013). *Analysis of* MAP/PH/c *Retrial Queue with Phase Type Retrials – Simulation Approach.* In: Dudin A., Klimenok V., Tsarenkov G., Dudin S. (eds) Modern Probabilistic Methods for Analysis of Telecommunication Networks. Communications in Computer and Information Science, vol 356. Springer, Berlin, Heidelbe.

Birkeland, S., Murphy-Graham, E. & Weiss, C. (2005). *Good reasons for ignoring good evaluation: The case of the drug abuse resistance education (D.A.R.E.) program*. Evaluation and Program Planning 28: 247–256.

Caroll, K. M & Miller, W. R (Ed) (2006). Rethinking Substance Abuse: What The Science Shows and What We Should Do About It. The Guilford Press, New York, London.

Dworkin, R. (1986). Law's Empire, Cambridge, MA: Harvard University Press.

Ehrlich, E. (1969). Judicial freedom of decisions: Its principles and objects, in Science of legal method: Selected Essays by Various Authors [1917] E. Bruncken and L.B. Register, trans., New York: A.M. Kelly.

Gouse, H., Magidson, J.F., Burnhams, W., Remmert, J.E., Myers, B., and Joska J.A. (2016) *"Implementation of Cognitive-Behavioral Substance Abuse Treatment in Sub-Saharan Africa: Treatment Engagement and Abstinence at Treatment Exit."* (ed.) Philip Anglewicz, Tulane University. https://doi.org/10.1371/journal.pone.0147900.

Leiter, B. (2007). *Naturalizing Jurisprudence: Essays on American Legal Realism and Naturalism in Legal Philosophy.* Oxford University Press Scholarship Online. Available at:http://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780199206490.001.0001/acprof-9780199206490

Fulbrook, M. (2003). Historical Theory. Routledge, New York.

Hart, H.L.A., (1994) [1961], *The Concept of Law.* Clarendon Press; 2nd edition with postscript by J. Raz & P. Bulloch (eds.), Oxford: Oxford University Press.

Kumpfer, K. L. (2014). *Family-Based Interventions for the Prevention of Substance Abuse and Other Impulse Control Disorders in Girls*. Hindawi Publishing Corporation. Department of

Health Promotion and Education, University of Utah, Salt Lake City, UT 84112, USA. http://dx.doi.org/10.1155/2014/308789

Maxwell, J.A. (2012) *A realist approach in qualitative research*. George Mason University. SAGE Publications, Inc. 2455 Teller Road, Thousand Oaks, California 91320.

Maxwell, J. A., & Mittapalli, K. (2010). *Realism as a stance for mixed methods research.* In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social and behavioral research*, 2nd ed.: pp. 145-167. Thousand Oaks, CA: Sage.

Muisener, P.P. (1994). *Understanding and Treating Adolescent Substance Abuse*. Sage Publications. Thousand Oaks, London, New Delhi.

Ray, O. & Ksir, C. (2004). *Drugs, Society, and Human Behavior.* McGraw Hill, New York.

Strader, T. N., Collins, D.A., & Noe, T.D. (2000). *Building Healthy Individuals, Families, and communities: Creating Lasting Connections*. Kluwer Academic/Plenum Publishers. New York, Boston, Dordrecht, London, Moscow.

United Nations Office on Drugs and Crime (UNODC) (2017). *Prevention of Drug Use and Treatment of Drug Use Disorders in Rural Settings*. United Nations, New York.

Van Eeden, A. (2000). *Drugs: Facts Arguments and Practical Advice*. Doctors for Life.

William, W.F. (2008). *Legal Theory and Legal Education, 1920–2000.* Cambridge University Press. Available at: https://dash.harvard.edu/bitstream/handle/1/32861749/CHLA.pdf?sequence=1

Journal articles

Adu-Mireku, S (2003). *The prevalence of alcohol, cigarette, and marijuana Use among senior secondary students in urban setting*. J Ethn Subst Abus. 2(1):53–65. doi:10.1300/J233v02n01_05

Alhyas L, Elarabi H, El-Kashef A, Wanigaratne S, Almarzouqi A, et al. (2015). *Parents' Perceptions and Beliefs on Adolescence and Substance Use: A Preliminary Qualitative Study in Abu Dhabi, United Arab Emirates* [UAE]. J Child Adolesc Behav 3: 195. doi: 10.4172/2375-4494.1000195

Atwoli L, Mungla P.A, Ndung'u M.N, Kinoti K.C, Ogot E.M (2011). *Prevalence of substance use among college students in Eldoret, western Kenya*. BMC Psychiatry. 11:1–9. doi: 10.1186/1471-244X-11-34.

Bana A, Bhat VG, Godlwana X, Libazi S, Maholwana Y, Marafungana N, Mona K, Mbonisweni AM, Mbulawa N, Mofuka J, Mohlajoa NA, Nondula NN, Qubekile Y, Ramnaran B. (2010). *Knowledge, attitudes and behaviours of adolescents in relation to STIs, pregnancy, contraceptive utilization and substance abuse in the Mhlakulo region, Eastern Cape.* Vol 52(2) SA Fam Practitioner.

Bhebhe, T.B., Bhebhe, R.K. & Bhebhe B.S. (2016). *An Investigation into The Causes of Unemployment Among Youths in The City of Harare.* Global Journal of Arts, Humanities and Social Sciences Vol.4, No.2, pp.90-102.

Bröning, S., Sack, P., Thomsen, M. Strolle, M. Wendell, A., Stapenbeck, J. & Thomasius, R. (2014). *Implementing and evaluating the German adaptation of the "Strengthening Families Program 10 - 14"– a randomized controlled multicentre study*. BMC Public Health 14:83 http://www.biomedcentral.com/1471-2458/14/83

Calafat, A., Garcia, F.,Juan, M., Becona, E., Fernandes-Hermida, J.R. (2014). *Which parenting style is more protective against adolescent substance use? Evidence within the European context.* Drug and Alcohol Dependence 138: 185-192.

Caria M.P., Faggiano F., Bellocco R. et al. (2011) *Effects of a school-based prevention program on European adolescents' patterns of alcohol use*. Journal of Adolescent Health: 48: 182–188.

Chakravarthy B, Shah, S., & Lotfipour, S. (2013). *Adolescent Drug Abuse - Awareness & Prevention.* Indian J Med Res. Jun; 137(6):1021-3.

Chesang, R.K (2013). Drug Abuse Among the Youth in Kenya. International Journal of Scientific & Technology Research Volume 2, Issue 6, 126.

Choate, P.W. (2015). *Adolescent Alcoholism and Drug Addiction: The experience of Parents.* Behavioral Science 5: 461-476.

Christiano, T. & Stefan, S. (2003). *Legal Positivism and the Nature of Legal Obligation*. 22 LAW & PHIL. 487, 489-90.

Davel, C.J. & Skelton, A.M. (2015). *Commentary on the Children's Act.* Juta RS 2, 2010 ch8-p12

de Looze, M., Vermeulen-Smit, E., ter Bogt, T.F.M. van Dorsselaer, S.A.F.M., Verdumen, J., Schulten, I., Engels, R.C.M.E., Vollerbergh, W.A.M. (2014). T*rends in alcohol-specific parenting practices and adolescent alcohol use between 2007 and 2011 in the Netherlands.* International Journal of Drug Policy 25:133– 141.

Doku, D, Koivusilta L, Rimpelä, A (2012). *Socioeconomic differences in alcohol and drug use among Ghanaian adolescents.* Addict Behav. 37:357–60. doi: 10.1016/j.addbeh.2011.11.020

Evans, R & Mallick, J (1997). *Drug Education: Supporting Parents to Support Children*. Early Child Development and Care, 136:1, 79-94, DOI: 10.1080/0300443971360107.

Faggianoa, F., Vigna-Tagliantia, F., Burkhartc, C., Bohrnd, K. et al. (2010). *The effectiveness of a school-based substance abuse prevention program: 18-Month follow-up of the EU-Dap cluster randomized controlled trial.* Drug and Alcohol Dependence 108: 56–64.

Fellingham, R., Dhai, A., Guidozzi, Y., Gardner, J (2012). *The 'War On Drugs' Has Failed: Is Decriminalisation of Drug Use a Solution to The Problem in South Africa?* South African Journal of Bioethics and Law,5(2),78-82.

Geyer, S., & Lombard, A. (2014). *A Content Analysis of the South African National Drug Master Plan: Lessons for Aligning Policy with Social Development*. Social Work, 50(3), 329–349.

Goliath,V & Pretorius, B (2016). *Peer Risk and Protective Factors in Adolescence: Implications for Drug Use Prevention*. Social Work/Maatskaplike Werk Vol 52 No 1; Issue 7 http://socialwork.journals.ac.za/pub doi:http://dx.doi.org/10.15270/52-1-482

Gottfredson, D. C. & Wilson, D. B. (2003). *Characteristics of Effective School-Based Substance Abuse Prevention.* Prevention Science, Vol. 4, No. 1, March 2003 file:///D:/Online%20Journal%20Articles/Characteristics%20of%20effective%20school%20based%20substance%20abuse%20prevention%202003.pdf.

Green, L. (1997). *The Concept of Law Revisited* [Book Review of the Concept of Law, Second Edition, by H. L. A. Hart]. Osgoode Hall Law School of York University. Michigan Law Review 94 (6): pp.1687-1757

Griffin, K.W., Samuolis, J. Williams, C.W. (2011). *Efficacy of a Self-Administered Home-Based Parenting Behaviors for Preventing Adolescent Substance Use.* Journal for Child and Family Studies 20:319-325.

Jones, J.D., Ehrlich, K.B., Lejuez, C.W., Cassidy, J. (2015). *Parental Knowledge of Adolescent Activities: Links with Parental Attachment Style and Adolescent Substance Use.* Journal of Family Psychology Vol 29 No 2, 191-200.

Kalantarkousheh, S.M., Nickamal, N., Amanollahi, Z. & Dehghani, E. (2014). *"Spiritual Intelligence and Life Satisfaction among Married and Unmarried Females"*. Open Journal of Social Sciences, 2,172-177

Kanyoni, M, Gishoma, D & Ndahindwa, V (2015). *Prevalence of psychoactive substance use among youth in Rwanda'* BMC Research Notes 8:190 DOI 10.1186/s13104-015-1148-2

Katselou, M., Papoutsis, I., Nikolaou, P., Spiliopoulou, C., Athanaselis, S. (2016). *α-PVP ("flakka"): a new synthetic cathinone invades the drug arena.* Forensic Toxicol. Volume 34, Issue 1, pp 41–50 https://doi.org/10.1007/s11419-015-0298-1

Karim, Q.A. (2016). *'Mental health of and substance use by adolescents'* S Afr MedJ;106(6):547

Kim-Spoon, J., Farley, J.P., & Holmes, C.J. (2014). *Does Adolescents' Religiousness Moderate Links Between Harsh Parenting and Adolescents Substance Use?* Journal of Family Psychology Vol 28 No 6, 739-748.

King, K.A., Wagner, D.I & Hedrick, B (2002) Parents' Reported Needs in Preventing Their Children from Engaging in Alcohol, Tobacco, and other Drug Use. Journal of Health Education, 33:2, 70-76, DOI:10.1080/19325037.2002.10609419.

Luk, J.W., Farhat, T., Jannotti, R.J., Simons-Morton, B.G. (2010). *Parent-child communication and substance use among adolescents: Do father and mother communication play a different role for sons and daughters?* Addictive Behaviors 35:426-43.

Mpanza, D.M. & Govender, P. (2017). *"Rural realities in service provision for substance abuse: a qualitative study in uMkhanyakude district, KwaZulu-Natal, South Africa"* 59(3) South African Family Practice 110-115.

Monyakane, M.M.M. (2016). *The South African Drugs and Drug Trafficking Act 140 of 1992 read with the South African Criminal Law Amendment Act 105 of 1997: An Example of a One Size Fits All Punishment?* Criminal Law Forum 27: 227-254.

Muchiri, B & Dos Santos, M.M.L. (2018) *"Family management risk and protective factors for adolescent substance use in South Africa"* 13(4) Substance Abuse Treatment, Prevention, and Policy 1-10.

Okoza J, Aluede O. (2009). *Drug abuse among students of Ambrose Alli University, Ekpoma, Nigeria*. Eur J Soc Sci.10:85–93.

Otieno A.O, Ofulla A. (2009). *Drug abuse in Kisumu town western Kenya*. Afr J Food Agric Nutr Dev. 9(3):846–58.

Otu, S. (2011). *A Nation at Crossroads: Debating South Africa's War on Drug Policy*. Nordic Studies on Alcohol and Drugs, 28(4), 379–388.

Orte, C., Ballester, L., March, M.X., Amer, J., Vives, M., Pozo, R. (2015). *"The Strengthening Families Programme in Spain: a long-term evaluation"*, Journal of Children's Services, Vol. 10 Issue: 2, pp.101-119, https://doi.org/10.1108/JCS-03-2013-0010

Parry, C., & Myers, B. (2011). *Beyond the rhetoric: Towards a More Effective and Humane Drug Policy Framework in South Africa*. South African Medical Journal, 101(10), 704–706.

Pelzer, K & Phaswana-Mafuya, N (2018). *'Drug use among youth and adults in a population-based survey in South Africa'* S Afr J Psychiat. 24(0), a1139. htps://doi. org/10.4102/sajpsychiatry. v24i0.1139

Pienaar, K., & Savic, M. (2016). *Producing alcohol and other drugs as a policy 'problem': A critical analysis of South Africa's 'National Drug Master Plan' (2013–2017).* International Journal of Drug Policy, 30 (2016) 35–42.

Puljević, C & Learmonth, D (2014). Substance abuse prevention in Cape Town's peri-urban settlements: local health trainers' perspectives, Health Psychology and Behavioral Medicine: An Open Access Journal, 2:1, 183-197, DOI: 10.1080/21642850.2013.878659.

Segrott, J., Gillespie, D., Holiday, J., Humphreys, I., Murphy, S., Philips, C., Reed, H., Rothwell, H., Foxcroft, D., Hood, K., Roberts, Z., Scourfield, J., Thomas, C. & Moore, L. (2014). *Preventing substance misuse: study protocol for a randomised controlled trial of the Strengthening Families Programme 10–14 UK (SFP 10–14 UK).* BMC Public Health, 14:49 http://www.biomedcentral.com/1471-2458/14/49

Slabbert, I. (2015). *Reflective Learning in Social Work Education in The Field of Substance Abuse.* Social Work/Maatskaplike Werk Vol 50 No 4; Issue 6

Setlalentoa, M & Strydom, H (2015). *Intervention Strategies Used to Address Alcohol Abuse in The North West Province, South Africa.* Social Work/Maatskaplike Werk Vol 50 No 1; Issue 5

Strang, J., Babor, T., Caulkins, J., Fischer, B., Foxcroft, D., Humphreys, K. (2012). *Drug Policy and the Public Good: Evidence for Effective Interventions.* The Lancet Vol 379.

Stoker, P (1997). A Rational Approach to Drug Prevention in the Primary School: Practice Review and Policy Developments. Early Child Development and Care, 139:1, 73-97, DOI: 10.1080/0300443971390106.

Telzer, E.H., Gonzales, N., Fuligni, A.J. (2014). *Family Obligation Values and Family Assistance Behaviours: Protective and Risk Factors for Mexican-American Adolescents' Substance Use.* Journal for Youth Adolescence 43:270-283.

Thobeka, S.N., Priscalia, K. & Nkosiyazi, D. (2017). *Investigating the Implementation of the Ke-Moja Substance Abuse Prevention Programme in South Africa's Gauteng Province.* Journal of Social Sciences. Vol 3 No. 2.

Tshabalala, T., Khosa M.T., Gazimbe, P. & Ncube A.C (2015). *Prevalence of Drug Abuse and Strategies for Combating It in Secondary Schools in Hwange District*. Scholars Journal of Arts, Humanities and Social Sciences ISSN 2347-5374 (Online) Available Online: http://saspjournals.com/sjahss.

Tshitangano, T., & Tosin, O. H. (2016). *Substance use amongst secondary school students in a rural setting in South Africa: Prevalence and possible contributing factors*. African Journal of Primary Health Care and Family Medicine, vol. 8, no.2: pp. 2-6. AOSIS.

Van Niekerk, J. P. (2011). *Time to Decriminalise Drugs?* South African Medical Journal, 101(2), 79–80.

West, S.L. & O'Neil, K.K. (2004). *Project D.A.R.E. Outcome Effectiveness Revisited*. American Journal of Public Health. Vol 94, No. 6.

Theses:

Dreyer, S. E. (2012). *The relevance and effectiveness of support structures available to high school learners with substance abuse problems in the Eersterust area.* Dissertation submitted in accordance with the requirements for the degree of Master of Education. University of South Africa. file:///D:/Online%20Journal%20Articles/The%20relevance%20and%20effectiveness%20of%20support%20structures%20available%20to%20high%20school%20learners%202012.pdf.

Mohasoa, I. P. (2010). Substance Abuse among Male Adolescents. Dissertation submitted in the fulfillment for the requirements of Masters of Arts, University of South Africa. file:///D:/Online%20Journal%20Articles/dissertation_mohasoa_UNISA.pdf.

Mothibi, M.S. (2014). *The requirements of taxation on companies and directors in relation to normal tax, secondary tax on companies, piercing of the veil as well as limitations connected.* Nelson Mandela Metropolitani University.
at: http://encore.seals.ac.za/iii/encore_nmmu/plus/C__Smothibi__Orightresult?lang=eng&suite=nmmu

Otingi, V (2012). *The wellbeing of the youth – A literature review of the drug abuse prevention methods and strategies between Finland and Kenya*. Helsinki Metropolia University of Applied Sciences Social Services, Degree Programme in Social Services.

Ronoh, K.C (2014). *Effectiveness of Drug and Substance Abuse Prevention Programs in Selected Public and Private Universities in Kenya*. A Thesis Submitted to The School of Humanities and Social Sciences in Partial Fulfilment of the Requirements for The Award of the Degree of Doctor of Philosophy in Counseling Psychology of Kenyatta University.

Government Reports:

Department of Social Development. (2015). *Substance abuse treatment*. Available from: http://www.dsd.gov.za/index.php/option=com_content&task=view&id=34&Itemid=58

Department of Social Development, (2013). *Substance use, misuse and abuse amongst the youth in Limpompo Province.* Limpompo Provincial Government. file:///C:/Users/ngcobop/Desktop/Substance%20Abuse%20DSD%202013.pdf

Hendricks, M (2010). *Ke Moja Project at the Laingsburg Thusong Service Centre - "I'm Fine without Drugs".* Thusong Service Centre: Government Services. http://www.thusong.gov.za/news/archive/kemoja.htm.

Zimbabwe Youth Investment Case Study (2016). Business Case Report, Ministry of Youth Indigenisation and Economic Empowerment. https://www.unicef.org/zimbabwe/ZYICS_Business_Case_Report_August_2016FINALA4.pdf

Media:

City of Cape Town. (2010). "Tafelsig Matrix treatment clinic internationally certified as a 'programme of excellence'" Available from: http://www.capetown.gov.za/en/MediaReleases/Pages/TafelsigMatrixtreatmentclinicinternationallycertifiedasaprogrammeofexcellence.

DrugWise. (2016). How much crime is drug related? Available at: http://www.drugwise.org.uk/howmuch-crime-is-drug-related/

Williams, D. (2016). Drug abuse is growing in SA. The Citizen, 27 June, p. 5. Available at: http://citizen.co.za/news/news-national/1179509/drug-abuse-is-growing-in-sa/ Accessed on 15 April 2017 @ 23:52 pm.

United Nations Office on Drugs and Crime (2015). World Drug Report. United Nations publication, Sales No. E.15.XI.6. Vienna, Austria. Available at: https://www.unodc.org/documents/wdr2015/World_Drug_Report_2015.pdf

United Nations Office on Drugs and Crime. (2016). UN World Drug Report. New York: United Nations. Available at: https://www.unodc.org/wdr2016/

Other:

Baxter, J (2012). '*The Rights of the Child' – A Pivotal Human Rights Issue for Drug Policy-makers.* Forging Leadership Conference, Miami 2012 – Jo Baxter, Drug Free Australia admin@drugfree.org.au Child-Centred Drug Policy – the way forward

Bhana, A (2007). *Costing of the Prevention and Treatment of Substance Abuse Bill*. Human Sciences Research Council (HSRC). Report submitted to: National Department of Social Development.

Chames, C., Norushe, T., Wessels, W. (2009). "*Ke Moja: Draft Report for the Evaluation of the "Ke Moja, I'm fine without drugs" Programme*. Published by Southern Hemisphere Consultants.

Dada.S., Pluddemann,A., Parry,C., Bhana,A., Harker Burnhams,N., Vawda,M., & Fourie,D. (2014). The South African Community Epidemiology Network on Drug Use (SACENDU Phase 32). Alcohol and Drug Abuse TRENDS.

Dada, S.P., Plüddemann, A., Bhana, A., Vawda, M., Pereira, T., Nel, E. (2012). *Monitoring Alcohol and Drug Abuse Treatment Admissions in South Africa*. mrcacza: SACENDU Research Brief; p. 1–5.

Executive director of the United Nations Office on Drugs and Crime. (2013). *Contribution to the high level review of the implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem.* Available at: https://www.unodc.org/documents/hlr/V1388514e.pdf

Galvani, S (2015). *Alcohol and other Drug Use: The Roles and Capabilities of Social Workers.* The University for World-Class Professionals, Public Health England.

Kimunya F. W (2012). Gender Differences in Reasons for Alcohol and Drug Abuse among Youth in Kenya: Programs for Prevention, The American University in Cairo.

Myers, B. (2013). *"Barriers to alcohol and other drug treatment use among Black African and Coloured South Africans*". BMC Health Serv Research. https://bmchealthservres.biomedicentral.com

National Institute of Alcohol abuse and Alcoholism (NIAAA). National Institute of Health (NIH). https://pubs.niaaa.nih.gov/publications/Social/Module3Prevention/mODULE3.HTML

Parry, C. & Freeman, M. (2006). *Alcohol Use Literature Review.* Prepared for Soul City. file:///D:/Online%20Journal%20Articles/Alcohol_Use_Literature_Review%202006.pdf.

Parry, C.D.H. (1998). *Substance Abuse in South Africa: Country Report Focusing On Young Person.* Mental Health & Substance Abuse, Medical Research Council. Tygerberg; South Africa. file:///D:/Online%20Journal%20Articles/SUBSTANCE%20ABUSE%20IN%20SOUTH%20AFRICA%201998.pdf.

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

Setlalentoa M, E. R. & Strydom. H. (2015). *Intervention strategies used to address alcohol abuse in the North West province, South Africa Social Work,* Stellenbosch, vol.51 n.1 Stellenbosch. Available at: http://www.soulcity.org.za/research/literature-reviews/soul-city-institute-drug-abuse-youth-south-africa.pdf

Shaffer, G. (2016). *Theorising Transnational Legal Ordering.* Legal Studies Research Paper Series No. 2016-06. University of California, Irvine School of Law. Available at: http://www.law.uci.edu/faculty/full-time/shaffer/pdfs/2016%20Theorizing%20Transnational%20Legal%20Ordering.pdf

Tamanaha, B. (2013). "*The Third Pillar of Jurisprudence: Social Legal Theory*." Legal Studies Research Paper Series Paper No. 13-04-01. School of Law, Washington University in St. Louis.: pp.1-44.

WHO Framework Convention on Tobacco Control. (2003). Geneva, World Health Organization, 2003 (updated 2004, 2005; Available at: http://whqlibdoc.who.int/ publications/2003/9241591013.pdf

WHO Framework Convention on Tobacco Control guidelines for implementation. (2013). Geneva, World Health Organization. Accessed at: http://www.who.int/fctc/ guidelines/adopted/guidel.

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

12 October 2017

Ms Precious Ngcobo (207507027)
School of Law
Howard College Campus

Dear Ms Ngcobo,

Protocol reference number: HSS/1848/017M
Project title: An examination of Substance Abuse Prevention Programmes and its impact on minors prone to Substance Abuse in South Africa

Approval Notification – No Risk / Exempt Application

In response to your application received on 21 September 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Dr Annette Singh and Ms Carol Anne Epstein
Cc Academic Leader Research: Professor Sharon Bosch
Cc School Administrator: Mr Pradeep Ramsewak

Humanities & Social Sciences Research Ethics Committee
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