PERCEPTIONS OF SUBSTANCE ABUSE PREVENTION PROGRAMMES IMPLEMENTED IN THE RAMOTSHERE MOILOA LOCAL MUNICIPALITY, SOUTH AFRICA

by

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DECLARATION

I, Irene Patience Mohasoa, declare that *Perceptions of substance abuse prevention programmes implemented in the Ramotshere Moiloa Municipality, South Africa* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

27 February 2018

Signature   Date

ABSTRACT

Substance abuse is a significant challenge facing the World and in particular South Africa. In this study, various Western and African traditional perspectives were considered to gain an understanding of the substance abuse problem among adolescents. The study was conducted in one of the rural villages of the Ramotshere Moiloa Local Municipality in the North West Province of South Africa. Participants included 24 African male and female adolescents between 13 and 19 years of age, as well as 2 parents and 9 professionals. The 9 professionals are educators, a social worker, a clinical psychologist, a mental health worker, a traditional leader and a traditional healer, between 37 to 53 years of age. A qualitative, explorative research design was employed. Data sources included individual face-to-face interviews, focus group discussions, and a document review. Thematic analysis was employed to analyse data. The findings were based on the perceptions of participants and revealed that adolescents are socially entrapped to substances such as alcohol, tobacco, cannabis, cocaine, glue, nyaope, and *segonyamahlo*. Reasons for their use of substances included individual, family, and environmental factors. The findings revealed the severe impact of substance abuse on adolescents and their families. There was evidence of primary, secondary, and tertiary levels of substance abuse prevention programmes targeting adolescents and other community members. In addition, stakeholders such as parents, peers, professionals, traditional leaders, traditional healers, government, and non-government organisations were recommended to implement substance abuse prevention programmes to address the substance abuse problem among adolescents. Furthermore, the study highlighted efforts made to reflect on the implemented substance abuse prevention programmes.

KEYWORDS

Adolescent; aftercare; African traditional perspectives; document analysis, interviews; qualitative research; relapse; substance abuse; substance abuse prevention programme; substance abuse treatment; thematic analysis; Western theoretical perspectives.

ACKNOWLEDGEMENTS

DEDICATION

I dedicate this study to my mother, Emmah, my husband Joseph, my children, Kelebogile and Boitumelo, the Sindanes family, and adolescents in the Ramotshere Moiloa Municipality.

ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMPS	Alcohol Misuse Prevention Study
ANC	African National Congress
AOD	Alcohol and Other Drugs
CBO	Community-Based Organisations
CDA	Central Drug Authority
COGTA	Cooperative Governance and Traditional Authorities
DAC	Department of Arts and Culture
DBE	Department of Basic Education
DCS	Department of Correctional Services
DOE	Department of Education
DOH	Department of Health
DPO	Designated Police Officials
DSD	Department of Social Development
DTI	Department of Trade and Industry
EE	Empowerment Evaluation
EPWP	Extended Public Works Programme
FBO	Faith- Based Organisation
FDA	Food and Drug Administration
FET	Further Education and Training
FM	Family Matters
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HSRC	Human Sciences Research Council
IDP	Integrated Development Plan
IDU	Injecting Drug Use
IHRA	International Harm Reduction Association
LDAC	Local Drug Action Committee
LO	Life Orientation
LRC	Learner Representative Council
MDFT	Multidimensional Family Therapy
MDMP	Mini Drug Master Plan

MEC	Member of Executive Committee
MRC	Medical Research Council
MSFT	Multisystem Family Therapy
NCS	National Curriculum Statement
NDMP	National Drug Master Plan
NGO	Non-Governmental Organisation
NIDU	Non- Injecting Drug Use
NW	North West
NYDA	National Youth Development Agency
PDAC	Provincial Drug Action Committee
POA	Programme of Action
PORI	Operational Plan of Integrated Responses
PSF	Professional Support Forums
QuASAR	Quick Analysis of Substance Abuse Reports
RADS	Radically Different Species
RSA	Republic of South Africa
SA	South Africa
SACENDU	South African Community Epidemiology Network on Drug Use
SADAG	South African Depression and Anxiety Group
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPS	South African Police Service
SASA	South African Schools Act
SFP	Strengthening Families Programme
SGB	School Governing Body
SHAHRP	School Health and Alcohol Harm Reduction Project
SSFT	Structural Strategic Family Therapy
TADA	Teenagers Against Drug Abuse
TC	Therapeutic Community
UNODC	United Nations Office on Drugs and Crime
US	United States
WHO FCTC	World Health Organisation's Framework Convention on Tobacco Control
WHO	World Health Organisation
YADA	Youth Against Drug Abuse

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CHAPTER 1
STUDY ORIENTATION

INTRODUCTION

Substance abuse among adolescents continues to be a major problem worldwide and in South Africa in particular (Charkravarthy, Shah, & Lotfipour, 2013; Dada et al., 2016; Kalantarkousheh, Rasouli, Abolfathi, & Nouri, 2014; Setlalentoa, Ryke, & Strydom, 2015; United Nations Office on Drugs and Crime, 2017). Substance abuse and its distressful consequences are related to medical, psychological, financial, spiritual, familial, and social problems that cause tremendous damage to the family and society (Daley, 2013; Kalantarkousheh et al., 2014; Setlalentoa et al., 2015).

In South Africa, various organisations, including both private and public institutions, are continually developing strategies to curb substance abuse among adolescents. These strategies range from policies prohibiting the sale and use of substances by minors, restricting the advertising of substances requiring an inscription of warning signs on the outside of both alcoholic beverages, as well as cigarette packages based on both national and international health promotion acts. Furthermore, these policies restrict the use of substances in public places (Liquor Act, 2003; Tobacco Products Amendment Bill B24, 2006; Tobacco Product Control Act, 1993; World Health Organisation Framework Convention on Tobacco Control, 2003) as well as in schools (Department of Basic Education, 2013; South African Schools Act, 1996).

In addition, there was a strategy in South Africa, called the Ke Moja Integrated Strategy (Department of Social Development, 2003). This strategy targeted adolescents both within educational and community settings. This programme was aimed at reducing the use of substances as well as preventing abuse of substances by young people (Department of Social Development, 2003; Department of Social Development, 2013). Through this strategy, various workshops were conducted for adolescents in schools, out-of-school youth, educators, school governing bodies representing parents, as well as parents of children abusing drugs. Furthermore, some aftercare support groups were established to provide support to adolescents returning from rehabilitation centres to avoid relapse. Substance abuse prevention for adolescents received considerable attention from various government and non-

governmental institutions due to the costs involved in treating such patients as well as the social impact it has on society. This includes the high rate of criminal activities that are linked to the use of drugs (Donald, Lazarus, & Peliwe, 2007; Karen Lesly, 2008; South African Police Service, 2015; United Nations Office on Drugs and Crime, 2015). The next section presents the research problem.

RESEARCH PROBLEM

Substance abuse among adolescents in the Ramotshere Moiloa Local Municipality (Previously known as Zeerust District) in the North West Province of South Africa is on the rise, despite various intervention strategies that were implemented by government and non-governmental institutions (NGOs) (Department of Social Development, 2013). In addition, data by the South African Police Services (2010) confirm that substance abuse among adolescents in the Ramotshere Moiloa Local Municipality is high. Intervention strategies employed to address the substance abuse problem include:

- life orientation lessons on matters related to substance abuse,
- substance abuse awareness campaigns and workshops by both government and non-governmental organisations and departments,
- Teenagers Against Drug Abuse programmes (TADA),
- school safety programmes,
- policies prohibiting the sale and use of substances by minors,
- policies prohibiting the use of substances by learners on school premises,
- referrals for the treatment of problems relating to substance abuse,
- aftercare support and the Local Drug Action Committee (LDAC) where substance abuse matters were discussed, and
- programmes developed and implemented in communities located in the Ramotshere Moiloa Local Municipality.

(Department of Basic Education, 2012; Liquor Act, 2003; Prevention of and Treatment for Substance Abuse Act, 2008;)

As advised by the National Drug Master Plan (Department of Social Development, 2013), the committee is made up of stakeholders from government and NGOs, and other community

members. Despite these intervention strategies, substance abuse among adolescents is still on the rise as reported by the South African Police Services (2010). In addition, previous research reports by Dada et al. (2016), Setlalentoa et al. (2015), and the United Nations Office on Drugs and Crime (2015) also point to the rise of substance abuse amongst adolescents. The next section provides the rationale for the study.

RATIONALE FOR THE STUDY

Parents, educators, social workers, health workers, and police members attempt to discourage adolescents to stop using substances through acts prohibiting the use of drugs, as well as substance abuse prevention programmes such as the Ke Moja Integrated Strategy (Department of Social Development, 2003). However, their efforts seem to be limited. Secondary schools are still facing a high rate of substance abuse that has an adverse effect on teaching and learning. Adolescents using drugs end up dropping out of school, which adds to the number of illiterate and unemployed youth in the Ramotshere Moiloa Local Municipality (Punt, Pauw, & Van Schoor, 2005; Ramotshere Moiloa Local Municipality Reviewed Integrated Development Plan, 2014; Statistics South Africa, 2011). Furthermore, treatment for substance abuse is quite costly. It is therefore better to try and prevent substance abuse problems, as most parents cannot afford to pay for rehabilitation centres (Setlalentoa et al., 2015; United Nations Office on Drugs and Crime, 2015).

There is little information on the effectiveness of substance abuse treatment services commonly available to adolescents. These findings suggest that more research is needed on the relative effectiveness of the types of programmes typically available to adolescents in communities (RAND Drug Policy Research Centre, 2004). There seems to be no research studies conducted in the Ramotshere Moiloa Local Municipality that explore perceptions on substance abuse prevention programmes for adolescents. There is thus a need to explore the perceptions of adolescents, parents, and other professionals about substance abuse, as well as on current substance abuse prevention programmes. Furthermore, gaps can be identified and recommendations can be made to already existing strategies to address the substance abuse problem before it escalates even further.

I already conducted a study on the reasons for substance abuse among male adolescents in Zeerust as part of my master's degree research project. The focus of the current study was

therefor more than just collecting data on prevention programmes. This study strives to afford participants an opportunity to investigate substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality. This will also allow participants to offer their views on suitable substance abuse prevention programmes to address substance abuse problems among adolescents. As a result, this will raise awareness and instil a sense of ownership for substance abuse prevention programmes. Ultimately, this study has the potential of contributing to the already existing strategies to reduce the abuse of substances in the Ramotshere Moiloa Local Municipality. The following section outlines the aim of the study.

STUDY AIM

The primary aim of this study is to gain an understanding of perceptions of substance abuse prevention programmes in the Ramotshere Moiloa Local Municipality in the North West Province of South Africa in order to formulate recommendations on the development and implementation of substance abuse prevention programmes. To achieve the aim of the study, the objectives listed below were formulated.

OBJECTIVES OF THE STUDY

The objectives of this study are to:

- Identify the substances abused by adolescents in the Ramotshere Moiloa Local Municipality
- Explore reasons for the use and abuse of substances
- Identify substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality to address substance abuse problems by adolescents
- Identify the group at whom substance abuse prevention programmes are targeted
- Describe the levels of prevention approaches employed within substance abuse prevention programmes
- Identify methods employed for the implementation of programmes
- Identify stakeholders required for the implementation of substance prevention programmes

- Identify strategies employed to reflect on substance abuse prevention programmes
- Reflect on the substance abuse prevention programmes targeted at adolescents, and to provide recommendations for the development and implementation thereof
- Develop a model of substance abuse prevention programmes for adolescents

I also identified the research questions in the next section, which assisted me in achieving the objectives of this study.

RESEARCH QUESTIONS

The following are the research questions for this study:

- Which substances are used and abused in the Ramotshere Moiloa Local Municipality in South Africa?
- What are the reasons for the use and abuse of substances in the Ramotshere Moiloa Local Municipality in South Africa?
- What are the substance abuse prevention programmes employed to address substance use and abuse problems of adolescents in the Ramotshere Moiloa Local Municipality in South Africa?
- What is the target group of substance abuse prevention programmes in the Ramotshere Moiloa Local Municipality in South Africa?
- What are the levels of prevention approaches employed within substance abuse prevention programmes in the Ramotshere Moiloa Local Municipality in South Africa?
- What methods are employed to implement substance abuse prevention programmes in the Ramotshere Moiloa Local Municipality in, South Africa?
- Who are the stakeholders required for the implementation of substance abuse prevention programmes in the Ramotshere Moiloa Local Municipality in South Africa?
- What are the reflections on substance abuse prevention programmes in the Ramotshere Moiloa Local Municipality in South Africa?

Further details about these questions are provided in Chapter 3 under the section on data collection. The next section provides the research paradigm or worldview utilised in this study.

RESEARCH PARADIGM OR WORLDVIEW

A paradigm or worldview is a basic set of beliefs that guide action. These beliefs are known as paradigms, philosophical assumptions, epistemologies and ontologies, or broadly conceived methodologies (Neuman, 2009). A paradigm is a general philosophical orientation about the world and the nature of the research that a researcher brings to a study. Four worldviews inform qualitative research. These worldviews are postpositivism, constructivism, advocacy or participatory, and pragmatism (Creswell, 2014; Lincoln, Lynham, & Guba, 2011). Social constructivism was considered for this study. A further detailed discussion about social constructivism is provided later in Chapter 3.

RESEARCH STRATEGY AND METHODS

To address the aim and objectives of this study, a qualitative research method is considered relevant for this study. However, the aim of this study is not to explain human behaviour in terms of universally valid laws or generalisation. The aim of this study is to understand and interpret perceptions of adolescents, parents, and other professionals in this study about substance abuse prevention programmes employed in the Ramotshere Moiloa Local Municipality (Brikci & Green, 2007; De Vos, Strydom, Fouche, & Delport, 2011; Nichter, Quintero, Nichter, Mock, & Shakib, 2004; Willig, 2009). Further, the objective of this study is to describe and explore substance abuse prevention programmes by focussing on the process of implementation rather than on quantifiable outcomes (Fetterman, 2001). A qualitative research approach was also considered, as purposeful and snowball sampling are considered as suitable in selecting a small number of participants. The primary method of data collection include qualitative interviews, focus groups and document analysis. Furthermore, the study was conducted in the natural settings of participants in their homes, the school and the office. In addition, thematic analysis was selected as a method of qualitative data analysis. I formed an integral part of the data collection and analysis. Further details about the rationale for selecting a qualitative approach, the context of the study, data

collection and analysis, and my role in the study will be provided in Chapter 3. The next section provides a discussion on ethical considerations in this study.

ETHICAL CONSIDERATIONS

Ethical issues considered in this study include permission to conduct the study, briefing sessions, voluntary participation, informed consent, confidentiality, and the protection of participants (Berg, 2009; Cho & Lee, 2014; Creswell, 2014; De Vos et al., 2011; Hennink, Hutter, & Bailey, 2011; Hiriscau, Stingelin-Giles, Wasserman, & Reiter-Theil, 2016; Li et al., 2013; Segrott et al., 2014). This study was conducted after, first, obtaining permission from the Ethical Committee of the Department of Psychology in the College of Human Sciences at the University of South Africa, as well as the Department of Basic Education, the Department of Health and the Department of Social Development in the North West Province in South Africa. Second, permission was obtained from parents, the traditional leader, and the traditional healer. Details about ethical issues are discussed further in Chapter 3. The next section provides a discussion on the context of the study and data sources.

CONTEXT OF THE STUDY AND DATA SOURCES

This study was conducted in two secondary schools in the Ramotshere Moiloa Local Municipality. Participants include male and female adolescents attending school, parents, and professionals such as educators, a social worker, a mental health nurse, a clinical psychologist, a traditional leader and a traditional healer who participated in substance abuse prevention programmes three years before this study was conducted. Data were also obtained from substance abuse prevention policies, programmes and documents. The selection criteria allowed for policies, programmes and reports aimed at adolescents. These contained family-based, community-based, media-based, and other multifaceted components. Further details about context of the study and data sources are provided in Chapter 3. The next section deals with the significance of this study.

SIGNIFICANCE OF THE STUDY

Findings of this study might be used to raise awareness about substance abuse problems among adolescents, parents and community members. The findings might also assist parents, educators, mental health professionals, social workers, the South African Police Services, traditional leaders, traditional healers, and other professionals involved in adolescent care. These findings may assist them to gain an understanding of the prevalence of adolescent substance use and abuse, risks and protective factors, associated morbidities, suitable prevention programmes as well as stakeholders required to review, develop and implement evidence-based strategies and policies that could be used to address substance abuse problems among adolescents. Further details about the contribution of this study are discussed in Chapter 5. The next section defines concepts used in this study.

DEFINITION OF CONCEPTS

Adolescent refers to a boy or girl between the ages 10 and 20 (Berk, 2007; Louw, van Ede, & Louw, 1998). In contrast, Psychology Today (2017) defines "adolescent" as a teenager between the ages 13 and 19. An adolescent is also referred to as a young person who has undergone puberty but who has not reached full maturity (American Heritage Dictionary, 2017). In this study, adolescent refers to a male or female between the ages of 12 and 20, in a transitional stage from childhood to adulthood.

Adolescence refers to the transitional stage from childhood to adulthood. The phase begins with the development of sexual characteristics, usually between the ages of 11 and 18, and continues through the teenage years and terminates legally at the age of 18 (Colman, 2015; Jaworska & MacQueen, 2015; UK Essays, 2017). In this study, adolescence refers to a developmental stage between childhood and adulthood in which behavioural challenges such as the use of substances occur among both males and females.

Aftercare means ongoing professional support to a service user after a formal treatment episode has ended. This professional support enables him or her to maintain sobriety or abstinence, personal growth to enhance self-reliance, and proper social functioning (Daley, 2013; Harris & White, 2013). In this study, aftercare refers to the ongoing support provided to adolescents after receiving treatment for substance abuse to maintain sobriety or abstinence and proper social functioning.

Decriminalisation refers to the process of removing criminal sanctions from any activity, either by removing any prohibition of the activity or by removing responsibility for enforcement to a non-criminal process (Gooch & Williams, 2015; International Centre for the Prevention of Crime, 2015). It also refers to ceasing to treat something as illegal (Oxford English Dictionary, 2015). In this study, decriminalisation refers to the removal of criminal sanctions from any activity related to the use and abuse of substances by adolescents.

Detoxification refers to the act or process of removing a poison or toxic properties of a substance in the body (American Heritage Medical Dictionary, 2007; Brody, 2013; McGraw-Hill Dictionary of Scientific and Technical Terms, 2003). It is also a medically supervised process by which the physical withdrawal from a substance is managed through the administration of individually prescribed medicines by a medical practitioner in a health establishment, including a treatment centre authorised to provide such a service (National Health Act, 2003; Prevention of and Treatment for Substance Abuse Act, 2008). In this study, detoxification entails treating a person for alcohol or drug dependence, usually under a medically supervised programme designed to rid the body of intoxicating or addictive substances (American Heritage Medical Dictionary, 2007). In addition, detoxification in this study refers to traditional African medicine administered by a trained traditional healer to rid the body of addictive substances (Ngobe, 2015).

Document review refers to a systematic procedure for reviewing or evaluating primary and secondary documents in an electronic or printed format (Bowen, 2009; Buckland, 2013; Evans, 2012; Mogalakwe, 2006). The documents may include institutional documents such as clinical, programmatic or organisational records. They may also include personal documents such as diaries, letters, artistic expressions, and public historical documents such as legislative testimony and legal documents. In this study, document review refers to the review of primary and secondary documents such as substance abuse prevention policies, programmes, and reports in an electronic and printed format. Further details about reviewed documents are provided in Chapter 3 under selection of documents.

Educator refers to a person involved in planning or directing education (Dictionary.com, 2017; South African Schools Act, 1996). In this study, educator refers to a person who has a teaching qualification, appointed by the Department of Education to facilitate teaching and learning in a public secondary school.

Evaluation refers to an act of examining or judging carefully. In addition, it refers to a systematic determination of the merit, worth, and significance of a programme or a project, using criteria governed by a set of standards (Department of Social Development, 2013; Fetterman, 2001; United Nations Office on Drugs and Crime, 2017; Van Dyk, n.d.). In this study, evaluation refers to a process of reflecting on substance abuse prevention programmes implemented among adolescents. It also refers to noting achievements and identifying specific areas that require change or improvement.

Harm reduction refers to public health policies, programmes and practices that aim to reduce the health, social, and economic harms associated with the use of psychoactive substances by individuals, communities and societies unable or unwilling to stop. The focus of harm reduction is on the prevention of harm rather than on the prevention of the substance itself. The focus is also on people who continue to use substances (Cram 101 Textbook Reviews, 2016; Department of Social Development, 2013; Harker, Myers, & Parry, 2008; International Harm Reduction Association, 2010; Tatarsky & Marlatt, 2010). In this study, harm reduction refers to substance abuse prevention policies and programmes aimed at reducing harms associated with substance abuse among adolescents. Harm reduction is centred on the nature of the substances abused, as well as the associated risk and protective factors.

Inpatient treatment refers to a type of treatment in which a patient is provided with care at a live-in facility. Drug rehabilitation, psychiatric and physical health assistance are included in this residential treatment (Casa Palmera, 2012; Prevention of and Treatment for Substance Abuse Act, 2008). In this study, inpatient service refers to a treatment centre in which adolescents are housed to rehabilitate them for substance abuse by providing physical and psychological health assistance.

Learner refers to a person who is learning a subject or skill (Collins English Dictionary, 2017; South African Schools Act, 1996). In this study, a learner refers to a person between the ages 12 and 18, who is enrolled in a public educational institution to acquire knowledge or skills imparted by an educator through various learning areas.

Local Drug Action Committee (LDAC) refers to the committee established by the municipality to give effect to the National Drug Master Plan (Department of Social Development, 2013; Prevention of and Treatment for Substance Abuse Act, 2008). In this study, LDAC refers to the local substance abuse committee established by the Ramotshere Moiloa Local Municipality. This committee is coordinated by the Department of Social Development and is made up of various stakeholders responsible for the prevention of matters relating to substance abuse.

Mini Drug Master Plan refers to the strategy employed by the national departments, provincial substance abuse committees, and Local Drug Action Committees (LDAC) to set out measures to control and reduce the supply of, demand for and harm caused by substances (Department of Social Development, 2013). In this study, it refers to the strategy developed by the Local Drug Action Committee in the Ramotshere Moiloa Local Municipality to prevent substance abuse among adolescents.

Monitoring refers to keeping track of something with the aim of collecting information. It also means using a monitor or a type of measuring device to keep close watch over, supervise or observe a situation for any changes which may occur over time(Business Dictionary, 2013; Department of Social Development, 2013; Van Dyk, n.d.). In this study, monitoring refers to keeping track of implementation processes and procedures of adolescent substance abuse prevention programmes to ensure that set targets are met.

Outpatient treatment refers to a non-residential service provided by a treatment centre or halfway house to persons who abuse substances and those affected by substance abuse and which is managed to provide a holistic treatment service (Prevention of and Treatment for Substance Abuse Act, 2008). In this study, outpatient treatment refers to the physical and psychological treatment for substance abuse in which adolescents are not admitted to a treatment centre. Instead, the adolescents consult with a therapist for a few hours and still live at home.

Parent refers to a person who acts as a mother or father to someone (English Oxford Living Dictionary, 2017). In this study, a parent refers to a biological mother or father taking care of a minor. It may also refer to an older adult taking care of a minor or any person serving as a guardian to a minor.

Professional refers to a person formally certified by a professional body or belonging to a specific profession by virtue of having completed a required course of studies and or practice. The competencies of a professional can be measured against an established set of standards (Business Dictionary, 2017). In this study, a professional is an educator, a clinical psychologist, a mental health worker, a social worker, a traditional healer, and a traditional leader. Further details about these professionals are provided in Chapter 3 under data collection and in Chapter 4 under the introduction of participants.

Prevention of substance abuse refers to any activity designed to prevent or delay the onset of substance use and reduce its health and social consequences. Prevention activities focus specifically on (i) preventing the use or uptake of psychoactive substances, (ii) delaying the age at which substance use begins and (iii) preventing the problematic use of legal substances such as alcohol (Chakravarthy et al., 2013; Griffin & Botvin, 2011; United Nations Office on Drugs and Crime, 2015; World Health Organisation, 2002).

In this study, prevention of substance abuse refers to a variety of individual, family, and community measures or programmes aimed at delaying and preventing the use of legal and illegal substances among adolescents.

Relapse refers to the recurrence of a disease or disorder following an apparent cure or improvement of the said condition (Nugent, 2013). It also refers to returning to drinking or other substance use after a period of abstinence (Levesque, 2011). In this study, relapse refers to a state in which an adolescent who was treated for substance abuse falls back into abusing substances if treated for only a short period or if aftercare support is not provided. It also refers to adolescents who return to using substances after they have been exposed to substance abuse prevention programmes.

Risk factor refers to any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury (Center for Disease Control and Prevention, 2016; Essau, 2014; Goliath & Pretorius, 2016; Harker, et al., 2008; Substance Abuse and Mental Health Services Administration, 2015). In this study, risk factor refer to individual, family, and environmental factors that contribute to the use of substances by adolescents.

Protective factor refers to individual, family, and societal factors that protect adolescents from risks associated with health such as substance abuse (Centers for Disease Control and Prevention, 2016; Essau, 2014; Goliath & Pretorius, 2016; Harker et al., 2008; Substance Abuse and Mental Health Services Administration, 2015). It also refers to factors that protect adolescents from the abuse of substances such as positive self-image, self-control, or social competence (Substance Abuse and Mental Health Services Administration, 2015). In this study, protective factor refer to individual, family, and community factors that protect adolescents from the abuse of substances.

Substance refers to a chemical used in the treatment, cure, prevention or diagnosis of disease or to enhance physical and mental wellbeing (Kring, Davison, Neale, & Johnson, 2007; Pressly & McCormick, 2007; Rice & Dolgin, 2008). Furthermore, a drug also refers to chemical substances that affect the central nervous system, such as tobacco, alcohol, cannabis (dagga), cocaine and heroin. These drugs are used for perceived beneficial effects on perception, consciousness, personality and behaviour. These chemical substances, both medicinal and recreational, can be administered orally, through the rectum, by inhalation, and by injection (Kring et al., 2007). These substances can be legal or illegal.

In this study, substances refer to legal and illegal substances abused by adolescents, which are not used for medicinal purposes, and which have an adverse effect on their mind, thinking, perception and behaviour. In addition, substances refer to alcohol, cannabis, cocaine, glue, methylated spirits, tobacco and other substances that are prone to be abused by adolescents.

Substance abuse refers to the chronic or habitual use of any chemical substance to alter the state of the body or mind, other than for medically necessary purposes leading to effects that are detrimental to the individual's physical or mental health or the welfare of others (Columbia Encyclopaedia, 2008; Kring et al., 2007; Rice & Dolgin, 2008). In addition, substance abuse is used to describe a pattern of abuse of both legal and illegal substances, which lead to significant problems or distress such as failure to attend work or school or continued substance use that interferes with friendships or family relationships (Wexner Medical Centre, n.d.). In this study, substance abuse refers to the misuse of legal and illegal products which are harmful to the adolescent's wellbeing, his or her studies, family, and community.

Substance dependence refers to the uncontrollable craving and use of substances despite the potential or actual harm to the person and society that may result from it (Kring et al., 2007; Pressly & McCormick, 2007; Rice & Dolgin, 2008). It includes both legal and illegal substances. Those who are dependent on substances are often unable to quit on their own and need treatment to help them to stop using substances (Ciccheti, 2007; Kring et al., 2007; Wexner Medical Centre, n.d.). In this study, substance dependence refers to the continued use of legal and illegal substances by adolescents, despite the physical and psychological harm that may result from the abuse.

Treatment refers to the provision of specialised social, psychological and medical services to service users and to persons affected by substance abuse in addressing the associated social and health consequences (Prevention of and Treatment for Substance Abuse Act, 2008). In this study, treatment refers to African, spiritual, and Western medical interventions, education, and counselling services offered to assist adolescents dependent on alcohol and other drugs to prevent further use of substances and maintain sobriety.

Treatment centre refers to a private or public medical institution registered or established for the treatment and rehabilitation of service users who abuse or are dependent on substances (Prevention of and Treatment for Substance Abuse Act, 2008). In this study, a treatment centre refers to a registered private or public institution providing treatment for adolescents abusing substances. It could also refer to a public treatment centre not registered but providing either African traditional healing or spiritual healing for substance abuse. The next section provides the chapter outline in this study.

CHAPTER OUTLINE

Chapter 1 provides a brief background and overview of the study, statement of the problem, the rationale for the study, aims of the study, research paradigm or worldview, research strategy, demarcation of the study, ethical considerations, and definition of concepts.

Chapter 2 discusses the literature review focussing on literature search procedures, primary substances of abuse, theoretical perspectives on the etiology of substance use and abuse, comparative analysis of substance abuse prevention strategies, and reflections on substance abuse prevention programmes employing principles of empowerment evaluation.

Chapter 3 describes the study's philosophical worldviews, social constructivism paradigm, qualitative research approach, research design, the context of the study, personal reflections, ethical considerations, data collection and analysis strategies, trustworthiness, and authenticity.

Chapter 4 presents the findings of this study, and the interpretation and discussion thereof.

Chapter 5 concludes the study. It covers a discussion of the study's limitations and provides recommendations for a policy framework, training and development, substance abuse treatment, stakeholders and incentives. The chapter ends with reflections on substance abuse prevention, future research and the contributions made by this study.

CONCLUSION

This chapter provided an overview of the study. This includes the background to the research problem, statement of the problem, rationale for the research, significance of the study, aims of the investigation, research strategy and research methods, ethical considerations, demarcation of the study, definition of concepts, and outline of the study. Substance abuse among adolescents is a worldwide problem. Preventing substance abuse among adolescents therefore becomes relevant and appropriate during the adolescent stage. There is also a need to develop, implement, and monitor current strategies employed to prevent the use of substances among adolescents. The next chapter deals with the literature review on substance abuse prevention programmes.

The key to growth is the introduction of higher dimensions of consciousness into our awareness - Lau Tzu

CHAPTER 2
LITERATURE REVIEW

INTRODUCTION

This chapter starts with a review of the procedure that was followed to obtain the literature for this study. This is followed by a discussion on aspects that were considered relevant to the aim and objectives of this study. These aspects include primary substances of abuse, theoretical perspectives on the etiology of substance use and abuse, comparative analysis of substance abuse prevention strategies, and a reflection on how substance abuse prevention programmes are implemented by employing principles of empowerment evaluation.

LITERATURE SEARCH PROCEDURES

The following literature search procedures and criteria as provided by Creswell (2014), Frodeman (2010), Golash-Boza (2015), Hewitt (2009), and Substance Abuse and Mental Health Services Administration (2015) were utilised to obtain literature for this study. Only literature in English that was considered relevant for the research aim and objectives of this study, peer-reviewed in the case of research articles and dissertations, as well as other sources not older than ten years except for literature on some theoretical perspectives, were consulted. I used both free online literature databases as well as those available through the library of the University of South Africa to search data sources from different disciplines such as economics, education, history, health, law, and psychology. My aim was to obtain multiple views and solutions for substance abuse problems by adolescents. This helped me to identify gaps in the literature. It also allowed me to contribute new knowledge or add knowledge to recommend prevention programmes that might be considered when developing, implementing, and reflecting on substance abuse prevention programmes. Further details about recommendations are provided in Chapter 5.

I considered substance abuse prevention strategies in countries such as Australia, Canada, the Netherlands, Portugal, Switzerland, the United States of America and the United Kingdom (International Centre for the Prevention of Crime, 2015), as well as South Africa's National Drug Master Plan (Department of Social Development, 2013). Information gathered from these strategies and data obtained from the findings of this study enabled me to develop a

substance abuse prevention model. Details about this model are provided in Chapter 5 under contributions of the study.

I also considered international and local policy frameworks such as depenalisation, decriminalisation, harm reduction, the Liquor Act (2003), the Norms and Standards for Liquor Act (Department of Trade and Industry, 2015), Prevention of and Treatment for Substance Abuse Act (2008) as amended, as well as the National Drug Master Plan (Department of Social Development, 2013). In addition, research reports on matters relating to substance abuse from the United Nations Office on Drugs and Crime (2016), World Health Organisation (2015), Human Sciences Research Council, Medical Research Council, South African national departments of Basic Education, Health, Social Development, South African Police Service , and the Central Drug Authority were also considered. For this purpose, terms such as "adolescent", "substance abuse", "risk and protective factors", "Western theoretical perspectives", "African traditional perspectives", "substance abuse strategies", "substance abuse prevention and treatment", "harm reduction", "decriminalisation", "restorative justice", "monitoring" and "evaluation" were considered relevant for this study's literature search.

The aforementioned terms were used to obtain information from scholarly research articles and published dissertations from Unisa's departments of Education, Health Studies, Psychology and Social Work. Google Scholar was used to obtain articles and dissertations from other institutions relevant to this study. In some instances only abstracts for dissertations and research articles were available. To access full copies of these dissertations and scholarly articles, I requested Unisa's subject librarian for Psychology to assist me in acquiring full copies of those dissertations and research articles. In instances where the email address of the author or the institution was provided in the abstract, I sent an email request for such dissertation or article. Other dissertations and research articles related to this study were readily available online. My supervisor and other supervisors who served as peer reviewers of this study provided some assistance. Information acquired from these sources was organised into the sections primary substances of abuse, Western and African theoretical perspectives on the etiology of substance use and abuse, as well as comparative analysis of substance abuse prevention strategies of various countries, including South Africa. These sections were based on lessons learned from previous studies and in relation to the research objectives of this study.

The organisation of the literature enabled me to understand how the current study adds to, extends to or replicates research already conducted (Creswell, 2014). The literature search was an ongoing process throughout the phases of this study. As and when I came across relevant literature through scholarly articles, research reports, and publications, I added it to the relevant section in this study. Annual reports relevant to this study's research questions, such as those from the United Nations Office on Drugs and Crime, the South African Community Epidemiology Network on Drug Use as well as reports from the Department of Social Development, The Department of Health, The Department of Basic Education, and the South African Police Services were also helpful. These publications aided me in keeping track of the latest developments regarding substance abuse problems, and prevention and treatment programmes employed.

PRIMARY SUBSTANCES OF ABUSE

Substance use and abuse among adolescents continue to be an important public health problem that contributes greatly to morbidity and mortality rates globally (Balogun, Koyanagi, Stickley, Gilmour, & Shibuya, 2013; Department of Basic Education, 2013; Griffin & Botvin, 2010; North, 2012; Royal College of Psychiatrists, 2016; United Nations Office on Drugs and Crime, 2015). Internationally, and in particular in South Africa, primary substances of abuse include alcohol, cannabis, cocaine, heroin, opiates, tobacco, stimulants and other substances. Alcohol remains the first primary substance of abuse both locally and internationally (Dada et al., 2016; Mothibi, 2014; United Nations Office on Drugs and Crime, 2017). The United Nations Office on Drugs and Crime (2017) established that cannabis remains the most widely produced and consumed illicit substance globally. The United Nations Office on Drugs and Crime (2015) estimated that in 2009 between 2.8 % and 4.5% of the world population aged 15 to 64, that is between 125 and 203 million people, had used cannabis at least once in the past year. Cannabis constituted 64% of substance of abuse, followed by opiods (18.9%), cocaine (5%), ATS (5.1%), methaqualone (3.7%), tranquillisers (2.3%), as well as solvents and inhalants (both at 3.2%). The highest prevalence during the previous year was among men between 18 and 24, and women between 16 and 17 and 18 and 24 (United Nations Office on Drugs and Crime, 2015).

The United Nations Office on Drugs and Crime (2017) also reported that cannabis constitutes the most widely trafficked and most readily available class of illicit drugs. The cannabis herb

continues to be trafficked throughout Africa, and Southern Africa continues to be a source, consumer and transit region for the cannabis herb. Ports of South Africa provide a gateway for the cannabis herb produced in neighbouring countries. The cannabis herb gets exported to consumer markets outside Africa. Previous studies revealed that substance abuse in South Africa increased from 2.2 million users in 2004 (Department of Social Development, 2010) to 3.74 million by 2013 (Reagon, 2016). Substances used and abused by young people in South Africa can be divided into three categories, namely substances that are used extensively, moderately and less frequently (Department of Social Development, 2013; Lakhanpal & Agnihotri, 2007).

Extensively used substances include alcohol, tobacco, cannabis, a combination of cannabis and mandrax (white pipe), cannabis and heroin (nyaope), solvents (glue), other over-the-counter drugs such as cough mixtures (with codeine), and pain relievers (Dada et al., 2016). The previous study established that South African adolescents younger than 13 years old were already abusing alcohol (Morojele & Ramsoomar, 2016). Furthermore, the South African National Council on Alcoholism established that the average age for male adolescents to start drinking alcohol was 11 and 13 for female adolescents in South Africa (PressReader, 2016).

Moderately used drugs include crack cocaine (cocaine in crystal form), amphetamines, heroin, ecstasy (Dada et al., 2016) and hashish. Hashish is a reddish-brown to black coloured resinous material of the cannabis plant. Hashish is collected, dried, and then compressed into various forms, such as balls, cakes, or cookie-like sheets. Pieces are broken off, placed in pipes, and smoked (The Partnership at drugfree.org, 2014).

Less frequently used substances included opium, rohypnol, and so on. Less frequently used drugs are categorised as such because they are not easily available to the South African youth, unlike the other substances mentioned previously. There is also evidence of polysubstance abuse, both locally and internationally, for example, alcohol is often combined with other substances (Centre for Behavioral Health Statistics and Quality, 2013; Connor, Gullo,White, & Kelly, 2014; Dada et al., 2016; Peltzer, Ramlagan, Johnson, & Phaswana-Mafuya, 2010; Robertson, Xu, & Stripling, 2010; Substance Abuse and Mental Health Services Administration, 2011). Further details about polysubstance abuse will be discussed later in this chapter under the progression theory.

Compared to research results both locally and internationally (Dada et al., 2016; United Nations Office on Drugs and Crime, 2016), primary substances of abuse among adolescents in the Ramotshere Moiloa Local Municipality in the North West Province of South Africa, where this study took place, include alcohol, tobacco, cannabis, cocaine and nyaope (Mohasoa & Fourie, 2010). Nyaope, also known as whoonga or wunga, is a dangerous and highly addictive South African new street drug (Mokwena, 2015). It is fine white powder usually combined with heroin. It is not always clear what the complete ingredients of nyaope are, and the ingredients vary from place to place. The fact remains that nyaope is made of a lethal combination of substances, which could include heroin, detergent powder, rat poison, and crushed anti-retroviral drugs (ARVs) used in the treatment of Human Immunodeficiency Virus (Home Detox South Africa, 2014; Hugo, 2015). According to Venter (2014), nyaope is prevalent among young and unemployed black people who live in socio-economically depressed areas. Mokwena (2015) also reported that nyaope is readily available and not costly. The next section provides a discussion on theoretical perspectives on the etiology of substance use and abuse.

THEORETICAL PERSPECTIVES ON THE ETIOLOGY OF SUBSTANCE USE AND ABUSE

Substantial research efforts were undertaken to gain an understanding of the epidemiology and etiology of substance use and abuse (Abbott & Chase, 2008; Dada et al., 2016; Griffin & Botvin, 2010; Makhanya, 2012; Peltzer et al., 2010; Shirungu, 2017; United Nations Office on Drugs and Crime, 2015; Washington, 2010). Theoretical perspectives discussed in this section include Western theoretical perspectives and African traditional perspectives. African traditional perspectives were considered because the study took place in one of the rural areas of the Ramotshere Moiloa Local Municipality. Western theoretical perspectives include, among others, developmental theories, biological theories, psychological theories, learning theories, progression theory, economic theories, availability theories, symbolic interaction theory and social control theory (Ciccheti, 2007; Crain, 2004; United Nations Office on Drugs and Crime, 2015).

Developmental theories and African traditional perspectives and practices were the points of departure in this study as I explored perceptions about the substance abuse prevention

programmes aimed at adolescents. Other theories were considered to understand other factors contributing to substance abuse and implications for substance abuse prevention programmes targeting adolescents.

Developmental theories

Adolescence is, according to developmental theorists, a transitional stage in which physical, biological, social, psychological and sexual development occurs. Other domains that develop include their thinking, identity and relationships with others (Berk, 2007; Colman, 2015; Griffin & Botvin, 2011; Louw et al., 1998; North, 2012; Rice & Dolgin, 2008). Furthermore, during this transitional stage, adolescents seem to be impulsive and more non-conforming than in other developmental stages (Broederick & Blewitt, 2010; Donald et al., 2007; Griffin & Botvin, 2010; Li et al., 2013; Louw et al., 1998; Psychology Today, 2016; Visser, 2007). During the adolescent stage, most of the adolescents may experiment with substances which are acceptable among their peers (Mudavanhu & Schenck, 2014). Risks associated with substance abuse include, among others, injuries, interpersonal violent acts, sexual behaviour, self-destruction (Berk, 2007; Griffin & Botvin, 2010; Li et al., 2013; Mokwena, 2015), difficulties with studies, and ultimately dropping out of school (Mothibi, 2014). Substance abuse has a significant impact on the lives of adolescents (Pressly & McCormick, 2007; Seggie, 2012; United Nations Office on Drugs and Crime, 2015).

Adolescents from various racial groups in South Africa encounter adolescence as a demanding developmental stage. Their experiences of adolescence reflect the effects of the changes taking place in the society in which they grow up. The South African society is not only characterised by rapid technological and social changes, but also by changes in roles, behavioural norms, ideologies and values (Bopape, 2008; Gouws, 2012; House, 2011). In addition, Visser (2003, cited in Mudavanhu & Schenck, 2014), established that trends worldwide indicate that when a country undergoes general and radical socio-economic change, as is the case in South Africa, those changes are reflected in spheres of risk-taking behaviour such as substance abuse.

The development of identity

The developmental psychologist, Erikson (1963) defined eight crisis stages that characterise our lives from birth through death. For this study, I have been focussing on identity achievement versus identity diffusion, which is the fifth crisis stage that individuals experience as they navigate the tempestuous years of adolescence. Furthermore, the establishment of identity is widely viewed as a critical developmental task of adolescence. Establishing an identity is sometimes accompanied by nervousness, as adolescents encounter difficulties with the question of who they are and what they want to become (Cherry, 2017; Donald, Lazarus, Peliwe, 2007; Louw et al., 1998; Psychology Today, 2016; Rice & Dolgin, 2008; Whitbourne, 2012). Identities could be based on roles, relationships, status in an organisation, or those related to character traits (psychological and behavioural attributes). Adolescents navigate between traditional expectations and contemporary conditions. Cheng and Berman (2012, cited in Grove 2015) argued that adolescents have been influenced by traditional non-Western perspectives such as imitation and internalisation of parental authority figures, values, beliefs, and behaviours.

It was also established in a study by Grove (2015) in which the aim was to determine whether a relationship exists between ego, identity, and perceived parenting styles in different family structures, that adolescents face social challenges because of the changing social context in South Africa, which might affect their identity development.

According to the Department of Education and Communities (2011), contemporary conditions include shared values, mutual affection, and respect. In addition, adolescents were encouraged to express their views without fear, to be assertive, independent, and make decisions about their lives. This enable them to develop a strong sense of self and feel that they are in control of their lives. The feeling of control strengthens their self-esteem and make them happier (Department of Education and Communities, 2011). The Department of Education and Communities (2011) further reported that young people tend to adapt to the values and customs of their old culture while striving to adopt the norms of the new culture to fit in with their peers. In addition, non-Western cultures place less emphasis on the importance of the individual. The family and the ethnic are valued more above the attainment of individual identity and plays role in shaping the development of the identity of the adolescent. Furthermore, the emphasis is on obedience, reliability, proper behaviour and social obligation. In order to preserve harmony in the family, the adolescent is expected to develop self-restraint and attunement to others. This may result in future obedience and a

sense of shame, which may lead to a decrease in self-esteem. These reprimands convey social norms and behavioural standards, which may hinder adolescents freely expressing themselves. Therefore, adolescence is considered as a period in which adolescents attempt to reconcile their desires and needs with the wishes of their parents or cultures.

According to Chang (2007), some adolescents get through this period without many problems. However, others experience many adverse effects such as the conflict between themselves and their parents due to their need for independence and wishes and expectations of their parents. Csikszentmihalyi (2016) cited in Encyclopaedia Britannica (2016) also established that some adolescents experience depression as a result of frustration. This may cause them in some instances to engage in risky behaviours such as substance abuse. Adolescents and their parents complain about each other's behaviour. Parents feel that they are losing control or influence over their children. Adolescents want their parents to be clear and consistent about rules and boundaries, but at the same time resent any restrictions on their growing freedom and ability to decide for themselves (Royal College of Psychiatrists, 2016). According to Csikszentmihalyi (2016) cited in Encyclopaedia Britannica (2017), adolescents have little power and little control over their lives. They therefore feel that they have a marginal status and are driven to seek the respect that they lack. Furthermore, without clear roles, adolescents establish their pecking order and spend their time pursuing irresponsible or deviant activities. For example, unwed teenage motherhood is sometimes a result of a desire for attention, respect, and control, while most gang fights and instances of juvenile homicide occur when adolescents (boys and girls alike) feel that others had offended them. This deviant behaviour may take many forms. Insecurity and rage may lead to vandalism, juvenile delinquency, illegal use of drugs, violence and crime.

Ginsberg, Kariuki and Kimamo (2014) indicated that the social, political and economic changes that take place break down the extended family system as well as the close-knit community system. In addition, Monyenye (2004) argued that educational opportunities, urbanisation, social mobility, and access to global media reduce youth participation in the traditional initiation and opens a debate about the value and relevance of the rites, particularly for girls. Exposed to a world of possibilities unknown to previous generations but with insufficient guidance as to how to access them, the resulting generational gap too often leaves the young unable to communicate with their grandparents, the generation traditionally charged with managing the transition to adulthood.

According to Ntozini (2015), social expectations play a significant role in shaping individuals' behaviour. Society also consists of shared values and assumptions between groups and individuals. Many times people within society subscribe to these shared values and assumptions. Brogan (2009) established that successful identity achievement develops through accepting traditional values and expressing them in a contemporary manner. Therefore, adolescents require the influence of parents for traditional values and the influence of friends for contemporary expression. However, too much influence from either parents or friends interferes with the adolescents' commitment. During this stage, adolescents explore and , question existing values, and experiment with alternative roles in order to develop their own set of values and goals.

According to Erikson (1968), to form an identity, all the developmental challenges that characterise the previous childhood years need to be successfully resolved. Having a strong identity in adolescence rests, in part, on having a strong sense of trust, autonomy, initiative, and industry to accomplish the tasks required for identity development. Identity development implies that adolescents need to define who they were, what is important to them, and what direction they want to take in life (Brogan, 2009; Louw et al., 1998; UK Essays, 2015). According to Erikson (1963), this experimentation, exploring, and questioning do not indicate adverse development, but rather how individuals form their personal and social identity. Furthermore, Erikson (1963) and Brogan (2009) reported that society allows adolescents a specified period, called the psychosocial moratorium, to find themselves and their roles as adults. Experimentation takes place during this psychosocial moratorium, by, for instance, "trying out" various identities through endless self-examining, investigating about careers and ideologies, and fantasising about roles and identities with other people and hero figures.

The elements gender, religion, politics, own value system, independence from parents, social responsibility, and work roles are essential in forming an identity. Erikson (1974) established that adolescents have to accomplish the formation of a continuous, integrated, unified image of the self, sociocultural identity, gender role identity, career identity and their own value system identity. The successful completion of these tasks would promote the sense of identity of adolescents and thus limit confusion (Erikson, 1974). The establishment of an identity also provides a sense of faithfulness or fidelity. Through self-examination, experimentation and the formulation of a personal value system and philosophy of life, adolescents know who

they are and what they want in life. Adolescents could, therefore, be faithful to their values and principles, and this assists in establishing self-confidence (Royal College of Psychiatrists, 2016). Cherry (2017) further argued that if adolescents manage the conflict emerging from this stage, they emerge with a psychological strength that serves them well in their lives.

Identity confusion

According to Erikson (1977), identity confusion occurs when adolescents are indecisive about themselves and their roles. They are unable to integrate the various roles, and when contradictory value systems confront them, they neither have the ability nor the self-confidence to make decisions. This confusion causes anxiety, apathy, or hostility towards roles or values (Erikson, 1977). Identity confusion can also result in an identity foreclosure or negative identity. Identity foreclosure means that the identity crisis is resolved by making a series of premature decisions about one's identity, based on other people's expectations of what one should be. This happens when external demands or role expectations pose a threat to the identity development of adolescents. In their confusion, adolescents fulfil roles merely to meet the expectations of others without genuinely identifying with those roles. They therefore develop a negative identity (Louw et al., 1998). Negative identity means that adolescents form an identity contrary to the cultural values and expectations of society, for example, juvenile delinquents and adolescents who abuse substances (Burger, 2008; Donald et al., 2007; Dumas, Ellis, & Wolfe, 2012; Visser & Routledge, 2007).

Developmental theorists also established that substance abuse is one of the high-risk behaviours during adolescence and young adulthood (Feldstein & Miller, 2006; Hernandez, Rodrigues, & Spirito, 2015; Li et al., 2013; Liddle & Rowe, 2006; Mudavanhu & Schenck, 2014; Royal College of Psychiatrists, 2016; Sdorow & Rickabaugh, 2002; Spirito, 2015; Stueve & O'Donnell, 2005). Data from around the world also suggest that substance abuse occurrs between the ages 11 and 14 (Morojele & Ramsoomar, 2016; PressReader, 2016; United Nations Office on Drugs and Crime, 2015). A large number of adolescents experiment with legal and illegal substances out of curiosity (Visser & Routledge, 2007). Many adolescents consider smoking and drinking as 'safe' habits that make them look more adult-like (Craig & Baucum, 2001). Other reasons for the abuse of substances by adolescents include coping with stress, peer group pressure, and following the example set by parents and other adults (Donald et al., 2007; Karen Lesly, 2008; Kumpfer, 2014; Promises Treatment

Centre, 2009; Rice & Dolgin, 2008; Trobisch, 2016). Although Visser and Routledge (2007) acknowledged that adolescents are vulnerable to the above-mentioned societal pressures, other previous studies established that adolescents abuse substances for fun even though they have been informed about their negative effects (Baucum & Smith, 2004; Berk, 2007; Mancini & Roberto, 2009; Richotso, 2002).

A study conducted among Kenyan schools and colleges reported that even though the school-based preventive strategies on drug and alcohol abuse in Kenya had to a large extent a positive impact on pupils, the positive behavioural change was not significantly influenced. Some pupils are still abusing drugs and alcohol to fit in with peer groups, believing that it could enhance their intellectual capacities or the feeling that they are grown-up (National Institute on Drug Use, 2014). This implies that they are attracted by the promise of the substances they use rather than averting its potential harm on them.

Adolescents confront difficult choices about drugs and sometimes respond by experimenting or rebelling against the traditional sources of authority (North, 2012; Poole, 2005; Royal College of Psychiatrists, 2016). Adolescents often rebel against adult authority as a means of learning to make decisions. They do the opposite of what parents or other adults want them to do and often think that they are not bound by the rules set by their parents (Csikszentmihalyi, 2016 cited in Encyclopaedia Britannica, 2016; Royal College of Psychiatrists, 2016). Experimentation with substances such as alcohol, tobacco, and cannabis is therefore common among adolescents (Department of Basic Education, 2013; Donald et al., 2007; Griffin & Botvin, 2010; Mothibi, 2014; United Nations Office on Drugs and Crime, 2016). This occurs because of their developmental need to behave in a way that looks more 'grown-up' as well as to challenge adult authority (Donald et al., 2007; Rice & Dolgin, 2008). Furthermore, Rice and Dolgin (2008) established that a convergence of developmental changes spark teenage alcohol consumption. The physical changes associated with puberty can, for example, increase a person's tolerance to alcohol, and can cause him or her to start drinking without feeling ill.

Adolescents who no longer view themselves as children might want to look more mature and adult-like. This is part of the process of searching for their identity. As part of this process, they tend to experiment with substances because they are now more free and independent than young children. They are usually less supervised by their parents and spend most of their

time with their peers. During this stage, their peers are more influential than their families. Furthermore, they might believe that having a drink in their hand would make them appear grown-up. During this stage they tend to question the authority of their elders. They often disrespect adults who may want to tell them about the risks associated with the use of alcohol, while they (the adults) drink alcohol themselves (Donald, 2004 cited in Mohasoa, 2010). The use of alcohol by their elders and other people may also serve as encouragement for them to consume alcohol (Kring et al., 2007; Louw et al., 1998; Scutti, 2014; Trobisch, 2016). Moreover, adolescents visiting bars and parties where alcohol is served, make themselves vulnerable to the use thereof. They perceive alcohol as something that relieves them from stress and makes them relax (Dada et al., 2015; Kring et al., 2007; Louw et al., 1998; Seggie, 2012; Substance Abuse and Mental Health Services, 2008). The next section provides African views on adolescent development with the emphasis on the coming of age and initiation rituals.

Coming of age and initiation rituals

Traditionally, many indigenous African ethnic groups have been relying on a complex system of rites to transmit adaptive cultural resources and to facilitate the adolescent-to-adulthood transition. These rites are referred to as rites of passage. They include those structures, rituals, and ceremonies by which age-class members or individuals in a group successfully come to know who they are and what they are in relation to the purpose and meaning of their existence to the next passage in their lives (Davis, 2011; Menash, 1990 cited in Williams, 2015). Initiation ceremonies are the means through which people are incorporated into a new status, an association, or an office. Like other transition rites, initiation involves making social or physical transformations. Initiation into adulthood is the widest spread initiation in Africa (Williams, 2015). According to Nsamenang and Tchombe (2011), some societies practise initiation rites in organised settings in which intense, definitive cultural preparation for adulthood occurs. Those developmental rituals transition children into the fifth stage when a naive novice begins to take on the status and role of a socialised neophyte or proto-adult. It is a period of internment for social induction and definitive socialisation for graduated entry into the status and roles of the adult world. Young persons are poised for adulthood, the most cherished social life stage.

According to the traditional African lifespan models, healthy human development requires one to progress through the five critical stages of birth, puberty years, marriage (adulthood), eldership (old age) and death. During each period of this life cycle, mental, physical, and spiritual wellbeing and successful development depend on resolving crises and mastering tasks related to the prominent role strains. For the purpose of this study, I focussed on the puberty years. Prominent goals during this stage include rites and celebration, manhood training and initiation into manhood. Pressing barriers include cultural disconnection and lack of role models. Critical conflicts during this stage include identity crises, chronic black adulthood strain, antisocial and self-destructive behaviour and unstable family structures (Bowman, 1989 cited in Williams, 2015). Davis (2011) and Johanson (2013) posited that rites of passage have value for both the individual and the community. In addition, ceremonies that mark the stages of life provide clear definitions of society's expectations of the individual and they provide individuals with a sense of identity and belonging. Furthermore, Davis (2011) considered those rites of passage as providing a clear and guided means for transition from one life stage and sphere of responsibility to another. Davis (2011) and Johanson (2013) further established that the hierarchies of values of the community and projects are an ideal sequence of personal development that the individual can look forward to. Upon reaching each stage, the individual can evaluate his or her maturation against a collective standard. Rites of passage have been providing the African with the foundation of his or her being – identity.

Sexual identity and the roles of gender identity are enshrined through the rites of passage. Males are prepared for their responsibilities in the community as men, and females are prepared for their responsibilities in the nation as women. The process and details of initiation differ from society to society. Songs, dances, masks, various tests, ordeals, and tattooing are utilised as the verification and ritual symbolism. The emphasis varies according to the society. Some societies focus on bravery and toughness, others focus on spiritual aspects or practical education (Davis, 2011). According to Davis (2011), the first step in initiation is the separation of a group of adolescent novices from their usual surroundings to be secluded in an isolated place away from the community. To begin their training, initiates travel to remote mountainside camps or schools where they live together in a community and join secret rituals before and after undergoing circumcision (Sanderson, 2013; South African History Online, 2016). They enter a special place, a sacred forest or a ritually built house. Only men are allowed to enter the camps during the month-long procedure and are sworn into

secrecy upon their return (Davis, 2011; Sanderson, 2013). Adolescents lose their childhood identities and gain their adult selves through initiation (Johanson, 2013). Males undergo a ritualistic operation known as circumcision on their male genitals performed by a traditional healer without any anaesthetic (Sanderson, 2013). They use leaves prescribed by their traditional leaders to heal the wounds after they have been circumcised.

Females undergo excision, which is a homologous surgical operation, or a ritualistic operation of their female genitals performed by a traditional female healer who is held in high social status (Davis, 2011; Nzama, 2015). A study conducted by Kitui (2012) through interviews and focus groups among women who underwent this procedure in Vryboom, Masia-Tshiphuseni, and Thohoyandou villages in Venda, established that traditional medicine and herbs are applied to the cuts to hasten the healing. As they enter the adult world during their teenage years, African youngsters undergo a variety of initiation rituals. These rites provide them with instructions about what is expected of them during the next phase of their lives. These include, among others, problem-solving skills, rules and taboos of the society, social responsibility, what is being considered appropriate behaviour for women and men, and clarification of their purpose or life mission. They further learn about the traditions and expectations of their community and are therefore able to contribute to the maintenance of social order. The shared experiences that they undergo during the initiation period also bring the individuals together and reinforce the idea of community (Davis, 2011; Johanson, 2013).

A qualitative study by Anathi (2015) was conducted in which individual interviews were conducted with a total of nine traditionally circumcised Xhosa male first-year psychology students. The results of the study lend support to the notion that male circumcision is being practiced as a rite of passage to manhood. The study also supports the notion that portrayals of bravery usually shown by an initiate withstanding the pressures inherent in the ritual are tested during that period. Mgqolozana (2009, cited in Anathi, 2015) observed that men who fail this test of bravery are not treated with respect and do not receive the same status as other men in their community. Many African societies also make additional transitions as the individual progresses through a series of stages in life, with roles and responsibilities defined for each age level (Johanson, 2013). When the period of seclusion is over, the initiates are incorporated into their community, and this marks the time of their rebirth. Their hair is shaved off, their old clothes thrown away, and they receive new names. All symbolic gestures

indicate that they are reborn, mature individuals. The reunion of new initiates with their family and community is a collective festive time. All the people rejoice that the new initiates are ready to assume their new place in the community. The successful completion of the rite of adulthood is usually publicly celebrated with a "coming out ceremony" or reintroduction to society (Davis, 2011).

Disease or biological theories

These theorists consider biological and genetic factors that contribute to substance use. Disease or biological theories recognise substance abuse as a chronic and progressive disease requiring medical treatment (Brande, 2017; Canadian Centre on Substance Abuse, 2007). Other disease or biological theorists argued that an individual's genetic makeup predisposes him or her to drug and alcohol abuse (Berk, 2007; Feldstein & Miller, 2006; Griffin & Botvin, 2010; Meyer & Salmon, 1988; Oldman, Skodol & Bender, 2005; Pressley & McCormick, 2007). In addition, disease or biological theorists argued that adolescents with family members who abuse drugs are also at risk of abusing substances. Furthermore, it seems as if substance abuse can be inherited from other family members (Alcohol and drug abuse module, n.d.; Griffin & Botvin, 2010; Liddle & Rowe, 2006; Manning, Best, Faulkner, Titherington, 2009; Trobisch, 2016; United Nations Office on Drugs and Crime, 2015). In agreement with disease and biological theorists, previous studies have established that children of alcoholic or drug dependent parents are vulnerable to developing substance abuse and related problems (International Centre for the Prevention of Crime, 2015; Liddle & Rowe, 2006; Manning et al., 2009; Morojele, Parry, Brook, & Kekwaletswe, 2012; NHS Information Centre, 2011; Substance Abuse and Mental Health Services, 2008; Trobisch, 2016). However, Hollard, Forrester, Williams, and Copello (2013) argued that the family environment plays a role in both promoting and protecting children from substance abuse and dependence.

The University of Maryland Medical Centre (2016) reported that teenagers who drink alcohol are first exposed to parents and their peers who drink alcohol themselves, and who act as role models for the heavy consumption of alcohol. However, according to Butcher, Mineka, Hooley, and Carson (2004), not all the children exposed to drinking by their parents may become problem drinkers as they grow up. In addition, Butcher (2004) argued that genetic or

biological factors alone are not sufficient to give rise to substance abuse. According to Butcher et al. (2004), as well as Rice and Dolgin (2008), a person must be exposed to a particular level of substance abuse for addictive behaviour to surface. In addition, Nordqvist (2017) indicated that a person must be able to consume large quantities of alcoholic beverages before becoming an alcoholic. Nevertheless, Davison, Neale and Kring (2004), established that Asians in general consume low quantities of alcoholic beverages.

A study by the Maryland University Medical Centre (2016) revealed that there is no difference in alcohol prevalence among African-Americans, Caucasians, and Hispanic-Americans. In addition, some population groups such as Native Americans have an increased risk of alcoholism while others such as Jewish and Asian Americans have a lower risk. According to the Maryland University Medical Centre (2016), the differences might be as a result of genetic susceptibility and cultural factors. Another study with a sample of 15 828 participants aimed at assessing the extent of alcohol use and problem drinking among Whites, Coloureds, Indians and Africans in South Africa, was conducted by Peltzer, Davids and Njuho (2011). They established cultural differences in the intake of alcohol. Their findings reveal that the highest levels of drinking were reported from white men (69.8%), followed by white women (61.7%) and coloured men (57.4%), while the lowest rates were reported by Black African and Asian women (10% and 15.2%, respectively). However, Davison et al. (2004) argued that the harmful effects of alcohol may deter or protect individuals from using it.

Psychological theories

Psychological theories consider the underlying psychological distress within an individual as a cause of substance abuse. According to psychological theorists, factors such as low self-esteem, anxiety, and a need to be accepted are risk factors for substance abuse (Balogun et al., 2013; Butcher et al., 2004; Davison et al., 2004; Gladding, 2004; Kring et al., 2007; Mancini & Roberto, 2009; Oldman et al., 2005; Rice & Dolgin, 2008). Psychological theorists further report that individuals who used drugs receive some form of psychological reward from drug or alcohol use (Balogun et al., 2013; Davison et al., 2004; Meyer & Salmon, 1988; Oldman et al., 2005). It was also established in previous studies (About the partnership-the partnership for a drug-free America, n.d.; Mohasoa & Fourie, 2010) that adolescents experiment with substances to taste them, to relax, and to socialise with others.

In addition, previous studies (About the partnership – the partnership for a drug-free America, n.d.; Mohasoa & Fourie, 2010; Zastrow, 2004) established that adolescents abuse substances to get high. Furthermore, other adolescents use substances to deal with anxiety and alleviate pain (Gonzales, Anglin, Beattie, Ong, & Glik, 2014; Karen Lesly, 2008; Rice & Dolgin, 2008; Zastrow, 2004). Others use substances to address their sleeping problems (Zastrow, 2004), caused by loneliness, insecurity, guilt, and resentment (Butcher et al., 2004; Gladding, 2004; Maryland University Medical Centre, 2016; Mothibi, 2014; Zastrow, 2004). Furthermore, AllPsychology.com (2008), Mohasoa and Fourie (2010), Schafer (2011) and Trobisch (2016) established that the most common reasons reported for drug use include a need to cope with individual challenges and other pressures in their lives, to avoid boredom, and for enjoyment.

Learning theories

According to the learning theorists, substance abuse is a behaviour acquired from parents, peers, and other people (Burger, 2008; Carson, Butcher, & Mineka, 2000; Griffin & Botvin, 2011; Lakhanpal & Agnihotri, 2007; Liddle & Rowe, 2006; Shaffer & Kipp, 2007; Simmons-Morton & Farhat, 2010; Trobisch, 2016). These theorists also acknowledge the environment in which individuals exist as a risk factor for substance abuse (Burger, 2008; Department of Basic Education, 2013; Griffin & Botvin, 2010; Lakhanpal & Agnihotri, 2007; Mothibi, 2014; Osman et al., 2016; Pressley & McCormick, 2007; Rice & Dolgin, 2008). This entails values and behaviour that adolescents acquire from their parents and others who serve as their role models during the early stages of their lives. Carson et al. (2000), Davison et al. (2004), Gladding (2004), Visser and Routledge (2007) argued that these formative experiences determine whether adolescents will engage in risky behaviours such as substance abuse.

However, evidence shows that other adolescents avoid substance abuse after witnessing how it destroys the lives of their parents (Promises Treatment Centres, 2013). Furthermore, Rice and Dolgin (2008) and Substance Abuse and Mental Health Services Administration (2011) posited that parents who raise awareness about the negative impact of substance abuse assist their children in avoiding the use of substances. Consistent with these scholars, North, (2012), Robertson et al. (2010), as well as Simmons-Morton and Farhat, (2010) indicated that adolescents from a supportive family environment with open communication and where they

were monitored were less likely to abuse substances. Therefore, the supportive family environment is a protective factor against substance use by adolescents, while the abuse of substances by parents correlate with the illegal use of substances by their children (Griffin & Botvin, 2010; North, 2012; Pressley & McCormick, 2007; Reddy et al., 2010; Trobisch, 2016). Liddle and Rowe (2006) reported that disagreements among family members as well as parents who are not emotionally supportive are risk factors for substance abuse by adolescents. In addition, disagreements in the family interfere with the mutual attachment between parents and their children. This makes it difficult for parents to entrench the required behaviour in their children. Corroborating with Liddle and Rowe (2006), Mothibi (2014) argued that disagreements among parents affect the quality of parenting and results in an increased risk of drug use.

Even though the family was identified as a risk factor for substance abuse, peer groups are acknowledged as another risk factor for substance abuse (Liddle & Rowe, 2006; North, 2012; Rice & Dolgin, 2008; Scalicy & Schulz, 2017; Simmons-Morton & Farhat, 2010). A study was conducted by Scalici and Schulz (2017) in 42 public and private middle schools in Ticino on the normative influence of parents and peers on smoking by adolescents between the ages of 11 and 14 . The results reveal that adolescents are influenced by their peers to smoke tobacco. In keeping with Scalicy and Schulz (2017), Davison et al. (2004), Liddle and Rowe (2006), as well as Trobisch (2016) posited that adolescents tend to select peers who abuse substances. By being part of peers who use substances, they feel popular and experience a sense of belonging among them. This, in turn, increases their risk of abusing substances.

On the other hand, these social relationships serve as protection against the influence of drugs or alcohol. This became evident when some of the adolescents reported that peers enhance their self-esteem and provide a source of social control that lessens the chances of substance abuse problems. This finding is supported in a quantitative study consisting of 1 223 Chinese male and female adolescents from two mixed-gender (co-ed) schools and one boys' school. These adolescents were 11 to 16 years of age. The measures consisted of a self-developed questionnaire for necessary demographic information and two validated tools, namely the self-esteem scale and substance-use measure to solicit information on adolescent multidimensional self-esteem and substance use respectively (Wu, Wong, Shek, & Loke, 2014).

Even though peers influence adolescents to abuse substances, those who believe that it is within their control whether to use substances or not are less influenced by their peers. Therefore, high self-efficacy is a protective factor for resisting peer group pressure to abuse substances (Davison et al., 2004). Schinke, Schwinn, Hopkins, and Wahlstrom (2016) also reported this finding in their study, which examined risk and protective factors associated with drug use among 507 Hispanic adolescents across the United States of America. Their study reveals that adolescents with higher levels of self-control are less likely to use drugs than those with lower levels of self-control.

In addition, a study by Chie et al. (2015) aimed at getting non-user opinions on drug abuse to determine what areas might require more attention when implementing drug education and prevention programmes, was conducted among universities in Malaysia. The results reveal that the lack of self-efficacy is one of the factors contributing to substance abuse. Some of the adolescents in the study grew up in drug-dependent cultural contexts, harsh social conditions such as poverty (United Nations Office on Drugs and Crime, 2016), as well as in families and peers who promoted the use of substances. These were identified as risk factors for substance abuse by adolescents(Berk, 2007; Venter, 2014).

Progression theory

Progression theorists posit that the use of gateway substances by adolescents such as alcohol, tobacco and cannabis increases the probability of addiction to other harmful substances. Progression theorists also established that adolescents experiment with legal substances before they use other illegal substances (Centre for Behavioral Health Statistics and Quality, 2013; Griffin & Botvin, 2010; Lopez, 2016; National Institute on Drug Use, 2014) . Commonly used legal substances include alcohol and tobacco which are considered less harmful, while illegal substances include cocaine, heroin and cannabis. These illegal substances are often considered as addictive and harmful to the developing adolescent. Studies were conducted in progression theory with varying results. Other studies proved that adolescents progress from the abuse of legal substances to illegal substances, while other studies proved that there is no progression.

Nkansa-Amankra and Minneli (2016) conducted a study to evaluate the consistency of the relationship between early drug use and illegal drug use in adulthood, as proposed in the gateway theory. Consistent with progression theorists, the results show that the abuse of legal substances such as cigarettes and alcohol is associated with increased use of illegal substances such as cocaine and cannabis. However, a study by Degenhardt et al. (2011) revealed that the order of drug use initiation was not constant across various countries and cultures. This study was conducted in 17 countries throughout the world, and it considered if differences in the prevalence of substance use was associated with substance use later in the gateway sequence. This study found that cannabis users in the United States were more likely to progress to the use of other illegal substances than those in the Netherlands. In addition, the findings of this study suggest that the age of onset and availability of substances determine which substances will be used first.

Other scholars acknowledged that polysubstance abuse, which is the concurrent abuse of more than one substance, is a growing phenomenon (Connor et al., 2014; Gladding, 2004; Griffin & Botvin, 2010; Promises Treatment Centre, 2009; United Nations Office on Drugs and Crime, 2016). Knowledge of the usual patterns and the progression of substance use have significant implications for the focus and timing of preventive interventions. Prevention programmes that effectively target risk factors for alcohol and tobacco use might not only prevent the use of these substances but decrease or eliminate the risk of using other substances further along progression (Griffin & Botvin, 2010).

Economic theories

The end of apartheid has increased the vulnerability of South Africa to illicit drug trafficking and consumption between source countries in Asia and South America and the major consumer markets in Western Europe and North America (United Nations Office on Drugs and Crime, 2016). While South Africa may not be the most direct route between these areas, the country might be used for transhipments of illegal substances. The quality of air and sea travel connections via South Africa to many parts of the world offers drug traffickers opportunities that did not exist before. The country's geography, porous borders and expanding international trade links with Asia, Western Europe and North America also made it an attractive drug transit country (Peltzer et al., 2010).

In addition, the growing presence of illicit drugs in South Africa is indirectly a result of the dramatic increase in the number of international flights to the country, relaxed visa requirements for South Africans to travel overseas, movement of large numbers of legal and illegal immigrants across the poorly monitored borders, and ill-equipped customs (Peltzer et al., 2010). Compared to other countries in sub-Saharan Africa, South Africa represents the most significant market for illicit drugs (Lakhanpal & Agnihotri, 2007; Parry, 1998; Peltzer et al., 2010).

Additional factors supporting the increase in the use of drugs in South Africa was the falling price of many drugs, which increased the street level trade in drugs, even among the impoverished (Parry, 1998). As a result, adolescents abused drugs because they were available and affordable (Kawaguchi, 2004; Liddle & Rowe, 2006; Mokwena, 2015; Peltzer et al., 2010; Seggie, 2012; Venter, 2014). The availability of substances was evident in a large number of licensed bottle stores and taverns. Seggie (2012) also established that there were unlicensed liquor outlets that outnumbered the licensed ones, particularly in disadvantaged communities. However, there were laws that restricted bottle stores and taverns from selling alcoholic beverages to children under the age of 18 (Department of Trade and Industry, 2015; Liquor Act, 2003). The increased usage of drugs such as crack cocaine might be ascribed to the increased marketing of cocaine because of this drug's decrease in the United States market as well as the related decrease in the quality of local mandrax (methaqualone). In addition, the increase in the use of amphetamine-type substances was probably due to the increase in the global production of these substances and an increase in local marketing (Liddle & Rowe, 2006; United Nations Office on Drugs and Crime, 2013). Economic factors such as easy access to the country by drug traffickers and costs of drugs contributed to their use by adolescents.

Availability theory

Consistent with economic theorists, availability theorists also argue that adolescents abuse substances because they are easily accessible (Carson et al., 2000; Liddle & Rowe, 2006; Mokwena, 2015; Morojele, Parry, & Brook, 2009; Mothibi, 2014; Peltzer et al., 2010; Reddy et al., 2010; Venter, 2014). Furthermore, availability theorists point out that the degree to which alcoholic beverages are accessible to people, affect the amount and pattern of their use. In addition, Rob Davies, the Minister of Trade and Industry in South Africa, reported that

there were more than 230,000 liquor outlets across the country and South Africans consumed more than five billion litres of alcohol each year (Goldstein, 2015). Adolescents tend to buy alcohol, tobacco and other drugs if they are available in stores. Previous studies (Parry, 1998; Seggie, 2012) revealed that adolescents access alcoholic beverages in liquor stores, bars and shebeens. Croff, Leavens and Olson (2017) acknowledged that alcohol is available in social gatherings. With regard to cigarettes, Davison et al. (2004) established that their accessibility and affordability increase the rate at which they are consumed. In addition, chemicals used to manufacture methamphetamine are easily accessible. However, the United States endorsed the Comprehensive Methamphetamine Control Act (1996) to terminate the manufacturing and supply of methamphetamine. Lakhanpal and Agnihotri, (2007) as well as Venter (2014) posited that illegal substances are prevalent in areas mostly affected by poverty.

Symbolic interaction theory

Symbolic interaction theory was developed in the light of the work of theorists such as Max Weber, George Hebert Mead, William, James, John Dewey, Charles S. Peirce, Charles Horton Cooley, William Isaac and Herbert Blumer (Aksan, Kisac, Aydin, Demirbuken, 2009; Crossman, 2016; Fine & Sandstrom, 2011). According to these theorists, adolescents who encounter difficulties in figuring out 'who they were'; are more susceptible to the effects of alcohol and cigarette adverts (Louw et al., 1998; Shadel, Taylor, & Fryer, 2008). Lee, Ling and Glantz (2012) reported that the tobacco industry is increasingly targeting people in low and middle-income countries, especially the youth and women.

Furthermore, according to the World Health Organisation report (2013) on the global tobacco epidemic, one-third of youth experimentation with tobacco occurs because of exposure to tobacco advertising, promotion and sponsorship. However, various factors are considered as contributing towards low smoking rates. These include higher tobacco prices and taxes, protection from exposure to tobacco smoke, regulation of the contents of tobacco products, regulation of disclosures in respect of tobacco products, packaging and labelling of tobacco products, education, communication, training, public awareness about the dangers of smoking, restrictions on tobacco advertising, promotion and sponsorship, as well as the reduction measures concerning tobacco dependence and cessation.

In addition, there have been supply reduction in illicit trade in tobacco products, sales to and by minors, enforcement of laws to reduce underage purchase, and school-based anti-smoking programmes (Centre for Disease Control and Prevention, 2015; World Health Organisation Framework Convention on Tobacco Control, 2003; World Health Organisation, 2013). Presently, there is a bill in South Africa controlling the advertisement of tobacco (Tobacco Products Control Amendment Bill B24, 2006). The bill restricts smoking in public places and prohibits indirect advertising including sponsorships of programmes, projects, bursaries and scholarships. The bill further prohibits the use of words such as *light* and *low tar*, increases the age of sale to minors from 16 to 18 years of age, and increases the penalties for transgressing certain laws from R500 to R50 000. The speech of the Minister of Health in South Africa, Dr Aaron Motsoaledi, revealed during World No Tobacco Day on 1 June 2016 that the percentage of smokers had decreased by 7% since the ban on smoking in public places (Van der Merwe, 2016). Duxbury, Rath, Paayai, Bosman, and Srinivas (2016) also reported that taxes charged on tobacco products were one of the most effective ways to reduce tobacco consumption and the effects thereof, as well as to generate revenue for the country. Furthermore, the increase in the prices of tobacco reduced the risk of the onset of smoking by 1. 1% – 2. 8% in males, which was the highest consuming group in South Africa. The positive impact of Tobacco Control Legislation was also evident in other countries.

In California, smoking prevalence rates obtained through the California Student Tobacco Survey from 2002 to 2012, proved that there was a reduction in smoking prevalence. According to the report of that survey, the decline from 2010 to 2012 coincided with the passing of the Federal Family Smoking Prevention and Control Act (2009) and the Food and Drug Administration (FDA) ban on marketing and flavoured cigarettes (California Department of Public Health, 2015). Progress have been made in reducing the level of tobacco use. Even though the Tobacco Products Control Act (1993) had a positive impact on the welfare of the society, it had economic implications such as job losses in industries within and peripheral to the tobacco industry. However, according to the World Health Organisation Framework Convention on Tobacco Control (2003), parties to this treaty should in cooperation with each other and with competent international and regional intergovernmental organisations, promote, as appropriate, economically viable alternatives for tobacco workers, growers, and individual sellers.

Even though there were efforts to enforce the Tobacco Products Control Act (1993), there is evidence that adolescents are exposed to tobacco adverts through the internet. This was established in a study conducted in two Australian states by Dunlop, Freeman, and Perez (2016). The objective of the study was to measure exposure of internet-based tobacco advertising and branding to Australian youth and examine the youth's susceptibility to this advertising and branding. The findings suggest that efforts of tobacco companies to attract young Australians are directed towards internet-based advertising. According to Dunlop et al. (2016), it is essential that tobacco advertising bans include internet-based media. In addition, the researchers are of the view that given the global nature of the internet-based content, cooperation among signatory nations to the World Health Organisation Framework Convention on Tobacco Control (2003) was necessary.

Social control theory

According to the social control theory, adolescents abuse drugs because of insufficient social controls restricting them from using drugs (Griffin & Botvin, 2010; Peltzer et al., 2010). Most of the adolescents in one study reported that they were left alone at home most of the time because their parents were always busy or away owing to demanding jobs (About the partnership – the partnership for a drug-free America, n.d.; Kumpfer, 2014; Lakhanpal & Agnihotri, 2007). These adolescents had more freedom to use drugs (About the partnership – the partnership for a drug-free America, n.d.). Lack of parental monitoring lead to an increased association with drug-abusing peers and subsequently higher drug abuse (Griffin & Botvin, 2010; Pressley & McCormick, 2007; Rice & Dolgin, 2008; Saminsky, 2010). In addition, adolescents who are not well nurtured and had a poor relationship with their parents were more likely to use drugs (Griffin & Botvin, 2010; Liddle & Rowe, 2006; Rice, 1992; Rice & Dolgin, 2008). The lack of emotional support by parents is linked to an increase in the use of tobacco, alcohol, and cannabis (Davison et al., 2004; Rice & Dolgin, 2008).

Parental control patterns that involve setting clear requirements for mature and responsible behaviour, in contrast to power-assertive or authoritarian techniques of discipline, result in lower drug use (Liddle & Rowe, 2006; Louw et al., 1998; Rice, 1992). In addition, parents with a democratic, respectful, and receptive character, especially those who respect

conventional rules and help their children in their gradual growth and independence, are less exposed to the dangers of addiction (Hoskins, 2014). Furthermore, appropriate parental monitoring was effective in reducing delinquency and substance use (Griffin & Botvin, 2010; Hernandez et al., 2015; Liddle & Rowe, 2006).

Studies of family structures around the world found that young people who live with both biological parents are significantly less likely to use substances or to report problems with their use, than those who do not live with both parents (Du & Johnson, 2015; Rice & Dolgin, 2008; Mothibi, 2014). However, family structure alone does not explain substance abuse. Disruptions in the family life cycle characterise these single-parent households. An unstable family environment with a father who was absent, or where one or both parents had immigrated, or where the parents had died, were associated with substance abuse (Du & Johnson, 2015; Rice & Dolgin, 2008).

Thus, family structure along with the characteristics of these families seem to account for substance abuse. Although they might place members at risk of substance abuse, family factors might also be protective (El-Awady, Elsheshtawy, Elbahaey, & Elboraie, 2017). As noted above, two-parent households appear protective. High levels of perceived support from family members seem to protect adolescents from alcohol use. Previous studies established that family involvement and communication, proactive family management, or attachment to a family served to protect adolescents against substance abuse across racial and cultural groups (Liddle & Rowe, 2006). Furthermore, greater family support and bonding during adolescence are an indicator of less alcohol use in adulthood (Rice & Dolgin, 2008). The next section provides a discussion on cultural and traditional perspectives about the causes of substance abuse.

Cultural and traditional perspectives

According to Abbott and Chase (2008), sociocultural beliefs could shape the approach to and behaviour regarding substance use and abuse. Culture also plays a role in the use of substances. In some cultures, substances such as home-brewed sorghum beer were used for ceremonial purposes such as *Badimo,* translated as a ceremony for speaking to the ancestors (Allen & Saunders, 2014). The location and nature of an ancestor-honouring place varied according to tradition and personal style. For example, cemeteries, tombs, and burial mounds

were natural points of physical contact with the ancestors. Some people perform ancestral rituals such as *Badimo* when confronted with challenges in life and asking for intervention. It could also be for thanking ancestors when they experienced achievements in their lives (Ancestral Medicine, 2017).

According to Hammond-Tooke (1989, cited in Juma, 2011), spirits of departed ancestors were believed to look after the best interest of their descendants and at the same time could also send them illness and misfortune when they were moved to wrath. In addition, Washington (2010) contended that mental illness such as psychosis was related to either not complying with the calling to become a traditional healer or having been bewitched. Makhanya (2012) and Shirungu (2016) also established that mental illnesses occurred due to bewitchment.

In some instances, when African people got married, African sorghum beer was prepared and used as a gesture to welcome the family's guests and other guests. It is known as *Pulamolomo*, which is a price for opening your mouth to express the purpose of your visit. In some instances, it was shared by men after lobola negotiations as part of the celebration for welcoming the bride and groom into their new families. *Lobola* in Zulu or *Bogadi* in Setswana is an African custom by which a bridegroom's family makes a payment in cattle or in cash to a bride's family shortly before marriage (Collins Dictionary, 2016). Thus, initiation into the use of substances occurred through the above cultural activities. Initiation into excessive substance use might also occur during periods of rapid social change, often among cultural groups with little exposure to a drug and undeveloped protective normative behaviour (Visser, 2003 cited in Mudavanhu & Schenck, 2014). Acculturation, the degree to which an individual identifies with his or her native culture, was thought to be related to substance use and abuse. Native American elders believed that many substance abuse problems were related to the loss of traditional culture. Higher rates of substance abuse were found in persons who closely identified with non-Native American values and the lowest rates were found in bicultural individuals who were comfortable with both sets of cultural values (Szelemko, Wood, & Thurman, 2006). A related situation was that of the immigrant who moved from his homeland to a new country. Immigrants left the protective environment of their family behind and were faced with a new set of cultural norms and values (Abbott & Chase, 2008).

Discussions of the abovementioned theories demonstrate how personal, family, and community or societal factors contribute to substance abuse by adolescents. Knowledge gained from these theories also provided a guideline or basis along which substance abuse prevention programmes designed to address reasons for substance use were explored in this study. Furthermore, it assisted to identify gaps in substance abuse prevention programmes implemented and provided recommendations to already existing knowledge or contributions by previous researchers. These theories are therefore contributing to effective prevention and treatment approaches for substance use and abuse by adolescents. This study was informed by a combination of Western perspectives such as developmental theories, psychological theories, learning theories, social control theories, availability theories, economic theories, symbolic interaction theories and African traditional perspectives.

COMPARATIVE ANALYSIS OF SUBSTANCE ABUSE PREVENTION STRATEGIES

The high rate of substance abuse and reasons for the use and abuse of such substances among adolescents as discussed in preceding sections necessitated the prevention programmes to address the substance abuse problems before it escalated further. Previous studies recommended that preventing or delaying the use of psychoactive drugs among adolescents was a critical national public health goal (Griffin & Botvin, 2010; United Nations Office on Drugs and Crime, 2015). Substantial progress was made in developing substance abuse prevention strategies for substance abuse by adolescents. These included universally selected, programmes for schools and families, along with comprehensive community-based prevention programmes (Griffin & Botvin, 2010). The most effective interventions targeted salient risks and protective factors at the individual, family, and community levels and were guided by relevant psychological theories regarding the etiology of substance use and abuse (Griffin & Botvin, 2010; United Nations Office on Drugs and Crime, 2015). This section presents a comparative analysis of substance abuse prevention strategies applied in Australia, Canada, the Netherlands, Portugal, Switzerland, the United Kingdom, the United States of

America, and South Africa (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015).

According to McDonald and David (2011) cited in the International Centre for the Prevention of Crime (2015), a decentralised approach might allow for a better understanding of local context, resulting in more targeted interventions. In South Africa, the substance abuse prevention strategy was formulated by the Central Drug Authority and approved by parliament to meet the requirements of international bodies concerned and at the same time address the specific needs of South African communities, which sometimes differ from those of other countries (Department of Social Development, 2013). The strategy was also linked to various policies. However, for the purpose of this study, the focus was on the Prevention of and Treatment for Substance Abuse Act (2008), Liquor Act (2003), Tobacco Products Control Act (1993), World Health Organisation Framework Convention on Tobacco Control (2003), and the South African Schools Act (1996). The aim of the Prevention of and Treatment for Substance Abuse Act (2008) was to provide a comprehensive national response for combating harmful drug use. The aim was also to provide mechanisms aimed at demand and harm reduction in relation to harmful drug use through intervention, treatment, and reintegration programmes. Furthermore, it provided for registration and establishment of treatment centres as well as halfway houses. The Liquor Act (2003) prohibits the sale and use of substances by any person less than 18 years of age. Reasonable measures were to be taken to accurately determine whether a person was a minor before selling or supplying liquor or methylated spirits to that person. According to the Anti-Substance Abuse Programme of Action (Department of Social Development, 2011), there was a need to review the legal age for alcohol consumption from the age of 18 to the age of 21.

Furthermore, the Liquor Act (2003) prohibits employment of any person 16 years of age and younger in any activity related to the manufacturing or distribution of liquor or methylated spirits unless the employee was undergoing training or a learnership as contemplated in section 16 of the Skills Development Act (1998). As indicated under the Symbolic Interaction Theory, the Tobacco Control Act (1993) prohibits the packaging of tobacco products in a deceptive manner, as well as advertising the sale of tobacco products to minors, and smoking in public areas. South Africa ratified the World Health Organisation's Framework Convention on Tobacco Control (WHO FCTC) in 2005. WHO FCTC was a treaty adopted by the 56th World Health Assembly on 21 May 2003. The aim was to protect present and future

generations from devastating health, social, environmental and economic consequences of tobacco consumption.

It also protected individuals from exposure to tobacco by enacting a set of universal standards stating the dangers of tobacco and limiting its use in all forms worldwide. Furthermore, devices were to be used for drug testing and the procedures were to be followed (Department of Education, 2008). The policy framework for the management of drug abuse by learners in public schools and in Further Education and Training Institutions (Department of Education, 2002), the South African Schools Act (1996) and the National Strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013) prohibited the use of substances in South African schools. All countries, including South Africa, encompassed legal and illegal substances in their substance abuse prevention strategies (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015).

All countries considered adolescents as an at-risk group and included them in their strategies. In Portugal, childhood and adolescence were considered as critical periods for the onset of substance abuse; while the strategy of Switzerland recognised the importance of strengthening protective factors among adolescents. Consistent with strategies of these countries, Shaw and Travers (2007) emphasised the importance of strengthening protective factors and postulated that effective adolescent prevention programmes should be inclusive. Furthermore, they should target the needs of specific at-risk groups, respect the rights of adolescents, be participatory and multisectoral, and include early intervention, social and educational programmes, restorative approaches, as well as crime control. The strategies of various countries further included activities such as job seeking support, housing assistance, poverty reduction, and support for families. Examination of these strategies revealed that the reduction of marginalisation whether mentioned explicitly or not, was operationalised at three different stages. These were before an individual developed a substance use disorder while the person was addicted and after the completion of treatment (International Centre for the Prevention of Crime, 2015). According to the United Nations Office on Drugs and Crime (2013b), the general objective of substance abuse prevention was the healthy and safe development of adolescents to realise their talents and potential, and also to become contributing members of their community and society. To achieve this, it was important not only to develop strategies targeting adolescents but also to involve them through a

participatory approach, such as data and information collection, problem analysis, solution identification, or programme implementation.

Adolescents were not only beneficiary groups of drug-related strategies, but had an important role to play in the development of such strategies. The Council on Drug Abuse (n.d.) established that the participation of adolescents in substance abuse strategies and prevention programmes resulted in positive outcomes such as decreased rates of substance abuse, lower crime rates, improved academic performance and more meaningful connections between adolescents and their communities. In addition, their participation assisted in developing strategies better suited to their unique needs and their contributions served to inform policies.

Countries had different ways of ensuring the participation of adolescents in substance abuse prevention. For example, in the United States of America, adolescents were mobilised and consulted on matters relating to substance abuse through community coalition and leadership programmes. In the United Kingdom, the participation of adolescents was used to improve the FRANK Campaign, while in Australia, adolescents were consulted in respect of the development of the National Anti-Drug Campaign. Meanwhile, in Canada, a participatory approach was adopted in all stages of implementation of substance abuse prevention programmes. In South Africa, adolescents were represented through membership of the National Youth Development Agency in the Central Drug Authority and the Local Drug Action Committees (Department of Social Development, 2013). However, in Switzerland, although there was recognition at the federal level that good prevention programmes should be participatory, it was impossible to guarantee that all programmes were participatory due to cantonal autonomy.

The International Centre for the Prevention of Crime (2015) indicated that for at-risk groups drug strategies needed to be varied, depending on the social or cultural context. Certain countries identified targeted at-risk groups more clearly than others. For example, the United States of America targeted indigenous communities. The Netherlands also placed particular emphasis on homeless populations, the Australian strategy focussed on indigenous people, and Canada focussed on Aboriginal people. Aboriginal communities were also identified as at-risk groups in Australia and the United States of America. Furthermore, the United States of America and the Netherlands also considered children of drug-dependent parents as an at-risk group. In Switzerland, programmes targeting specifically at-risk groups were rare,

although programmes established focussed on the migrants. Previous studies established that other at-risk groups included African adolescents, orphans, child-headed families, adolescents whose parents work away from home, and adolescents whose parents abuse substances (Goliath and Pretorius, 2016; Harker et al., 2008; Mothibi, 2014; National Institute of Health, 2003; Poole, 2005; Substance Abuse and Mental Health Services Administration, 2015).

Shaw and Travers (2007) defined an integrated multisectoral approach as one in which primary and secondary substance abuse prevention programmes were conducted in collaboration with parents, police, and the community. Strategies of Portugal and the United States of America incorporated an integrated multisectoral approach. Portugal funded integrated response programmes addressing multisectoral issues, including illicit substance abuse; while the strategy of the United States of America funded approaches that were multisectoral and integrated, addressing several issues simultaneously with the involvement of a myriad of partners.

Canada also advocated for an integrated multisectoral approach through its Canadian Standards for Youth Substance Abuse Prevention, which ensured implementation of programmes that respect this criterion. However, England, the Netherlands, Australia and Switzerland applied a decentralised approach (International Centre for the Prevention of Crime, 2015). In South Africa, a multisectoral approach was considered and implemented. The Department of Social Development (DSD) collaborated with other government departments and agencies such as the Department of Health (DOH), the Department of Basic Education (DBE), the South African Police Services (SAPS), the Department of Arts and Culture (DAC), the Department of Correctional Services (DCS), the National Youth Development Agency (NYDA), as well as civil society organisations. Roles and responsibilities of different departments, other government agencies and NGOs regarding the prevention of substance abuse were specified in the National Drug Master Plan (Department of Social Development, 2013).

Substance abuse prevention

Substance abuse prevention was implemented through the primary, secondary, and tertiary levels. Primary prevention was aimed at preventing substance abuse in the entire population, whether they were at risk of substance abuse or not. The report of the International Centre for

the Prevention of Crime (2015) revealed five ways in which primary prevention was implemented, as well as strategies employed to provide information to adolescents. Primary prevention was implemented through schools, families, in the community, by focussing on a particular group, or by addressing the broader public through media campaigns. All strategies of various countries entailed the implementation of primary prevention in schools and families.

The United Kingdom placed particular emphasis on families by providing support to vulnerable families and children to avoid parental substance use leading to substance use by their children. This was an evidence-based strategy. In Portugal, primary prevention was carried out through community interventions such as the Operational Plan of Integrated Responses (PORI). This was aimed at addressing matters relating to substance abuse holistically. The Netherlands targeted a particular group through the "Nightlife" programme aimed at educating adolescents and their parents about the harmful effects of substances. Strategies of Australia, Canada, the United Kingdom, and the United States of America included national campaigns aimed at preventing substance use. Additionally, all strategies employed telephone hotlines, websites and social media to provide information to adolescents and respond to their questions (International Centre for the Prevention of Crime, 2015).

All strategies recognised the importance of a holistic approach that addressed risk and protective factors for substance use. For example, The United States of America employed a strategy that promoted a healthy lifestyle, while Portugal's PORI provided funding to organisations that implemented systemic projects. Australia, Canada and the Netherlands emphasised presentations on the risks associated with substance use. In Australia, information was provided through media campaigns such as video, radio and information materials that focussed on the devastating effects substances had on the lives of individuals and their families. The Canadian Government employed Royal Canadian Mounted Police's Public Engagement programme and media campaigns on substances to illustrate the dangers of different substances and connections to severe offences and crime. Portugal focussed on primary systemic prevention that addressed risk and protective factors through efforts to reduce the risks and reinforce the protective factors. The Netherlands employed the Nightlife Programme to provide information about the dangers associated with substances. The United Kingdom and the United States of America focussed more on building social resistance skills for resisting peer pressure. They employed the "Talk to Frank" and "Above the Influence" to

encourage young people to make their own choices rather than scaring them with the adverse effects of substance abuse (International Centre for the Prevention of Crime, 2015).

Switzerland also recognised that interventions needed to focus on building the social resistance skills of adolescents. They were of the view that presentations on risks associated with substances were not useful and counterproductive. In South Africa, the Ke Moja Integrated Strategy was launched on 26 June 2003 in Cape Town in the Western Cape Province of South Africa by the then Minister of Social Development, Dr. Z.S.T. Skweyiya. The programme was one of the substance abuse prevention strategies employed in the National Drug Master Plan (Department of Social Development, 2013). The strategy sought to bring awareness of and discourage substance abuse among young people by using a range of media, radio clips, television clips, drama, videos, DVDs as well as printed material such as newsletters, brochures, flyers, and posters. Sussman and Ames (2008) asserted that the contents of mass media campaigns that appeared to exert the strongest effects on drug misuse were those that appealed to adolescents through the fast-paced material which depicted exciting activities. The Ke Moja Integrated Strategy (Department of Social Development, 2003) also provided alternative healthy lifestyles to adolescents through education and counselling. One of the key focus areas of the strategy was to address the drivers of substance abuse by shielding young people from pressures that exposed them to substance abuse and providing them with knowledge and life skills to equip them to make informed choices on substance abuse.

Complying with strategies applied in the abovementioned countries, Griffin and Botvin (2010) contended that social resistance skills were designed to make adolescents more aware of various social influences that support substance use and to teach them specific skills to effectively resist peer and media pressures to smoke, drink or use other drugs. Adolescents were taught ways to avoid or deal effectively deal with these high-risk situations. Resistance skills programmes also included content to make adolescents aware of techniques used by advertisers to promote the sale of tobacco products or alcoholic beverages. Adolescents were taught techniques for formulating counter-arguments to appealing but misleading messages used by advertisers. In addition, there were competence enhancement programmes, which recognised that social learning processes were critical in the development of substance abuse among adolescents. Furthermore, they recognised that adolescents with poor personal and social skills were more susceptible to influences that promote substance use and abuse.

Adolescents might also be motivated to use substances as an alternative to more adaptive coping strategies.

Griffin and Botvin (2010) established that competence enhancement taught a combination of life skills such as problem-solving, decision-making skills, general cognitive skills for resisting interpersonal or media influences, skills for increasing self-control, and self-esteem. In addition, they provided adaptive coping strategies for relieving stress and anxiety through the use of cognitive coping skills or behavioural relaxation techniques, general social skills, and general assertive skills. Competence enhancement programmes were designed to teach the kind of generic skills that could be applied broadly to the lives of adolescents. The National Adolescent and Young Adult Health Information Centre (2014) established that for this programme to be effective among adolescents, they needed to provide the knowledge and skills that would empower them to adapt and apply the knowledge acquired to their behaviour. In addition, they required motivation to use these skills, as well as a family, school, and community environment that supported their use of the acquired knowledge and skills.

In addition to competence enhancement programmes aimed at assisting adolescents to resist substance use, there were harm reduction strategies. Recent documented trends in the increasing use of substances by adolescents and its negative impact on the individual, family, and communities resulted in calls for harm reduction strategies. Harm reduction strategies have become a more realistic aim to lessen the risk of harm not only to the adolescent drug user but also to the family and community. These strategies aim to reduce the harmful consequences of substance use and other risky behaviours without requiring abstinence (Logan & Marlatt, 2010; Tartasky & Kellogg, 2010). Initially, this strategy was developed for adults with substance abuse problems for whom abstinence was not feasible. When applied to substance abuse, harm reduction conceded that a continuing level of drug use (both licit and illicit) in society is inevitable and defines objectives as reducing adverse consequences (Karen Lesly, 2008). Harm reduction, as an approach, was applied successfully to the public health, substance use treatment, and psychotherapy (Tatarsky & Kellogg, 2010). The majority of countries included harm reduction in their strategies. For example, harm reduction was more prominent in the strategies of Australia, the Netherlands, Portugal, Switzerland, South Africa, and the United Kingdom. These countries employed a broad range of harm reduction strategies, which were not available in the strategies of Canada and the United States of

America (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015).

Secondary prevention

Secondary prevention targeted children and adolescents who were identified as being at risk for substance use or using substances occasionally. According to the International Centre for the Prevention of Crime (2015), these strategies assisted in identifying social causes of substance use such as low self-esteem or weak social ills. The strategy of Switzerland focussed on training professionals who were in contact with adolescents so that they were able to identify those who were at risk, reach out to them, and refer them to appropriate support services. Unlike Switzerland, strategies of other countries did not include training of professionals (International Centre for the Prevention of Crime, 2015). Portugal and the United States of America had a mixed approach; their strategies incorporated both interventions (International Centre for the Prevention of Crime, 2015). In South Africa, professionals in contact with adolescents were trained through strategies such as the Ke Moja Integrated Strategy (Department of Social Development, 2003).

In addition, the Department of Basic Education (2013) provided for the training of educators on substance abuse prevention through the Life Orientation Curriculum and through other substance abuse prevention training workshops conducted by NGOs. These prevention activities could be educational or psychosocial in focus. Educational interventions were aimed at preventing the onset of substance abuse through awareness raising and information-sharing activities. In contrast, psychosocial interventions were aimed at developing psychosocial skills (for example, to resist peer pressure and to enhance self-esteem). Educational interventions were the most common prevention activity in South Africa. In its narrowest sense, these interventions targeted individuals and their peers, and at the broadest level it took the form of international treaties, conventions, and other structural interventions (Department of Basic Education, 2013; Harker et al., 2008).

Substance abuse prevention programmes might be integrated into the school curriculum. In the Netherlands, the inclusion of health promotion in primary and secondary education was provided by law, making it mandatory. Similarly, in Australia, Portugal, and the United States of America, prevention programmes were incorporated into the school curriculum

(International Centre for the Prevention of Crime, 2015). In South Africa, the National Drug Master Plan (Department of Social Development, 2013) provided for the Department of Basic Education to incorporate matters relating to substance abuse prevention into the Life Skills and Life Orientation Curriculum for Grades R-12. It therefore made substance abuse prevention matters compulsory for primary and high schools in South Africa. Additionally, all strategies focussed broadly on the promotion of a healthy lifestyle and on strengthening life skills (Department of Basic Education, 2013; Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015).

Findings of the International Centre for the Prevention of Crime (2015) revealed that strategies focussing on scare tactics about substance abuse were ineffective. In addition, Griffin and Botvin (2010), as well as Poole (2005) established that many initial attempts at prevention were ineffective because they focussed primarily on lecturing adolescents about the dangers and long-term health consequences of substance use. Over time, more effective contemporary approaches to school-based prevention were developed and tested. Programmes became available that were derived from psychosocial theories on the etiology of adolescent substance use and focussed their primary attention on the risk and protective factors that promote the initiation and early stages of substance use.

In addition, the International Centre for the Prevention of Crime (2015) reported that strategies that focussed on personal development were favoured and included activities that corrected inaccurate perceptions regarding the high prevalence of substance use. Griffin and Botvin (2010) established that adolescents overestimate the prevalence of smoking, drinking, and the use of certain drugs, which make substance use seem to be a normative behaviour. Therefore, educating adolescents about actual rates of abuse could reduce perceptions regarding the social acceptability of substance use. Saminsky (2010) further indicated that for these programmes to be effective, they needed to incorporate various aspects of adolescence into the curriculum.

Community-based interventions

Community prevention programmes delivered to entire communities had multiple components such as a school-based component and a family or parenting component, along with mass media campaigns, public policy initiatives, and other types of community

organisation and activities. These programme components were often managed by a coalition of stakeholders such as parents, educators, and community leaders. These programmes targeted substance use directly through attempting to change adult behaviour and by addressing structural issues that support and maintain drug availability and consumption (Griffin & Botvin, 2010; Loxley, Toumbourou, & Stockwell, 2003). For this study, a discussion on programmes targeting educators was provided in the preceding section. Therefore, the next section provides a discussion on parent or family targeted prevention programmes.

Parent or family targeted prevention programmes: These include programmes that offer early childhood education, social support for parents, parenting skills training, parent-child communication skills, and building healthy relationships (Griffin & Botvin, 2010; Spoth, Greenberg, & Turrisi, 2012). Examples of evidence-based family programming included the Strengthening Families Program (SFP) and Family Matters (FM). The Strengthening Families Program emphasised improving family relationships, parenting skills and the youth's social and life skills (Griffin & Botvin, 2011).

Family Matters was a home-based programme designed to prevent tobacco and alcohol use presenting in adolescents in rural, suburban, and urban areas (Sussman, 2011). The programme was initially implemented in 1996 to 1997 in the United States and currently offered by organisations nationwide (DuPage County Partners, 2016). In addition, Miller (2014) established that the programme was adapted and implemented in countries such as Botswana, Cote d'Ivoire, Kenya, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe. The programme helped to develop appropriate parenting skills for families at risk, enabling them to recognise the early warning signs of substance use, and equipped them with information on appropriate responses and available services (Sussman, 2011). Parent or family targeted prevention programmes appeared to be effective in reducing or preventing substance use. However, the limitation of these programmes was the difficulty of obtaining parental buy-in or parental participation, particularly the parents of adolescents most at risk for substance abuse (Pettersson, Ozdemir, & Eriksson, 2011; Usher, McShane, & Dwyer, 2015). There are sufficient theoretical reasons to suggest that these initiatives enhanced protective factors especially when the prevention messages were consistent and community-wide (Loxley et al., 2003). In addition, there were sports and recreation activities

implemented in communities. Adolescents were engaged in sports, arts and recreational activities, thus ensuring the productive and constructive use of their leisure time.

The Department of Social Development, (2013) recommended that the Department of Sports and Recreation should implement sports and recreation activities that engage adolescents and keep them away from the use of substances. Community prevention programmes empowered communities to understand and to be proactive in dealing with challenges related to substance abuse, its link to crime, HIV and AIDS, as well as other health conditions. Community-based substance abuse intervention strategies proved to be promising (International Centre for the Prevention of Crime, 2015). These community-based substance abuse intervention strategies were aimed not only at changing an individual's behaviour, but also at generating change at the community level. In addition, these strategies focussed on community empowerment and strengthening protective factors such as strong and positive family bonds, academic success, good social skills and opportunities for employment.

By involving communities in solutions to substance-related challenges, strategies achieved broader objectives and fostered economic and social community development. Community stakeholders such as adolescents, community groups, faith-based organisations, government, and law enforcement agencies would allow for the adoption of a comprehensive approach to matters relating to substance abuse. All strategies of countries analysed acknowledged the important role of communities in matters relating to substance abuse (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015). These interventions required a significant amount of resources and coordination, given the broad scope of activities involved. Thus, community-based programmes that delivered a coordinated and comprehensive message about prevention could be effective in adolescent substance use (Griffin & Botvin, 2010). However, if there were no resources or no buy-in from stakeholders, or when stakeholders were not properly consulted, these programmes could not be effective (Department of Social Development, 2013; Pullen & Oser, 2014; Rural Health Information Hub, 2016; World Health Organisation, 2009). Further discussion on resource allocation will be provided later in this chapter.

Involvement of law enforcement officials

Law enforcement officials play an essential role in the prevention of illegal substance use in all the substance abuse strategies analysed. Findings of the International Centre for the Prevention of Crime (2015) revealed that in the Netherlands, Portugal, Scotland, Switzerland, the United Kingdom, and the United States of America, law enforcement officials took part in the development and implementation of substance abuse prevention programmes to ensure public safety. In South Africa, the National Drug Master Plan (Department of Social Development, 2013) and the Strategic Plan of South African Police Service (2014) provided for the involvement of the South African Police Services in the development, implementation, and evaluation of substance abuse prevention programmes.

With regard to the implementation of substance abuse prevention programmes, the Office of the National Drug Control Policy (2014, cited in International Centre for the Prevention of Crime, 2015), reported that in some regions of the United States, police members were trained by the Department of Health to use naloxone to counter the effects of an overdose. In Canada and South Africa, the police members assisted in raising public awareness on the dangers of substance abuse. Police members in South Africa and Switzerland were also trained on appropriate ways of interacting with adolescents (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015). However, in the United Kingdom, such an approach was encouraged through discretionary powers granted to police members (International Centre for the Prevention of Crime, 2015). Furthermore, similar to the "Safe Schools Programme" implemented by law officials in Canada, the Strategy of the South African Police Service (2014) established the "Community Policing Forum" and "Safe Schools Project." Raymond (2010) also established that law enforcement officials such as police members were important in educating adolescents about skills required for responsible citizenship.

Police members collaborated with social services when individuals were arrested for drug use by referring them for treatment. For example, individuals were sent to the "Safety Houses" in the Netherlands. Switzerland also adopted a strong public health focus, which resulted in most addicts being integrated into the health network. This was consistent with the decriminalisation strategy applied in Portugal in which drug users were no longer considered offenders but rather persons requiring care (Drug Policy Alliance, 2015). By applying decriminalisation strategies, Portugal experienced reduced rates of adolescent drug use. As a result; fewer adolescents were arrested and incarcerated, and a significant number received

drug treatment (Drug Policy Alliance, 2015). In the United States of America, 17 states reduced or eliminated criminal penalties for personal marijuana possession. Some states, such as California, passed reforms to lessen penalties for possession of other drugs. Sixteen states, the Washington District of Columbia, and the federal government treated personal possession of drugs other than marijuana as a misdemeanour (Drug Policy Alliance, 2015).

However, possession of large quantities of substances results in prison sentences in most of the countries (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015; South African Police Service, 2014). Even though it was reported that police members collaborated with other stakeholders in substance abuse prevention programmes, the International Centre for the Prevention of Crime (2015) further established that there was occasional collaboration because of resistance in the sharing of data in Canada.

Tertiary prevention

Substance abuse prevention strategies of all the countries analysed in this study recognised the importance of treatment as a means of preventing the recurrence of substance abuse and lowering crimes related to substance abuse. Those strategies emphasised the need to facilitate access to treatment for those who require it (Department of Health, 2013; Department of Social Development, 2013; International Centre for the Prevention of Crime 2015). Previous studies established that referral of adolescents for admission in treatment centres was done by adolescents themselves, families, schools, community organisations, alcohol or substance abuse care providers, other health care providers, as well as through the statutory and criminal justice system (Centre for Behavioral Health Statistics and Quality, 2013; Dada et al., 2016; International Centre for the Prevention of Crime, 2015). Strategies of various countries reflected an awareness of the connection between addiction and other mental health issues, as well as a need to treat them collectively. For example, the Netherlands viewed addiction as a mental health issue, with addiction treatment being the responsibility of the Dutch Association of the Mental Health and Addiction Care. In the United States of America, the Substance Abuse and Mental Health Services Administration (SAMHSA) was responsible for overseeing the treatment of mental health disorders. Australian and South African strategies for the treatment of substance abuse and other mental health issues were an integral part of the National Mental Health Plan (Department of Health, 2016; Department of Social Development, 2013; International Centre for the Prevention of Crime 2015).

The United Kingdom and Portugal referred addicted patients diagnosed with mental health disorders to other national care networks. In Canada, however, findings of the International Centre for the Prevention of Crime (2015) revealed that mental health issues were addressed in an ad hoc manner, and the decision was left to the discretion of different programmes. According to the provisions of the World Health Organisation programme (2013), health evolves throughout the life cycle. Therefore, governments had to put in place actions to prevent mental disorders, and to protect and promote mental health at all stages of life. Furthermore, the World Health Organisation (2013) indicated that the early stages of life presented a particularly important opportunity to promote mental health and prevent mental disorders, as up to 50% of mental disorders in adults began before the age of 14.

In keeping with the recommendations of the World Health Organisation (2013), treatment strategies of various countries include *outpatient methadone programmes*, which provide methadone to reduce cravings for heroin or opiates. Counselling, vocational training, and case management were used to stabilise patient functioning. *Long term residential programmes* offered drug free treatment in a residential community of counsellors and recovering addicts. Patients generally stayed in programmes for a year or more. *Short-term inpatient programmes* kept patients for up to 30 days and focussed on medical stabilisation, abstinence, and lifestyle changes. Staff members were primarily medical professionals and trained counsellors. *Outpatient drug free programmes* used a wide range of approaches, including problem-solving groups, specialised therapies, cognitive-behavioural therapy, and 12-step programmes (Department of Social Development, 2013; International Centre for the Prevention of Crime 2015; Morojele & Ramsoomar, 2016; Prevention of and Treatment for Substance Abuse Act, 2008).

Previous studies recommended individual and family psychotherapy for addressing the developmental, psychosocial, and family issues that contributed to and resulted in the development of a substance abuse disorder (Brody, 2013; Centre for Behavioral Health Statistics and Quality, 2013; Wexner Medical Centre, n.d.). Brannigan and colleagues (2004, cited in Sussman, 2011), further recommended nine key elements which were effective for adolescent substance use treatment programmes. Substance abuse treatment programmes involve parents in the youth drug use treatment and include comprehensive assessments

covering psychological and medical problems, learning disabilities, family functioning, other aspects of youths, as well as public activities.

Programmes were to reflect developmental differences between adolescents and adults, and build a climate of trust, which could maximally engage and retain teenagers in treatment. Staff were to be well trained in adolescent development, co-morbidity issues, and substance use. In addition, programmes were to address the distinct needs of adolescents as a function of their gender and cultural competence. Furthermore, programmes needed to include information on continuing care, relapse prevention, aftercare plans, follow-up, as well as rigorous evaluations to measure success and improve treatment services (Department of Social Development, 2013; International Centre for the Prevention of Crime 2015; Morojele & Ramsoomar, 2016; Prevention of and Treatment for Substance Abuse Act, 2008).

The National Institute on Drug Abuse (2009) established that substance abuse treatment was the most cost-effective way to reduce addiction, improve the health of drug abusers, and relieve the growing burden of drug-related health care costs. According to them, addicts could be rehabilitated with treatment to become productive members of society. Brody (2013) argued that to avoid a possible relapse there was a need for intense treatment and aftercare support for as long as the individual required it (Brody, 2013). Lending support to Brody (2013), findings of the extensive national studies revealed that of tens of thousands of addicts, one third of those who stayed in treatment longer than three months were still drug free one year later (Partnership for Drug Free Kids, 2016). Although various countries acknowledged the importance of treating substance abuse and other disorders, previous studies established that treatment facilities were limited (Brody, 2013; Myers, 2012; National Institute on Drug Abuse, 2009). The next section provides a discussion on substance abuse treatment within the African healing context.

Substance abuse treatment within the African healing context: How Africans relied on African medicine

Traditional African health practice was mainstreamed in South Africa through the promulgation of the Traditional Health Practitioners Act (2004). This Act had fundamental importance in the mental health care scenario with its emphasis on mental health in the definition of traditional health practice. In addition, the World Health Organisation

programme (2013) provided for greater collaboration with "informal" mental health care providers, including families, religious leaders, faith healers, and traditional healers. The report on substance abuse prevention strategies of Australia, Canada, the Netherlands, Portugal, Switzerland, the United Kingdom and the United States of America seems not to be making provision for the inclusion of traditional healers in substance abuse prevention (International Centre for the Prevention of Crime, 2015). Only the substance abuse prevention strategy of South Africa provided for the inclusion of traditional healers. In accordance with the provisions of the National Drug Master Plan (Department of Social Development, 2013), Skuse (2007) contended that traditional healers were a significant source of psychiatric support in many parts of the world, including Africa. Traditional healers also offered a parallel system of belief to conventional medicine regarding the origin, and hence the proper treatment of mental health problems. Skuze (2007) further established that traditional healers were regarded as still more important than psychiatrists trained in Western medicine.

According to proponents of traditional beliefs, illness or disease is a supernatural phenomenon, governed by a hierarchy of vital powers. At the top of the hierarchy is the greatest power, followed by spiritual entities, ancestral spirits, living people, animals, plants, and objects. These entities are interrelated, and should they be disharmonious, illness could ensue. However, harmony could be restored through intervention by a well-trained person treating the patient holistically within the context of his or her family and community (Skuze, 2007). Ngobe (2015) conducted a study among ten traditional healers, six females and four males in Kanyamazane township in the Mpumalanga Province of South Africa, to explore the conceptualisation of the causes and treatment of mental illness by Swazi traditional healers. of the causes and treatment methods among ten traditional healers. The results revealed that cleansing the patient of evil spirits through washing, steaming, induced vomiting, casting out evil, and herbal medication were some of the methods used to treat mental illness.

Furthermore, Melato (2000) established that different cultures had different ways of treating patients. Some people required help from traditional healers, while others considered religious leaders and priests. The study by Melato (2000) further indicated that traditional healers perceived themselves as equal to Western practitioners because of their training and ability to heal various illnesses, including spiritual illness. They viewed themselves as

providing alternative healing through being a medium between people and ancestors. In addition, traditional healers perceived integration as a source of unity and recognition.

Although challenges such as disunity among traditional healers, fears of oppression, and subordination from their Western counterparts were identified, traditional healers in that study emphasised preference for collaboration to total integration with the Western practitioners. Cassey Chambers, Operations Director at the South African Depression and Anxiety Group (SADAG), cited in the report of the South African College of Applied Psychology (2013), also underscored the need to incorporate Western medicine and traditional healing when addressing mental health issues in South Africa. Agreeing with Chambers, Skuse (2007) emphasised that traditional healers had an important role to play in building the health system in South Africa because needs were greater than resources. The next section provides a discussion on how individuals abusing substances are connected to their communities after treatment.

Connecting with the community

Substance abuse treatment often encompasses more than treating addiction; it also involves helping clients prevent relapse when treatment ends. Vocational and educational training, access to health care and other social services were provided by many treatment programmes to help prepare their clients for life in the community when the structure and supervision of treatment were no longer there to support them (National Institute on Drug Abuse, 2009; Prevention of and Treatment for Substance Abuse Act, 2008). This included the developmental programmes such as skills development, aftercare, and reintegration, which provided for the integration of people who underwent the formal treatment episode into their families and communities. Individuals were equipped with additional skills to maintain their treatment gains, sobriety, and avoid relapse.

Furthermore, mutual support groups might be established to enhance the individual's self-reliance and optimal social functioning. Those support groups provide a safe and substance-free group experience where service users practised re-socialisation skills. They also facilitated access by service users to those who recover from substance abuse. They could serve as role models to service users who were in the beginning or middle stages of the recovery process. In addition, it encouraged service users to broaden their support system.

Support groups might be established at community level by a professional, NGO, or a group of service users or persons affected by substance abuse (Department of Social Development, 2013). Strategies of the Netherlands, Portugal, South Africa, Switzerland, the United Kingdom, and the United States of America emphasised reintegration after treatment (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015). The International Centre for the Prevention of Crime (2015) established that individuals who did not receive reintegration support in the form of job opportunities, support, housing assistance, and reintegration with the community, had little chance to succeed.

In addition, strategies of those countries except for South Africa, offered treatment as an alternative to incarceration. However, access to treatment was dependent on whether those countries considered drug use as a criminal or administrative offence. Prison sentences were not considered as an effective means of encouraging adolescents to refrain from abusing substances (International Centre for the Prevention of Crime 2015). The United Nations Office on Drugs and Crime (2008) emphasised that incarceration should be considered when an important societal aim could not be achieved by less restrictive means. The next section provides a discussion on the barriers to substance abuse treatment.

Barriers to substance abuse treatment

According to the United States Department of Health and Human Services Report (2010), large rural health populations had greater shortages of mental health providers and fewer facilities to provide treatment services. Although family doctors, psychologists, social workers and pastors were available in rural areas for delivering basic substance abuse services or social support, facilities providing comprehensive substance abuse treatment services were limited. In addition, a study by Pullen and Oser (2014) compared rural and urban counsellors' perceptions on barriers to providing effective treatment services. They established that although rural and urban counsellors encountered similar constraints that hampered successful treatment outcomes, rural counsellors were subject to special circumstances within their communities that presented unique challenges to treatment efficacy. Furthermore, rural areas lacked basic substance abuse treatment services as well as the supplemental services necessary for positive outcomes. According to Pullen and Oser

(2014), inpatient, intensive outpatient or residential care were not available in rural areas. The absence of these treatment services required patients to travel long distances to receive proper care. Furthermore, Pullen and Oser (2014) reported that the greater the travelling distance to receive substance abuse treatment often resulted in lower completion rates of substance abuse treatment programmes. In this regard, rural communities often lacked public transportation services, which further impeded access to ongoing treatment and support groups.

A study conducted by Myers, Louw, and Pasche (2010) aimed at examining whether access to treatment was equitable as well as the profile of variables associated with treatment utilisation for people from poor communities in Cape Town, South Africa, also established that there were barriers to accessing treatment. The study used a case-control design. In this study 434 individuals with substance use disorders from disadvantaged communities who had accessed treatment were compared with 555 controls who had not accessed treatment on a range of predisposing treatment needs and enabling or restricting variables thought to be associated with treatment utilisation. Findings of this study pointed to inequitable access to substance abuse treatment services among people from poor South African communities. The study also identified financial and geographic access barriers to substance abuse treatment for people from poor communities in Cape Town. In terms of the financial barriers, there were greater concerns regarding the affordability of treatment. The study also found that persons who self-reported that they had considerable or extremely serious problems associated with their substance use, were significantly more likely to access treatment than those with less serious problems. Therefore, various barriers make it difficult to access treatment for substance abuse. The next section provides a discussion on restorative justice as a process to reintegrate substance abusers into society.

Restorative justice: process to reintegrate substance abusers into society

Restorative justice as an alternative to traditional court processing involves offenders, victims and community representatives in the reparation process. Restorative justice is based on a set of principles that guide the response to conflict and harm (Ashley & Burke, 2010; Morozini, 2011; Patchin & Keveles, 2004; Umbreit, Vos, Coates, & Lightfood, 2005). These principles include wrongdoers accounting to those they harmed and repairing the harm, community safety through strategies that build relationships and empower the community to take responsibility for the wellbeing of others, as well as increasing the pro-social skills of the

harmed, and addressing underlying factors that led young people to engage in delinquent behaviour (Morozini, 2011; Patchin & Keveles, 2004). Previous studies established that handling misbehaviour in a restorative way allowed offenders and victims to make amends and repair harm. Handling misbehavior in a restorative way promoted positive feelings, rather than resentment and alienation (Pitsoe & Letseka, 2014; Winfield, 2015). According to Pitsoe and Letseka (2014), restorative justice also provide opportunities to socialise adolescents and teach them how to be productive members of society by employing inclusive and educational approaches. A study by Liebenberg, Hay, and Reyneke (2016) recommended that in order to address disciplinary problems in schools, there was a need for primary, secondary, and tertiary level interventions. These primary levels of interventions were consistent with primary prevention provisions of the National Strategy for the Prevention and Management of alcohol and drug use among learners in schools (Department of Basic Education 2013). According to provisions of that strategy, schools were required to implement life skills training and information and awareness campaigns as part of the Life Orientation learning area.

Morozini (2011) further emphasised that the majority of substance users who were taken to endless trials, accused of possessing substances, and viewed as criminals, were not criminals. They were usually disadvantaged, marginalised and traumatised victims who needed to be taken care of. In support of Morozini (2011), Johnson, Lee, Pagano, and Post (2016) established that many of the inmates were raised in dysfunctional homes. The gathering of Hawai's Friends of Restorative Justice (2016), consisting of former justice system consumers including parolees, people working in the justice system, students, academics, and community members also resolved that there was a need to organise regular meetings of interested parties that would plan and carry out agreed strategies to move the punitive justice system to a restorative justice system.

Examples of identified restorative approaches included innovative therapeutic courts, alternative sentencing, and mental health and substance abuse treatment. The gathering also emphasised the importance of training all the role players such as teachers of the criminal justice system, police, medical professionals, lawyers, and parole officers on restorative justice principles. Restorative justice offered an alternative to traditional approaches in addressing substance abuse disorders (Johnson et al., 2016).

Resource allocations for substance abuse prevention programmes

According to the International Centre for the Prevention of Crime (2015), countries should ensure that developed strategies are balanced, in order to ensure their efficiency. Countries also need to allocate budgets equitably and use different and complementary types of approaches, including early intervention, social, and educational programmes, restorative approaches, and crime control. Findings of the International Centre for the Prevention of Crime (2015) revealed that countries were allocated a larger budget for law enforcement than for prevention. However, the percentages allocated varied from one country to the other. In the Netherlands, as little as 1.9% of the strategy's budget was allocated for prevention, while the United States of America's allocation was 5.1%, and Australia's 23%.

The majority of the budget for the strategies of other countries was for law enforcement and the fight against trafficking. For example, the United States of America allocated 50.7% while the Netherlands allocated 75.33% for law enforcement and the fight against trafficking. Most of the countries did not include harm reduction in their budgets, with the exception of the Netherlands allocating 10.07% and Switzerland allocating 5%. According to the International Centre for the Prevention of Crime (2015), the initiatives of prevention programmes will remain limited if the budget allocated is limited, even if the focus of the prevention strategy is on evidence-based approaches.

Evidence-based strategies for substance abuse prevention

According to the Department of Social Development (2013), Fetterman (2001), Minnesota Department of Health (201), and Van Dyk (n.d.), programmes were evaluated to determine the achievement of objectives, improve programme implementation, provide accountability to funders and the community, increase community support for initiatives, contribute to the scientific base for community public health interventions, and inform policy decisions. Linell (2014), established that there were two types of evaluation, namely process evaluation and outcome evaluation. According to Linell (2014), process evaluation focus on describing the nature and extent of the programme activities including the number of individuals reached, while outcome evaluation is used to assess whether the project had met its goals, whether there were any unintended consequences, lessons learnt, and how to improve the programme. Internal and external evaluation tools might be employed to evaluate programmes, for

example, attendance registers, evaluation forms, and client satisfaction forms (Harker et al., 2008; Linnell, 2014; Substance Abuse and Mental Health Services Administration, 2015). Analysis of all strategies revealed that their implementation decisions regarding prevention initiatives were evidence-based.

Such evidence comes from specialised centres. The work in these centres helped to shape the strategy. For example, the Canadian Standards for Youth Substance Abuse Prevention provided an explanation on how best to plan, select, implement, and evaluate prevention efforts with the school, communities, and families. In South Africa, the National Drug Master Plan (Department of Social Development, 2006; Department of Social Development, 2013) provided for the monitoring and evaluation of substance abuse prevention activities by designated members of the Central Drug Authority. They attended monthly and quarterly meetings of the Provincial Drug Action Committees in each province in South Africa to carry out the monitoring and evaluation as required. In addition, they attended meetings of the Local Drug Action Committees when necessary. Monitoring was based on the requirements of the standardised reporting tool and the Quick Analysis of Substance Abuse Reports . Reports were submitted quarterly, that is the last day of March, June, September, and December of each year. In addition, the CDA was required to submit an annual report to the Minister of Social Development for onward transmission to Parliament by the end of September each year (Department of Social Development, 2013).

Sussman (2011) established that two programmes that were successfully implemented and evaluated were based on a harm reduction philosophy. These programmes are the Alcohol Misuse Prevention Study (AMPS) in the United States, and the School Health and Alcohol Harm Reduction Project (SHAHRP) in Australia. The Alcohol Misuse Prevention Study programme was a curriculum aimed at Grade 5 and Grade 6 students, and included information about the harms of alcohol abuse and how to deal with social pressures to misuse alcohol. In a randomised, controlled study, participants in the Alcohol Misuse Prevention Study demonstrated a reduction in the normative increases in alcohol use and misuse in early to late adolescence (Sussman, 2011). The School Health Alcohol Harm Reduction Project demonstrated significant reductions in alcohol consumption and alcohol-related harms among students who participated in the programme. However, Sussman (2011) established that those prevention programmes were ineffective in changing behaviour in the students who were

already engaged in harmful drinking. The next section provides reflections on substance abuse prevention programmes employing principles of empowerment evaluation.

Fetterman (2001) established that another strategy for evaluating programmes was empowerment evaluation. According to Fetterman (2001), empowerment evaluation was a collaborative activity and not an individual pursuit. Rather, it was fundamentally democratic in the sense that it invited participation and identified issues of concern from the participants. In addition, Fetterman (2001) indicated that the exploration of the programme's value and worth was not an endpoint of the evaluation as was often the case in traditional evaluation, but it was part of an ongoing process of programme improvement. In line with Fetterman (2001), strategies of Australia, Canada, the Netherlands, Portugal, South Africa, Switzerland, the United Kingdom, and the United States of America emphasised the participation of stakeholders in the evaluation of substance abuse prevention programmes (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015). The reflections of participants on substance abuse prevention programmes implemented in this study as discussed later in Chapter 3 under data collection and in Chapter 4 under programme reflections, were based on the following principles of empowerment evaluation: improvement, community ownership, inclusion, democratic participation, social justice, community knowledge, evidence-based strategies, capacity building and accountability (Fetterman, 2001).

CONCLUSION

The risk of substance use and abuse increases greatly during adolescence. Adolescents are exposed to a variety of substances which they abuse as a result of individual, family, and societal factors. Various Western and African traditional theoretical perspectives were provided to give an understanding of the etiology of substance abuse problems among adolescents. In addition, a comparative analysis of substance abuse prevention strategies employed in various countries were discussed. Several strengths were identified from the substance abuse prevention strategies of various countries. Firstly, substance abuse prevention are targeted at all community members. Secondly, substance abuse prevention programmes address legal and illegal substances of abuse. And thirdly, the policy framework guides substance abuse prevention programmes. Information gathered from these strategies indicate that planners should explore and target risk and protective factors when designing

prevention programmes. In addition, these strategies emphasise multisectoral collaborations which include adolescents, the use of various platforms when addressing challenges relating to substance abuse, as well as the allocation of resources.

Furthermore, all strategies regard reflections on the effectiveness of programmes as paramount, because, by preventing substance use, the risk of progressing to later abuse and addiction can also be reduced. Despite the strengths identified, there are also gaps in these strategies. For example, contrary to the National Drug Master Plan (Department of Social Development, 2013), none of the substance abuse prevention strategies consider the inclusion of traditional healers and traditional leaders (International Centre for the Prevention of Crime, 2015). However, the information acquired from these strategies assisted in the development of the substance abuse prevention model as provided under the contribution for this study in Chapter 5. The next chapter will outline the research strategy and method employed in this study.

When I read great literature, great drama, speeches, or sermons, I feel that the human mind has not achieved anything greater than the ability to share feelings and thoughts through language. - James Earl Jones

CHAPTER 3
RESEARCH STRATEGY AND RESEARCH METHODS

INTRODUCTION

In this chapter, the social constructivism research paradigm, the qualitative research approach, and the research design are discussed. The research design commences with an overview of the research site, the researcher's role, and ethical clearance and permission to conduct the study. Further, the selection of participants, inclusion and exclusion criteria, selection of documents analysed, and theoretical perspectives on document review are described. The research design concludes with a discussion on data collection, data analysis, as well as measures to ensure trustworthiness and authenticity in this study. Figure 1 below provides the study's research framework.

Philosophical Worldview Design

Social Constructivism   Qualitative research   Exploratory

Research Design
Overview of the research site
Role of the researcher
Ethical considerations & permissions
Selection of participants
Inclusion and exclusion criteria
Selection of documents
Data collection`
Interviews, Focus groups, Document review
Data analysis
Thematic data analysis
Trustworthiness and authenticity

Figure 1: Research framework for this study – the interconnection of the worldview, design and research methods (adapted from Creswell, 2014).

SOCIAL CONSTRUCTIVISM PARADIGM

In order to address the research aim, a social constructivism paradigm was considered for this study. Social constructivists hold that the meaning of acts, behaviours and events is not an objective quality of those phenomena, but assigned to them by human beings in social interaction. According to social constructivists, meaning is socially defined, organised, and subject to social change (Collin, 2013; Rosenfeld, 2009). Social constructivists also believe that individuals seek an understanding of the world in which they live and work; and develop subjective meanings of their experiences directed towards certain objects or things. These meanings are varied and multiple, leading the researcher to look for complexity of views rather than narrowing meanings into a few categories or ideas. Furthermore, the goal of the research is to rely as much as possible on participants' views of the situation being studied. The questions asked become broad and general so that participants can construct the meaning of a situation, typically forged in discussions of interactions with other persons. The more open-ended the questioning, the better, as the researcher listens carefully to what people say or do in their life settings. Often these subjective meanings are negotiated socially and historically. These meanings are not simply imprinted on individuals but are formed through interaction with others (hence social constructivism) and through historical and cultural norms that operate in the lives of individuals (Creswell, 2014).

Furthermore, constructivist researchers pay attention to specific contexts in which people live and work in order to understand historical and cultural settings of participants. These researchers recognise that their own backgrounds shape their interpretation, and they position themselves in the research to acknowledge how their interpretation flows from personal, cultural, and historical experiences. The researcher's intent is to make sense of or interpret meanings others have about the world and generate or inductively develop a theory or pattern of meaning (Creswell, 2014). The social constructivism paradigm was considered in a study by Goliath and Pretorius (2016) on risk and protective factors associated with drug use from the perspective of adolescent research participants. The study allowed for a complete narrative of the studied phenomena, contextualised in the cultural and social context of research participants. Participants in this study were allowed to order their world through narratives, making connections and meanings by linking the past, present, self, and society.

The social constructivism paradigm was also used in a study on substance abuse prevention in American Indian and Alaska Native Communities. The purpose of the study was to identify the ways indigenous theoretical perspectives may guide current and future substance abuse prevention programmes (Walsh, 2014). Another study in which the social constructivism paradigm was considered was by van Staden (2015), in which the researcher wanted to gain information and insight into contributing factors of juvenile delinquency in the Zwelentlanga Fatman Mgcawu Region in the Northern Cape Province of South Africa.

QUALITATIVE RESEARCH

Qualitative research is an approach for exploring and understanding the meaning that individuals or groups ascribe to a social or human problem (Creswell, 2014). It seeks answers to a research question. In qualitative research a set of predetermined procedures are systematically used to answer the research question by collecting evidence, and producing findings that are not determined in advance, and applicable beyond the immediate boundaries of the study. Qualitative research also seeks to understand a given research problem or topic from the perspective of local participants involved in the study. Qualitative research is effective in obtaining culturally specific information about the opinions, behaviours, and social contexts of particular participants (Creswell, 2014; Patton, 2002).

The purpose of qualitative research is to increase knowledge of people or situations that are not usually studied, especially the experiences of women, persons of colour, and people who are often marginalised in society. It also provides information that might be used for social change (Patton, 2002). In addition, qualitative research can offer important benefits for studies that involve special populations, including those that are traditionally underrepresented in research and those with low literacy. Qualitative research methods such as open-ended interviews may be less intimidating than surveys for those who were historically marginalised in research. Qualitative research might also be used to improve recruitment methods and retention of underrepresented groups. A qualitative research approach was employed in this study as the aim of this study was not to explain human behaviour in terms of universally valid laws or generalisation, but rather to understand and interpret perceptions of participants regarding substance abuse prevention programmes employed in the Ramotshere Moiloa Local Municipality in the North West Province of South Africa (Brikci & Green, 2007; Denzin & Lincoln, 2000; De Vos et al., 2011; De Vos,

Strydom, Fouche, & Delport, 2002; Nichter et al, 2004; Willig, 2009). Furthermore, this study describes and explores substance abuse prevention programmes, focussing on the process of implementation (Fetterman, 2001).

A qualitative research approach was also employed in other substance abuse prevention studies and proved successful in addressing the goals of those studies (Department of Social Development, 2013; Maithya, 2009; Nichter et al., 2004). The objective of the study by the Department of Social Development in Limpopo Province (2013) was to collect baseline data to enable government and the private sector to improve the treatment, prevention strategies, and approaches to reduce substance abuse among the youth in Limpopo. The research study by Maithya (2009) aimed to establish the current trend of drug abuse among students in Kenyan secondary schools, analyse the strategies used to address the problem, and propose a programme for prevention and intervention. Research methodology information acquired from the above scholars enabled me to consider employing a qualitative research approach and relevant ethical aspects. Further, it enabled me to select interviews, focus groups and document analysis as suitable methods for data collection, as well as thematic data analysis, thus ensuring trustworthiness of this study. These studies also provided guidelines on how to proceed with this study and make recommendations for substance abuse prevention programmes for adolescents in the Ramotshere Moiloa Municipality.

Qualitative research methods such as unstructured face-to-face individual interviews, focus groups interviews, and document reviews including substance abuse prevention policies, plans, programmes, and published reports targeting adolescents were utilised in this study. These data sources allowed me to identify substance abuse prevention programmes implemented in the Ramotshere Moiloa Municipality and explore multiple dimensions of substance abuse prevention programmes. Furthermore, data obtained from the documents analysed enriched and complemented data obtained from interviews (Cho & Lee, 2014; De Vos et al., 2011). Also, using more than one data source in this study provided insights, diverse perspectives, and holistic views about the development, implementation, and reflections on substance abuse prevention programmes (Cornett, 2010; Tonkin-Crine et al., 2016). Furthermore, it improved my understanding of substance abuse prevention programmes for adolescents that enabled me to address the aim of this study from multiple perspectives.

According to Burden and Roodt (2007), Hyett, Kenny, and Dickson-Swift (2014), Patton (2015), Yeasmin and Rahman (2012), using more than one data source enhances the credibility of the study's findings. Further details about these research methods and credibility matters are provided later in this chapter under data collection as well as the sections on trustworthiness and authenticity. Qualitative data obtained through these methods took the form of transcripts and summaries; which were rich in detail, and provided meaningful insights and experiences about substance abuse prevention (Brikci & Green, 2007; De Vos et al., 2011; Mouton, 2001; Qualitative Research Consultants Association, 2015; Woods, 2006). The qualitative research approach employed made it possible for me to identify substances abused by adolescents, explore reasons for their use of substances, identify substance abuse prevention programmes in place to address the substance abuse problem, identify stakeholders involved, reflect on programmes implemented, and provide recommendations on substance abuse prevention programmes (Brikci & Green, 2007; Woods, 2006).

By employing qualitative research methods, my relationship and interaction with participants were less formal and participants had the opportunity to respond more elaborately and in greater detail. I had the opportunity to respond immediately to what participants said by amending changes to subsequent questions based on responses provided by the participants. Information gathered from these scholars provided guidance on how to interact with participants and amended changes on research questions for this study (Brikci & Green, 2007; Denzin & Lincoln, 2000; De Vos et al., 2002; Nichter et al, 2004; Willig, 2009).

RESEARCH DESIGN

In this section, I provide a discussion on the research site, researcher's role, ethical clearance and permission to conduct the study. This is followed by an explanation on the enablers and barriers for the recruitment of participants, the selected participants, the inclusion and exclusion criteria, and selection of documents. Finally, data collection, data analysis, as well as trustworthiness and authenticity are described. An exploratory design was considered in this study, as the number of selected participants was small. I also had to rely on individual interviews and focus group discussions with participants, as well as reviewing data from documents. Open-ended questions were employed during individual and focus group discussions that allowed me to gain insight about substance abuse prevention programmes.

Furthermore, I was able to develop recommendations for the development and implementation of substance abuse prevention programmes, as well as to identify future research on substance abuse prevention programmes for adolescents (Eugene & Lynn, 2016; FluidSurveys, 2014; Nardi, 2016).

OVERVIEW OF THE RESEARCH SITE

Salmons (2015) defines the research site as the physical, social, and cultural site in which the researcher conducts the study. This study took place in one of the villages in the Ramotshere Moiloa Local Municipality in the North West Province of South Africa. There is a town called Zeerust, which is a commercial hub for most of the villages situated in Lehurutshe area, a few of which include Borakalalo, Dinokana, Gopane, Lekgophung, Mokgola, Moshana, Mosweu, Ntsweletsoko, Senkapole, Serake and Supingstad. Batswana people refer to Zeerust town as Sefatlhane. The main languages in the Ramotshere Moiloa Municipality are Setswana, English, and Afrikaans. Following the democratic dispensation in 1994, the name of the Zeerust Municipality was changed to Ramotshere Moiloa Local Municipality. The municipality was named after a mid-20th century chief of Bahurutshe boo Moiloa who was a political enemy of the apartheid state.

Ramotshere Moiloa Municipality is one of the five local municipalities in the Ngaka Modiri Molema District in the North West Province of South Africa. The municipality is situated in Marico valley, approximately 240 kilometres northwest of Johannesburg and on the N4, the main road link between South Africa and Botswana (Ramotshere Moiloa Municipality Reviewed Integrated Plan, 2014; Statistics South Africa, 2011). Figure 2 below represents a map of Zeerust.
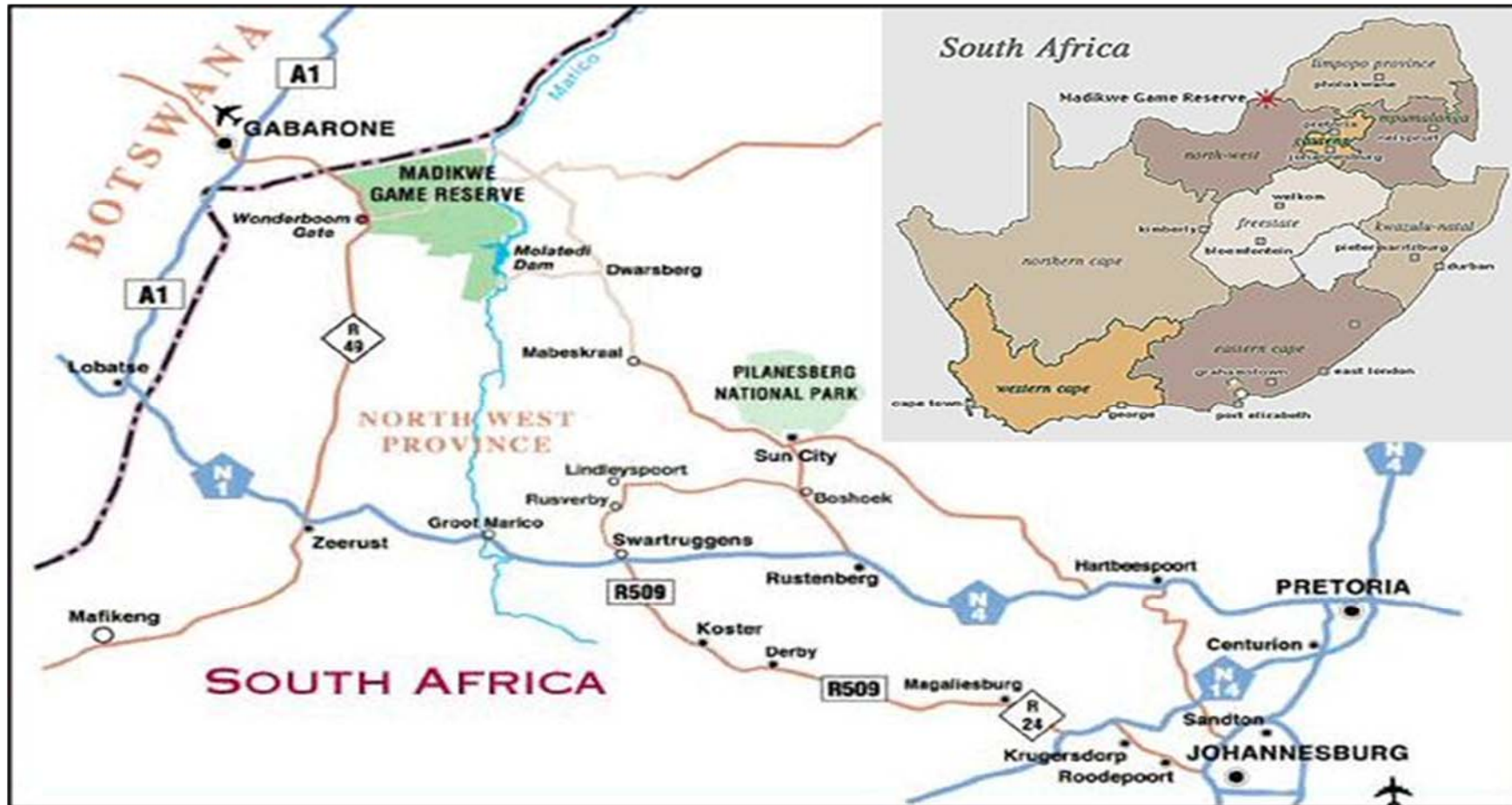
Figure 2: Map of Zeerust (currently referred to as Ramotshere Moiloa Local Municipality) where the study was conducted. This map is adapted from Google maps.

Population

According to the Census report of 2011, Ramotshere Moiloa Local Municipality had a total population of 155 513 of which 99.6 % were African, with Asian or Indians, Coloureds, Whites and other population groups making up the remaining 0.4%. Furthermore, the total population consisted of 32.9% young people from 0 to14 years of age, 59.7% people of working age 15 to 64 years, as well as 7.5 % people aged 65 years and above (Statistics South Africa, 2011).

Households

The settlement type consisted of 70.5% tribal or traditional area, 11% farm area, and 18.5% urban area. There were 40 740 households, with an average household size of 3,6 persons per household. Sixty four per cent (64%) of these households were owned and fully paid for, 16.9% were occupied rent free, 9.5% were rented, 5.9% were owned but not yet paid off and 3.5% fell under other households not specified. It was reported that 19% of households had access to piped water in their dwellings and 38.2% had access to piped water in their yards. Only 8.3% of households did not have any access to piped water. The main source of water, 65.4%, were provided by the regional or local water scheme operated by the municipality or other service providers for water. Twenty one point three per cent (21.3%) of water was from a borehole, 0.3% was from a spring, 0.4% was from a dam, pool or stagnant water, 0.6% was from the river or stream, 0.6% was from water vendors, 8.9% was from a water tanker, and 2.3% was from other sources not specified in the Census Report (Statistics South Africa, 2011).

With regard to toilet facilities, 59.1% of households had pit toilets without ventilation, 6.4% had pit toilets with ventilation, 0.5% used chemical toilets, 0.2% used bucket toilets, 22.3% had flush toilets connected to the sewage system, 4.2 % used flush toilet with a septic tank, 1.5% had other toilet facilities, and 5.7% did not have any toilet facilities. This information confirms the current challenges with the supply of water within the Ramotshere Local Municipality and other municipalities in the North West Province, South Africa. In the municipality, 81.9% of households had access to electricity for lighting, 58.1% for cooking, and 52.8% for heating. A very limited number of households used other sources of energy such as gas, paraffin, solar, candles, wood, coal, and animal dung for cooking, heating and

lighting. For example, there were 16.7% households using candles for lighting. Thirty five point three percent (35.3%) of households used wood for cooking, while 33.7% households used it for heating. There were 0.1% of households using animal dung for cooking, while 0.2% used it for heating. (Ramotshere Moiloa Reviewed Integrated Development Plan, 2014; Statistics South Africa, 2011).

Education

The Zeerust Area Project Office in the Ngaka Modiri Molema District of the Department of Basic Education in the North West Province of South Africa has 55 primary schools and 26 high schools. There used to be about 11 middle schools, starting with Grades 7 up to 9. Seven middle schools were merged with some primary schools and high schools. Four middle schools were not yet merged with either primary or high schools. Through the restructuring of these schools, Grade 7 learners from these middle schools were transferred to neighbouring primary schools and all the Grade 8 and 9 learners were transferred to neighbouring high schools. Therefore, primary schools have learners from Grade R to 7, while high schools have learners from Grade 8 to 12 (Department of Basic Education, 2014).

These changes were implemented in the North West Department of Basic Education as informed by the National Department of Basic Education (2014), which stated that middle schools were a legacy of the former Bophuthatswana Homeland. The concept of middle schools therefore did not fit into the current basic education framework of South Africa. These changes were challenged by the South African Democratic Teacher's Union (SADTU), which felt that the costs involved in implementing these changes could be spent on infrastructure and resources (South African Democratic Teachers Union, 2014).

These schools are divided into clusters managed by cluster managers appointed by the Department of Basic Education, North West Province. The role of cluster managers is to ensure that schools are provided with the required physical and human resources, which depend on the number of learners enrolled in those schools. The minimum educational qualification for school principals, deputy principals, heads of departments, and educators is a three-year teaching qualification, while the educational qualification for support staff including administrators and cleaners is Grade 12. Cluster managers are responsible for ensuring that each and every school has a School Governing Body (SGB) consisting of the

principal, parent component, educator component, and learner representative council. The term of office for the School Governing Body is three years (Department of Basic Education, 2014).

The Department of Basic Education also appoints subject specialists for Grades R to 12. The role of subject specialists is to provide curriculum support to educators and to ensure quality learning and teaching in all schools. All these schools are public schools and managed by the Zeerust Area Project Office (Department of Basic Education, 2017). The educational levels of employees in the Ramotshere Moiloa Municipality include Grade 12, undergraduate, and postgraduate qualifications (Ramotshere Moiloa Local Municipality Reviewed Integrated Development Plan, 2014; Statistics South Africa, 2011). The current educational status in the Ramotshere Moiloa Municipality might be informed by the fact that the Department of Basic Education in the North West Province puts substantial effort in ensuring that they advance the academic success of learners in schools starting from Grade R to 12. In addition, there are support programmes aimed at ensuring that learners pass Grade 12 with good marks. The support programmes include extra classes after school hours, weekends, and during school holidays (Department of Basic Education, 2016).

Furthermore, each high school or secondary school has Life Orientation educators responsible for implementing Life Orientation lessons to learners. Some of the tasks of these educators are to teach learners about healthy lifestyles and available careers, and to expose them to career exhibitions aimed at providing learners with information about career opportunities as well as institutions offering courses in these careers. Furthermore, information about the scores required to be admitted to study certain courses are provided (Department of Basic Education, 2012). In some instances, tertiary educational institutions and organisations offering financial assistance to learners in higher educational institutions visited schools to provide information about requirements to be met before funding is allocated (National Student Financial Aid Scheme, 2015; Ralarala, 2007).

Information provided by tertiary educational institutions and organisations offering financial assistance encouraged learners to work hard and improve their Grade 12 scores so that they are accepted into higher educational institutions with scores high enough to obtain financial support. In addition, because of career guidance offered in schools; once these learners complete their undergraduate qualifications, they seemed to be encouraged to further their

studies in order to stand a better chance of meeting the requirements for various employment opportunities. The benefits of post-secondary education are well documented and have major implications for economic growth, equality, and social mobility. Obtaining a post-secondary qualification led to greater lifetime earnings, lower unemployment, and lower poverty rates. Over the course of one's working lifetime, the median earnings of Bachelor's degree recipients were 65% higher than median earnings of high school graduates (Baum, Kurose, & Ma, 2013).

In addition, the United States Bureau of Labor Statistics (n.d.) revealed that college graduates were more likely to find a job, and that the unemployment rate for Bachelor's degree recipients was half the unemployment rate of high school graduates. These findings were also reported by Carnevale, Smith, and Strohl (2010) in their research article on "Help Wanted: Projections of Jobs and Education Requirements Through 2018". Tatlow (cited in Halman, 2016), also established that a postgraduate degree enhanced earnings over time, but that unless a postgraduate qualification is a requirement to enter a particular profession, there was no evidence that employers preferred postgraduate qualifications. A Statistics South Africa Report (2015) also revealed that the education level of employed youth had a direct influence on their employability. It was interesting to note that there were educators from other African countries such as Ghana, Zambia and Zimbabwe in those schools.

In addition, there were educators from other racial groups such as Indians and Whites in those rural schools. The majority of those educators were recruited during the Bophuthatswana Homeland Era to assist with subjects such as Mathematics, Physical Science, Economics, and Accountancy. Bophuthatswana was one of the homelands of the former government of South Africa, which was led by President Lucas Mangope (South African History Online, 2015; Stillwater, 2007).

In order to advance academic success among learners from Grade R to 12, there is a nutrition programme in which learners are provided with meals during school hours. The project is an initiative of the National Department of Basic Education in South Africa (2009). The programme is informed by the fact that the majority of learners would go to school without anything to eat during break or lunch. Thus, this project was introduced to provide food to such learners. In order to avoid stigma and discrimination against learners who could not

afford to bring lunch boxes to school, this feeding programme is for all learners. It is up to learners to decide whether or not they want to receive food during break or lunch.

The Department of Basic Education also provides financial support to all needy learners. Thus, no learner is excluded from attending school because they cannot afford to pay fees. All learners who cannot afford to pay fees are exempted from paying fees. All their parents need to do is apply for exemption from paying school fees (Department of Basic Education, 2016; South African Schools Act, 1996). Information about this financial support is provided to parents, caregivers or guardians during parents' meetings in schools. In addition, parents are given exemption forms to complete. There are requirements to be met before a learner is excluded from paying school fees.

Economic matters

According to the Census Report (Statistics South Africa, 2011), 22 437 people were employed; 12 743 persons were unemployed and 9 030 persons were classified as discouraged work seekers in the Ramotshere Moiloa Municipality. In 2011, the unemployment rate was 36.2%. Among the youth aged 15 to 34, 9 329 were employed, while 5 609 were unemployed. The employment rate for this group was 45.8% higher than the total number of all other unemployed persons in the municipality (Statistics South Africa, 2011). The majority of people were employed as public servants, domestic servants and farm workers in the neighbouring farms in the Ramotshere Moiloa Local Municipality. In addition, there were large cattle farms in the area, as well as wheat, maize, tobacco and citrus fruit farms. The majority of people were employed on these farms. There are fluorite and chromite mines in the vicinity. Tourism was also a developing industry. There are guest houses in the Ramotshere Moiloa Municipality and some people were employed at these guest houses. The reason for these employment sectors is because there are no factories in Zeerust.

Traditional authorities

All the villages in the Ramotshere Moiloa Municipality were under the control of traditional leaders. These traditional leaders were recognised by the Ramotshere Moiloa Municipality and worked hand in hand with ward councillors. One of the traditional leaders from the

Ramotshere Moiloa Municipality served in the house of traditional leaders for the North West Province of South Africa (Parliamentary Monitoring Group, 2017).

Politics

The Ramotshere Moiloa Municipality consisted of the following political organisations that participated in the municipal elections: the African National Congress, Congress of the People, Independent Working Together Political Party, South African Political Party, United Democratic Christian Party, Democratic Alliance and the Economic Freedom Fighters (Independent Electoral Commission, 2011). The African National Congress won the majority of the wards in this municipality. Thus, a majority of ANC Counsellors managed these wards. All the wards except the one in Zeerust formed part of the former Bophuthatswana Homeland (Independent Electoral Commission, 2011).

Religion

The majority of community members in the Ramotshere Moiloa Municipality Local Municipality were Christian and Islamic. There were also traditional healers in the communities. Religious leaders, traditional leaders and traditional healers served in community development programmes within the Ramotshere Moiloa Local Municipality (Ramotshere Moiloa Local Municipality Reviewed Integrated Development Plan, 2014). The Ramotshere Moiloa Municipality also experienced satanism. Satanism is a broad term referring to a group of social movements with diverse ideological and philosophical beliefs. It includes symbolic association with, or admiration for Satan, whom satanists see as an inspiring and liberating figure (Brown, 2011; Nicolson, 2013). There were incidents of satanic attacks among high school learners reported in some schools in the Department of Basic Education, Zeerust Area Project Office.

Satanism signs reported included satanic symbols on clothes and personal belongings, attitudes of extreme hatred and destructive behaviour towards self and others, and obsession with death, violence and evil. Satanism is also associated with concurrent drug, alcohol, and sexual activity, and Satan has a reputation among other students as someone to be feared because of personal power. This also applies to self-proclaimed satanists or devil worshippers. These signs were also reported in other provinces within South Africa as well as international studies on satanism (Brown, 2011; Nicolson, 2013). Thus, the Department of Basic Education worked hand in hand with school management teams, school governing bodies, and religious leaders to address these challenges through prayer meetings conducted

in schools (Department of Basic Education, 2014). In addition, religious leaders also raised awareness about satanism during their church services.

THE RESEARCHER'S ROLE

In qualitative research studies, the researcher has direct contact with participants, situations, and the phenomenon under study. In addition, the researcher's personal experiences and insights were an important part of the enquiry and critical to understanding the phenomenon. Furthermore, the qualitative researcher owned and was reflective about her own voice and perspective. A credible voice conveyed authenticity and trustworthiness. Complete objectivity was impossible and pure subjectivity undermined credibility. The researcher's focus became balanced. Her understanding and depiction of the world in all its complexity was authentic, while she remained self-analytical, politically aware, and reflexive in her consciousness (Patton, 2002).

Personal and professional reflections

My interest regarding matters relating to substance abuse has developed over the years as I was employed by the North West Department of Basic Education in the Zeerust Area Project Office from 1993 to 2009. As an educator, head of guidance and counselling, and Life Orientation subject specialist, one of my duties was to refer learners abusing substances to social workers and psychologists for counselling. I also served as a member of the committee for health promotion in schools, the local AIDS council and local drug action committee. My role in the committee for health promotion in schools was to represent the school where I was employed. My main tasks included identifying health challenges facing learners in the school and reporting them to the committee for intervention by identified health nurses.

I ensured that learners participated in health promotion programmes taking place in the Department of Health in the Zeerust District. In addition, I coordinated healthy lifestyle awareness campaigns in the school and invited health nurses to make presentations on health issues affecting the learners and to raise awareness about health services available in the local clinics and hospitals. I also participated in a committee for the establishment and launch of the user-friendly youth health centre for the Ramotshere Moiloa Local Municipality in 2008.

Furthermore, I served as a member of the Ramotshere Moiloa Municipality Local Drug Action Committee. I represented the Zeerust Area Project Office of the Department of Basic Education in that committee as a subject advisor responsible for Life Orientation and HIV/AIDS programmes. I participated in the Ke Moja (I am fine without drugs) workshops targeting learners as well as parents and educators in primary, middle and secondary schools from 2007 to 2009. In addition, I conducted awareness campaigns about substance abuse among learners and ensured that learners and educators attend the annual World Drug Day activities within the Ramotshere Moiloa Local Municipality and at other municipalities within the North West Province. These activities were coordinated in collaboration with stakeholders such as the departments of Correctional Services, Health, Social Development, Sports and Recreation, Arts and Culture, the South African Police Services, and Love Life.

I attended Master Trainers Workshops on matters relating to substance abuse and in turn coordinated substance abuse workshops for parents, educators and learners in schools. As a Life Orientation subject specialist I ensured that information pertaining to substance abuse forms part of the Life Orientation Curriculum and that learners were also assessed on this information. I also ensured that schools participated in substance abuse awareness campaigns conducted by the Ramotshere Moiloa Local Drug Action Committee. In addition, I assisted with the referral of learners to substance abuse rehabilitation services.

I came across challenges of primary and secondary school learners who were abusing substances and referred such cases to social workers for intervention. I realised that in as much as intervention programmes were implemented, more cases were reported. I became interested in reasons why adolescents abused substances. These issues were addressed through my master's dissertation, which focussed on male learners from Grade 7 to 9 in secondary schools around the Ramotshere Moiloa Municipality. With the current study the focus is on exploring perceptions of adolescents regarding substance abuse programmes implemented in the Ramotshere Moiloa Local Municipality. Additional data were obtained from educators, parents, a mental health nurse, a clinical psychologist, a social worker, a traditional leader, a traditional healer as well as the documents analysed.

Views and beliefs

I believe my understanding of the context and role enhanced my awareness, knowledge and sensitivity to many of the challenges, decisions and issues encountered with substance abuse among adolescents. This assisted me in working with the participants in this study. I brought knowledge of the substance abuse problem and prevention programmes implemented among adolescents in the Ramotshere Moiloa Local Municipality in the North West Province of South Africa. I paid particular attention to exploring adolescent perceptions about substance abuse prevention programmes implemented and provided recommendations that might contribute to already existing policies and initiatives aimed at addressing the substance abuse problem. I believe that substance abuse among adolescents is a challenge to both the adolescents and their family members, communities, educators, and workers, as well as police members, traditional leaders, health professionals and policymakers.

Due to previous experiences and participation in the Local Drug Action Committee, I brought certain biases to the study. Although every effort was made to ensure credibility, these biases might have shaped the way I viewed and understood the data I collected and my interpretation of my experiences. I commenced the study with the perception that adolescents and parents were not consulted when substance abuse prevention programmes were developed and implemented. The guiding question during the study was: Why do adolescents continue abusing substances despite all the efforts employed to prevent substance abuse by various stakeholders?

In this qualitative investigation, I formed a key component for both collecting and analysing data as a form of subjective research (Sutton & Austin, 2015; Terre Blanche & Durrheim, 1999). I wanted to learn more about substance abuse prevention programmes for adolescents and felt compelled to participate in the study to meet the demands of reciprocity (Marshall & Rossman, 1995). The reciprocity that I offered during individual and focus group discussions included my interest in the participants' experiences, attending to what they said, and honouring their utterances when presenting the data (Hennink et al., 2011).

ETHICAL CONSIDERATIONS

According to Creswell (2014), ethical considerations need to be considered throughout all the phases of the study. These phases are prior to the beginning of the study, the beginning of the study, when collecting the data, when analysing the data, and when reporting, sharing and storing the data. Ethical issues considered in this study included permission to conduct the study, voluntary participation, informed consent, confidentiality and anonymity, the protection of participants, and briefing sessions (Berg, 2009; Cho & Lee, 2014; Creswell, 2014; De Vos et al., 2011; Hallinan, Forrest, Uhlenbrauck, Young, & McKinney, 2016; Hennink et al., 2011; Hiriscau et al., 2016; Li et al., 2016; Segrott et al., 2014; Woods, 2006). In this study, data were collected immediately after obtaining an ethical clearance certificate from Unisa's College of Human Sciences and permission from government departments and individuals participating in this study.

Permission to conduct the study

Before conducting the study in the Ramotshere Moiloa Municipality, an application for ethical clearance was submitted to the Department of Psychology in the College of Human Sciences, of the University of South Africa, and approval was granted in 2013 (See Appendix 1 for a copy of the Ethical Clearance Letter). Immediately after obtaining ethical clearance, requests to conduct the study were made to the departments of Basic Education, Health, Social Development, South African Police Services, and the parents (See Appendix 2-5 for permission letters to conduct the study). The process of obtaining permission to conduct the study unfolded as follows:

Department of Basic Education: I had a telephonic discussion with the Zeerust Area Project Office Manager of the Department of Basic Education during which I introduced myself, explained the purpose of the study and identified schools where I intended to conduct the study. I followed that up with an email. Permission was granted for me to conduct the study and a permission letter was emailed to me in September 2014 (See Appendix 2 for a copy of the permission letter). The Zeerust Area Project Office Manager notified the cluster manager for those schools. In addition, a communiqué was sent to the principals of the identified schools. I obtained contact numbers and email addresses of the two principals from the Zeerust Area Project Office Manager. I followed them up through telephonic discussions. In

the telephonic discussions, I explained the purpose of the study and the required information regarding the participants. Both principals referred me to the Life Orientation educators responsible for substance abuse prevention programmes in these schools. I scheduled meetings with the two educators in one school (school A) and two educators in another school (school B). I explained the purpose of the study and processes that would be followed for the study and indicated that I required assistance with the learners participating in substance abuse prevention programmes.

The educators notified learners about the study and requested all the learners interested in participating in the study to make themselves available for a meeting with me. I had two separate meetings at the two schools in September 2014 with the learners participating in the Teenagers Against Drug Abuse Prevention Programme. In these meetings I explained the purpose of the study and the fact that because they were minors, their parents or guardians needed to provide permission for them to participate in the study. In school A, seven learners agreed to participate and in school B, fifteen learners made themselves available to participate. These learners were asked to request permission from their parents to participate in the study. Parents who agreed that their children participate in the study were convened for a briefing session about the purpose of the study. All of them agreed that their learners should participate in the study and signed consent forms in that meeting.

The parents' willingness to consent that their children participate in the study was aided by the fact that their children were members of the Teenagers Against Drug Abuse (TADA) and they participated in substance abuse prevention programmes in their schools. Four educators from two different schools also agreed to participate. In the first phase of data gathering in 2014, only one educator from school B agreed to participate. Other educators were not willing to participate. I respected their views and did not force them to participate. In January 2016 I was advised by my supervisor and a qualitative research specialist that the collected data were limited. I then followed up with the educators who initially did not agree to participate. Three other educators; two from school A and one from school B, were contacted telephonically and requested to participate. I explained that I initially accepted their decision not to participate. However, I explained that I had a challenge with limited data and that their input was important for the success of this study. In addition, I also explained the benefits of participating in the study. The benefits included that they would be afforded an opportunity to express their views about substance abuse problems among adolescents, reflect on prevention

programmes implemented and offer suggestions on how these programmes might be implemented in their schools and community settings.

In addition, I explained that after completion of the study, their views would be published and presented in various forums and contribute to already existing knowledge about factors to be considered as and when substance abuse prevention programmes were implemented. Furthermore, their participation would assist in developing strategies that would address challenges related to substance abuse among adolescents in their own schools and community. These educators realised the importance of their input and agreed to participate. See Appendix 6 for a letter of informed consent. It was not an easy process; however, through persuasion and exercising patience with participants, I was able to convince them to participate.

Furthermore, in January 2016, my supervisor and the qualitative research specialist advised me to consider further interviews with two learners who abused substances and went through a rehabilitative process, as well as with parents who were willing to participate in the study, as this would enrich the data obtained for this study. I had separate telephonic discussions with the educators participating in this study to assist me in identifying two learners, together with their parents, who were referred for substance abuse rehabilitation. They would be asked if they were willing to share their experiences about substance abuse problems and prevention programmes implemented. In March 2016, two educators in school B confirmed that two learners from their school were referred for substance abuse rehabilitation. They made the learners aware of the study and informed them that other learners in their school had already participated in this study in 2014. The educators also asked the learners if they were willing to share their experiences about substance abuse problems and the support they received. If the learners agreed, the educators would notify me so that I could request permission from their parents. Immediately after the learners indicated their willingness to participate, the educators contacted their parents and notified them about the study. In addition, the educators indicated to them that if they were willing to participate, they should send their contact details to me so that I could have a discussion with them. The two educators notified me about the willingness of the parents and the learners to participate in the study and provided the contact details of the parents.

After obtaining the parents' contact details, I had separate telephonic discussions with them in which I introduced myself and provided information about the purpose of the study. I also requested permission for their children to participate in the study. They agreed that their children may take part in the study. I made the parents aware that they needed to complete informed consent forms which they had to complete before their minor children could participate in the study. The informed consent forms would be discussed with the parents and their children and signed on the day of the interview.

I then contacted the learners and they confirmed their willingness to participate in the study. They were also informed that informed consent forms would be completed on the day of the interview. The willingness of the parents for their children to participate in the study was informed by the fact that they were beneficiaries of the substance abuse prevention programmes implemented in the school. Furthermore, their children were assisted with their substance abuse problem. In addition, the fact that educators explained the purpose of the study and that other learners participated in this study, made it easy for them to agree.

Permission from the Department of Social Development: A letter to request permission from the Department of Social Development was emailed to the Assistant Director in the Department of Social Development in the Zeerust Service Point. Approval and permission letters to conduct the study were emailed to me in September 2014. Approval to conduct the study from the Department of Social Development was aided by the fact that substance abuse prevention programmes were part of their priority programmes and they were one of the key stakeholders in substance abuse prevention (National Drug Master Plan, 2013). Additionally, outcomes from this study might contribute to already existing information about the development and implementation of substance abuse prevention programmes in the Ramotshere Moiloa Municipality.

Permission from the Department of Health: A letter requesting permission to conduct the study was emailed to the Deputy Director: Department of Health in the Ramotshere Moiloa Municipality in 2014. In response, I received an email referring me to the directorate responsible for research programmes at the North West Provincial Office of the Department of Health. Contact numbers and the email address of the person responsible for research-related matters were provided. I emailed a letter of request and called the person responsible for research-related matters several times without any response in 2014. The administrator in

that office promised to notify the director responsible for granting permission for research. After several attempts, I realised that I was not getting assistance. Based on those challenges, I decided not to include participants from the Department of Health, as it was a challenge to obtain permission. In February 2016, I sent another request to conduct the study and explained that it was not the first time that I submitted the request.

I was notified that the person who was responsible for research-related matters had resigned. Therefore, I had to make a new submission and also include a letter requesting permission to conduct the study, a research proposal, and ethical clearance from the University. I was also informed that the departmental reviewers committee would review this study and recommend it to the head of the Department of Health in the North West Province. I emailed the required information, and the approval letter to conduct the study from the Department of Health in the North West Province was issued in March 2016. I was requested to sign the letter and return it to the North West Department of Health. In addition, by signing the letter, I agreed to certain requirements from the North West Department of Health. The requirements entailed that I furnish the North West Department of Health with an electronic copy of the final research report; or provide an electronic summary with the recommendations that would assist the department in its planning to improve some of its services where possible.

When I received the approval letter in March 2016, I immediately contacted the Department of Health in the Ramotshere Moiloa Local Municipality and requested the contact details of the mental health nurse and the clinical psychologist responsible for substance abuse prevention programmes. Upon receiving their contact details, I had separate telephonic discussions with them; explaining the purpose of the study, sharing the approval letter with them, and made them aware that they would be required to sign informed consent forms before the interview sessions. They immediately agreed to participate in the study. Their willingness to participate was informed by the fact that they were assisting with matters relating to substance abuse in the Department of Health and referred such cases to the social workers. The mental health nurse also served in the Ramotshere Moiloa Local Drug Action Committee.

Permission from the South African Police Services: A letter requesting permission to conduct the study was emailed to the South African Police Services (SAPS), Lehurutshe Police Station in 2014. Unfortunately, there was no response. I followed up telephonically.

Several attempts were made to contact the person responsible for granting permission to conduct the study. However, I could not get hold of him. In January 2016, after my supervisor and a qualitative research specialist assisting with this study persuaded me to obtain additional information from other stakeholders who were initially identified but not willing to participate, I realised how important additional data from the South African Police Services were. I followed up on this request by calling the South African Police Services in Lehurutshe. I requested to speak to the station commander and was informed that he was out of office attending meetings. I then explained to the receptionist that in 2014 I emailed a request to conduct the study and that I received no response. The receptionist at the police station advised me to submit a new request and provided the name and surname of the station commander as well as the email address. I emailed the letter on 2 February 2016 and followed it up with an email on 15 February 2016 without any response (See Appendix 5 for the permission letter).

I then contacted the Lehurutshe Police Station in May 2016. When I could not get hold of the station commander, I requested a referral to any senior person available. I was referred to one of the seniors in that office and explained that I sent requests in 2014 as well as February 2016, and made follow-ups in March and April 2016. He then provided his email address and fax number so that I could resend the request letter. I made follow-ups again without any response. In January 2017, I sent an email and called. Unfortunately, one of the senior people I initially spoke to was not available. The police officer who assisted me requested that I leave my contact number, which I did. On 31 January 2017 I received a call from one of the senior police members notifying me that they were unable to approve my request because requests for research-related matters need to be approved by the National Office of the South African Police Service in Pretoria.

The senior police member provided me with the contact numbers, email address, and postal address of the senior person dealing with research-related requests at the National Office of the South African Police Service. I contacted the responsible person, who requested that I submit the ethical clearance, letter of request to conduct the study, letter of informed consent and approved research proposal. All the required documents were submitted and an email acknowledging receipt of the documents was sent. With due regard to the fact that the waiting period for approval to conduct the study was delaying the conclusion of this study, I opted to use the South African Police Service documents addressing the research questions of this

study. Details about these documents and how they were accessed are provided later in this chapter under selected documents.

Permission to conduct the study with parents: I obtained a list of the contact details of five parents involved in substance abuse prevention programmes from a social worker participating in this study. When I tried to contact all of them in 2014, none of them were available to participate even though I was willing to interview them at their homes and at times convenient to them. By keeping in mind that they were a previously marginalised and vulnerable group, I respected their right not to participate and did not force or try to influence them to participate. This decision was informed by the research ethics guidelines of the United States Department of Health and Human Services (2010) and the University of South Africa (2014).

In January 2016, as per the advice from my supervisor and a qualitative research specialist to get hold of parents who were willing to participate in this study, I followed up with two parents whose children were referred for rehabilitation, as discussed in the preceding section. I explained the importance of their participation for the success of this study and the fact that information obtained from them would assist other parents encountering challenges of children abusing substances. Upon realising the value that the information obtained from them would add to the study and how other parents would benefit from this study, both parents agreed to participate and were notified about the informed consent form which they were required to complete on the day of the interview. I further requested them to indicate the suitable date, time and venue for the interview. Both parents requested to be interviewed after working hours at their homes (See Appendix 3 for informed consent letters).

Permission to conduct the study with the traditional healer: I requested one of the educators participating in this study to help me to identify a traditional healer willing to participate in the study. The educator made me aware of one traditional healer who was staying not far from the two schools where the study was conducted and provided his contact numbers. I contacted the traditional healer in February 2016 and informed him that I obtained his contact numbers from one of the educators participating in the study. I explained the purpose of the study and the need for him to participate in the study. I told him that if he agrees to participate in the study, I would schedule a session with him and take along an informed consent form for him to sign. The traditional healer agreed to participate because, in his

discussion with me, he indicated that he assisted people with drinking problems. This sparked an interest in him to participate in this study (See Appendix 6 for the informed consent letter).

Permission to conduct the study with the traditional leader: I obtained information and contact numbers of the traditional leader from one of the educators participating in this study. I called him and explained the purpose of the study. After providing an explanation about the study, the traditional leader confirmed his willingness to participate in the study. I informed him that he had to sign an informed consent form and he agreed to sign it just before the interview session. The willingness of the traditional leader to participate was informed by the fact that his village was also encountering substance abuse challenges among adolescents and the departments of Education, Health, Social Development, and South African Police Services were implementing substance abuse prevention programmes in his community (See Appendix 6 for the informed consent letter).

Enablers and barriers for recruitment of participants

Recruitment of study participants is one of the critical steps in a research journey. Various researchers had to overcome challenges regarding the recruitment of participants. Schwiesow (2010) highlighted the challenge of institutional gatekeepers who were not willing to approve the study especially if the study was regarded as controversial, which makes it difficult for the researcher to recruit participants. Schwiesow (2010) further recommended the following aspects for the recruitment of the study participants: building of relationships with people who will assist in gaining access; sending requests to the relevant officials in particular institutions; providing required documentation regarding the proposed study; considering the snowball sampling technique and alternative avenues such as sending the request via email, having face-to-face meetings or telephonic conversations; as well as persevering until approval is granted. Additionally, Oviedo-Joekes et al. (2015), in the SALOME study stated that recruitment experiences in a clinical trial offering injectable diacetylmorphine and hydromorphone for opioid dependency identified community engagement processes as well as establishing relations with agencies within the community as enablers for the recruitment of study participants.

Enablers for recruitment of participants in this study

In this study, the easy recruitment of participants in the Department of Education and Department of Social Development was aided by the fact that I was previously employed as an educator and Head of Department for Guidance and Counselling in a secondary school from 1993 to 2004. I was also a Life Orientation subject specialist from 2004 to 2009 at the Zeerust Area Project Office of the Department of Education in the North West Province. In addition, I served in the Local Drug Action Committee of the Ramotshere Moiloa Local Municipality as indicated earlier under personal reflections. Furthermore, regarding the traditional leader and healer, the process of recruitment was made easy by the fact that I was referred to them by the educators. Furthermore, in my interaction with them, I realised that they had a passion for substance abuse prevention programmes. In my telephonic discussion with them about the purpose of the study, they both told me about substance problems in their community. Further details about the substance abuse problems in their community are provided in Chapter 4.

Barriers for recruitment of participants in this study

Barriers for recruitment of participants in this study entailed my lack of understanding the protocols to be followed in the Department of Health and the South African Police Services, difficulty in obtaining the contact details of the officials relevant for receiving and approving research requests in the Department of Health and South African Police Services, and delays in obtaining feedback after submitting all the required research documents. Further, the unwillingness of some of the participants to take part in this study, and having to wait for more than a year before approval was granted to conduct the study, also served as barriers.

These barriers delayed the conclusion of this study. Mack, Woodsong, MacQueen, Guest, and Namey (2011) argued that if the recruitment strategy was not working as anticipated, qualitative research as an iterative process permitted the researcher to change the strategy as long as the proper approvals were obtained. In this study, certain strategies were followed to address the aforementioned challenges. Some of the study participants were requested to provide contact details of the officials responsible for substance abuse prevention programmes in those government departments. Follow-up emails and calls were made to the Department of Health and South African Police Service (SAPS) where approval was delayed as well as to some of the educators who were not willing to participate. Also, the purpose of the study and the importance of the information were explained.

With regard to parents who were not willing to participate, some of the educators provided the contact details of other parents whose children had substance abuse problems. Follow-up calls were made and meetings were set up with those parents in which I explained the purpose of the study and the importance of the information that would be obtained from them for the success of this study. I also explained that the results of the study would assist other parents encountering challenges relating to substance abuse by their children. However, despite follow-up emails and calls, I still encountered a challenge with the National Office of the South African Police Service where I was referred to for approval to conduct the study. Instead of delaying the completion of this study, I used public documents from the South African Police Service, which were freely and easily accessible on their website.

Several factors assisted me in obtaining rich data and addressing issues of triangulation. First, I demonstrated an understanding of the protocols to be followed in some of the government departments where approval of the study was delayed, Second, I obtained assistance from other participants about contact details. Third, I exercised patience in the recruitment of the participants who initially did not agree. Finally, I used available documents from the relevant department where there were delays in approving this study. The data and triangulation will be presented in detail later in this chapter under the section on trustworthiness and authenticity.

SELECTED PARTICIPANTS

In qualitative research, the objectives of the study determine which and how many people to select. The sampling methods used to select participants in qualitative research are purposive sampling, quota sampling, and snowball sampling. Purposive sampling of a group of participants is according to preselected criteria relevant to a particular research question (Anderson, 2010; De Vos et al., 2011; Patton, 2002). With quota sampling, the researcher determines how many people and with which characteristics to include as study participants. Characteristics may include age, gender, class, profession, marital status and place of residence.

According to Mack et al. (2011), the criteria selected allowed the researcher to focus on participants with experience, knowledge, or insights into the research topic. Patton (2002)

affirmed that study participants were selected because they were "information rich" and offered useful manifestations of the phenomenon of interest. Quota sampling involved the selection of predetermined characteristics of units of the sample used for the research (Marshall & Rossman, 2010). Application of quota sampling ensured that the sampled group represented certain characteristics of the population chosen by the researcher (Dudovskiy 2016). Snowball sampling is also known as a chain referral sampling. In this method, recruited participants used their social networks to refer the researcher to other people who could participate in or contribute to the study. In addition, snowball sampling was used to recruit participants not easily accessible to the researchers (Mack et al., 2011).

In this study, purposeful and snowball sampling were employed. Through purposive and snowball sampling, I managed to recruit 35 participants. The participants were 24 African male and female adolescents between 12 and 18 years of age in secondary schools in Zeerust who participated in substance abuse prevention programmes in the three years prior to conducting this study. Other participants recruited were four African educators, a social worker, a mental health nurse, a clinical psychologist, a traditional leader, a traditional healer, and two parents. These participants were between the ages 35 and 55. Corroborating with Anderson (2010), Curry, Nembhard and Bradley (2009), Patton, (2002) and Wyse (2011), the number of participants selected in this qualitative research was small and the adequacy of the study participants was determined by the principle of theoretical saturation. Theoretical saturation is a point at which no new concepts emerge from participants and documents analysed (Bowen, 2009; Morse, 2004; O'Reilly & Parker, 2013). In addition, the appropriate depth was reached and I was able to make sense out of the data obtained (Constantinou, Georgiou, & Perdikogianni, 2017).

Inclusion and exclusion criteria

Inclusion criteria for participants were based on the following: residing in a community in the Ramotshere Moiloa Municipality; participation in substance abuse prevention programmes as a learner in a secondary school, as a parent, educator, mental health nurse, psychologist, social worker, health worker, traditional leader, traditional healer or member of the Ramotshere Moiloa Municipality Local Drug Action Committee for the past three years; and willingness to participate in this study. Participation in this study was open to all eligible participants. However, for the adolescents, educators, social worker, mental health nurse, and

clinical psychologist, participation was subject to participants consenting to take part as well as obtaining permission from the department where they were employed or studying.. In addition, only adolescents attending school, and whose approval was attained from their parents as they were minors, were allowed to participate in this study. Adolescents who were not registered in any school during the time of the study were excluded.

Selection of documents

Documents reviewed in this study included:

- Devices to be used for Drug Testing and the Procedures to be followed (Department of Education, 2008)
- Ke Moja Integrated Strategy (Department of Social Development, 2003)
- Life Orientation Curriculum and Assessment Policy Statement (Department of Education, 2012)
- Liquor Act (2003)
- National Drug Master Plan (Department of Social Development, 2013)
- Policy framework for the management of drug abuse by learners in public schools and in Further Education and Training Institutions (Department of Education, 2002)
- Prevention of and Treatment for Substance Abuse Act (2008)
- Programme of Action (Department of Social Development, 2008)
- Rapid Participatory Assessment (2009)
- South African Schools Act (1996)
- The National Strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Education, 2013)
- Strategic Plan for the South African Police Service (2014)
- National Rural Safety Strategy (South African Police Services, 2010)
- South African Police Service annual report 2015/2016; tips for parents, caretakers or guardians of teenagers or young adults with substance abuse problems (South African Police Service, 2016)

The inclusion criteria for documents in this study entailed substance abuse prevention policies, programmes and plans involving, in part, a school-based intervention component. In addition, selection criteria allowed for policies, plans and programmes containing family-

based, community-based, media-based or other multifaceted components that were implemented by government and non-government organisations. In addition, these documents entailed reports from government and non-government organisations. Only substance abuse prevention policies and programmes targeting adolescents were selected. Furthermore, these documents provided data that were relevant to research questions of this study and were implemented in the community in which the study was conducted.

These documents were obtained from the websites of the departments of Basic Education, Health, Social Development, the South African Police Service, Department of Trade and Industry and the Unisa Library. Google search using key words such as *substance abuse prevention policies*, *programmes*, *reports*, and *strategies* were used. All documents analysed were freely available at the above institutions as well as on the internet. Therefore, there was no need to obtain approval to use those documents in line with the University of South Africa Policy on Research Ethics (2014) and views of Bowen (2009) regarding the analysis of documents as a qualitative research method. There were other documents available and which may have been relevant for this study. However, these documents were not considered, as the documents selected for inclusion seemed sufficient. The next section provides a discussion on the ethical considerations prior to collecting data. These include briefing sessions, voluntary participation, informed consent, protection of participants, as well as confidentiality and anonymity.

Briefing sessions

Before conducting interviews and focus groups, separate briefing sessions were conducted with two focus groups of learners, as well as parents, educators, a social worker, a nurse, a clinical psychologist, a traditional leader and a traditional healer who agreed to participate in the study. During these sessions, I explained the purpose of and procedures in this study. Furthermore, I provided details about dates and venues for the study. An attempt was made to address any queries or concerns that the participants had about the study (Segrott et al., 2014). Furthermore, in the interest of ensuring no harm to participants during the interview session, I briefed them and determined whether they required any assistance, counselling or explanations for questions asked during the course of the interview (Berg, 2009). Arrangements were made with the social worker of the area to assist participants in case they needed counselling or debriefing after the interviews. I also provided my contact details,

which enabled the participants to contact me at any time if they had any concerns or questions after completing the interview (Berg, 2009).

Voluntary participation

Participants were informed that participation in the study was voluntary and that they may withdraw from the study at any time if they wished to do so (Hennink et al., 2011; Segrott et al., 2014). However, the participants were informed that their participation was important for this study and that it would contribute to the development and implementation of effective and efficient substance abuse prevention programmes for adolescents.

Informed consent

Berg (2009), Brikci and Green (2007), Hennink et al. (2011), Segrott et al. (2014), and Spicker (2007) assert that informed consent should be obtained from participants before conducting the study. In this study, informed consent was obtained from the participants who were willing to participate in the study and doing so of their own choice. Informed consent was also obtained from the parents of the adolescents participating in this study because they were minors. The participants were afforded an opportunity to ask questions. The consent to participate in this study was ensured in writing (See Appendix 6 and Appendix 7). Informed consent slips were signed by adolescents participating in this study and their parents, other parents participating in this study, as well as the educators, social worker, nurse, clinical psychologist, traditional leader, and the traditional healer participating in this study.

Signed informed consent slips provided a means by which to monitor the voluntary participation of participants should the need arise. However, obtaining informed consent in writing presented a slight ethical dilemma. A written record of the participants' names meant that a formal record of participants' details existed. In order to preserve privacy, these slips would be revealed only if questions arise concerning ethical practices in this study. After completion of this study, these consent slips would be destroyed (Berg, 2009).

Protection of participants

As advised by Creswell (2014) and Hennink et.al.(2011), participants in this study were protected from any harm during this study. Participants were also notified that there were no known medical risks for participating in this study. As mentioned in the preceding section, participants were informed that arrangements were made with the area's social worker to assist them in case they needed counselling or debriefing after the interview session. When initiating contact by telephone with participants, I took care not to reveal details of the study participants if they were not available or if a voice message had to be left.

Confidentiality and anonymity

In conformity with Berg (2009), Hennink et al. (2011) as well as Liamputtong and Ezzy, (2005) the participants were assured that all the information obtained would be treated as confidential, used for the stated purposes, and would not be accessed by anyone else. The participants were informed that pseudonyms instead of their names would be used for all the interview transcripts. The participants were also informed that when the findings of the study are discussed, the learners would be identified as adolescents, the parents as parents, and all other participants as professionals (Brikci & Green, 2007; Hennink et al., 2011; Protection of Personal Information Act, 2013).

In addition, data were anonymised. Participants were informed that the research information obtained would be reported anonymously so that participants could not be identified in any of the research data and reports (Brikci & Green, 2007; Hennink et al., 2011). The participants were also guaranteed that if their anonymity were to be threatened, all the records would be destroyed. These guarantees were given to avoid biased responses from participants.

All participants were requested to sign a statement of confidentiality confirming that they would not disclose any information obtained during the course of the study (Berg, 2009). See appendices 8 and 9 for details about a Statement of Confidentiality and Group Agreement for Maintaining Confidentiality. The use of these documents allowed participants to think about issues of confidentiality. In addition, these documents provided participants an opportunity to withdraw if they were fearful about confidentiality and not ready to keep the research information confidential. Furthermore, this was done in order to avoid research data being compromised. Immediately after discussion of the above ethical issues with the participants,

individual and focus group discussions were conducted. The next section provides a discussion on the data collection processes in this study.

DATA COLLECTION

The qualitative research methods included face-to-face interviews, focus group discussions, and document review (Berg, 2009). Interviews were optimal for collecting data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics were explored. Focus groups were effective in eliciting data on the cultural norms of a group and in generating broad overviews of issues of concern to the cultural groups or subgroups represented. The format of questions was open-ended and participant responses affected how and which questions researchers asked next (Patton, 2002). In this section, a discussion about unstructured interviews, focus groups, and document reviews employed in this study is provided.

Unstructured interviews

Berg (2009), Hennink et al. (2011), Marshall and Rossman (1995), Mouton (2001), and Woods (2006) identified three main types of unstructured interviews; which are open-ended interviews, unstructured interviews with a guide or schedule, and in-depth interviews. For the purpose of this study, unstructured interviews with an interview guide were considered. The main purpose of the interview guide was to direct the discussions during interviews with study participants. I developed the interview guide and it was informed by the aim and objectives of this study, questions asked in this study, literature reviewed on important aspects to consider when developing questions, and previous studies (See Appendix 10).

The rules for asking questions were considered, namely, asking questions in a clear and neutral way, avoiding double-barrelled questions, and using everyday vocabulary to ask open-ended questions requiring more than yes or no answers. These questions were discussed with my supervisor, two other doctoral supervisors and a qualitative research consultant. The purpose was to check the relevance of the questions, the suitability of the questions for the study, whether the questions would provide the data required for the study, and to ensure easy comprehension by participants (Brikci & Green, 2007; Nichter et al., 2004). Demographic

questions, essential questions pertaining to the study, probing questions, and validating questions were posed.

Demographic questions included information about age, family, education, employment status and background information about Zeerust town. The rationale for demographic questions was to capture demographic details for this study and to allow me and the participants to develop a degree of rapport before more serious and important questions regarding the study were asked. In addition, it fostered a degree of commitment on the part of participants since they had already invested some time in the interview session by answering easy to answer questions (Berg, 2009; Hennink et al., 2011). Demographic questions were also used to calm the participants and make them feel at ease. Essential questions concerning the focus of the study were also posed. These questions were aimed at eliciting desired information about the research question. The questions in Table 1 below are essential questions that were asked to adolescents, the educator, parents, social worker, mental health nurse, clinical psychologist, traditional leader and traditional healer. These questions were also considered as I analysed documents in this study.

Table 1: Questions asked during individual and focus group discussions

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Demographic questions

- *Could you please tell me a little bit about yourself and what it is that you do?*
- *Not everybody is familiar with the town Zeerust., May you please tell me something about it?*
- *What is it like to live here?*
- *What is it like to grow up here?*

Essential questions concerning the focus of this study

- *Tell me more about teenagers living in Zeerust. How do their lives differ from teenagers growing up in Johannesburg?*
- *Is substance abuse in your opinion widely used and abused by them?*
- *Which substances are abused among adolescents?*
- *What do you think are reasons for them to use or abuse substances?*
- *Are there any substance abuse prevention programmes implemented in Zeerust? If*

yes, name the programmes.

- *May you please tell me a little bit more about the programmes?*
- *Who are programmes aimed at?*
- *What are the main activities of those programmes?*
- *Do adolescents seem to respond well to programmes?*
- *Were you involved in the development of those programmes?*
- *If no, who developed those programmes?*
- *How were those prevention programmes implemented?*
- *Were you trained before implementing those programmes?*
- *After implementation of programmes, did you participate in their evaluation process?*
- *In your opinion, do you think these programmes are enough to prevent substance abuse? Or could more be done to prevent substance abuse among adolescents?*
- *In your opinion, who do you think can be the main stakeholders for the development and implementation of those substance abuse prevention programmes?*
- *If you were to develop a substance abuse prevention programme, what aspects or activities do you think would be important to include?*
- *Why would you include such activities or aspects?*
- *How can adolescents be encouraged to get involved in the development of substance abuse prevention programmes?*
- *Should parents or guardians be involved in substance abuse prevention programmes? If yes, why should they be involved? If no, why must they not be involved?*
- *How can parents be involved in substance abuse prevention programmes?*
- *Who else in the community could get involved in substance abuse prevention programmes?*
- *Is there anything you think we have not discussed thus far which you think I need to know?*

The schedule or interview guide provided me with guidelines for interviews and contained questions that were important to the study. Exclusion or wording of particular interview questions was done as and when required during data collection. Furthermore, the responses of participants affected how and which questions were asked next. During individual and focus group discussions, responses obtained from participants enabled me to ask follow-up

questions from those responses. This made it possible for me to draw more complete stories from participants (Berg, 2009; Hennink et al., 2011). It also enabled me to obtain data on unexpected dimensions regarding substance abuse prevention programmes (Bogdan & Biklen, 1992). When I realised that participants provided responses to other questions in the interview guide, I did not ask such questions because responses were already provided.

Research questions were adjusted according to what was learned (Anderson, 2010; Curry et al., 2009; Locke, Silverman, & Spirduso, 2010; Mack et al., 2011; Patton, 2001). By using unstructured interviews, I was able to obtain views of participants about substance abuse prevention programmes (Patton, 2001). These questions allowed me to identify key programme content and processes, and explore implementation, context and completeness of programme delivery. The questions also enabled me to examine the participation and reach of substance abuse prevention programmes implemented. Furthermore, I established the knowledge of adolescents, educators, the health nurse, the clinical psychologist, parents, the social worker, the traditional healer and the traditional leader regarding substance abuse prevention programmes in the study. Moreover, I figured out the reception and response to these programmes by all participants (Segrott et al., 2014).

Setting of individual face-to-face interviews and focus group discussions

Previous scholars argued that qualitative research occurred in the natural settings of participants (Creswell, 2014; Curry et al., 2009; Patton, 2002; Wyse, 2011). Consistent with these scholars, data in this study were obtained in natural settings of participants and at times convenient to them. Preferences of participants in terms of when and where to be interviewed were considered; while at the same time ensuring that research questions were addressed. Individual and focus group discussions took place as follows:

Interviews with educators: Individual face-to-face interviews with four educators took place at their homes in Wilbedacht on their request. This is a location about 12 kilometres from Zeerust town and one of the former locations that were established during the Bophuthatswana era.

Interviews with the mental health nurse and clinical psychologist: An individual face-to-face interview with the mental health nurse was conducted after working hours at his home in

Zeerust town; while the individual face-to-face interview with the clinical psychologist was conducted at her office at the Department of Health in Zeerust town. The Department of Health in Zeerust town provided health services to all the areas within the Ramotshere Moiloa Local Municipality (Department of Health, 2016; Ramotshere Moiloa Local Municipality, 2014).

Interviews with parents: Individual face-to-face interviews with the parents were conducted at their homes in Dinokana after working hours.

Interview with the social worker: The face-to-face interview with the social worker was conducted in her office at the Department of Social Development in Zeerust town. The Department of Social Development in Zeerust falls under the authority of the Department of Social Development in the North West Province of South Africa. The office serves all the areas within the Ramotshere Moiloa Municipality (Department of Social Development, 2016; Ramotshere Moiloa Reviewed Integrated Development Plan, 2013).

Interviews with the traditional healer and traditional leader: The traditional healer and traditional leader preferred to be interviewed at their homes in Dinokana in the morning. They were only available at that time; as they were busy with their clients during the day and in the afternoon. Dinokana is about 29 kilometres from Zeerust town, and 30 kilometres from Dinokana to Lobatsi, a border gate towards Botswana.

Individual interviews with two adolescents: Separate face-to-face individual interviews with two learners who were referred for rehabilitation took place at school B immediately after school hours to respect teaching and learning time. The school was not far from their homes. All individual interviews were conducted in both Setswana and English and took two hours each. Where participants did not understand questions, a Setswana translation was provided.

Focus group discussions with adolescents: Two focus group discussions with learners were conducted in two secondary schools situated in Dinokana, one of the rural villages in the Ramotshere Moiloa Municipality. These schools were convenient and not far from where participants stay. Focus groups were conducted after school hours in order to respect learning and teaching time. Focus groups were conducted in school A with seven learners and in school B, with fifteen learners. Rabie (2004) cited in Nyumba, Wilson, Derrick, and

Mukherjee (2018) recommended that researchers may over recruit by 10-25%. This is to overcome a lack of guarantee that all the participants recruited will attend the focus group discussion. These schools were managed by the Zeerust Area Project Office in the Department of Basic Education in the North West Province of South Africa. The schools were close to the N4 highway leading to Lobatsi, which was one of the border gates into Botswana. The two schools were public schools from Grades 7 to 12. All the learners, educators, and School Management Teams (SMTs) were of African descent and Setswana was the first language in both schools. SMTs and educators were appointed by the Department of Basic Education in the North West Province of South Africa (Department of Basic Education, 2014).

These schools were also supported and managed by School Governing Bodies (SGBs) consisting of the parent component, teacher component, and a member of the Learner Representative Council (LRC). These schools were classified as no-fee schools. According to the South African Schools Act (1996), Chapter 4 on the funding of public schools, these two schools fall under Section 21 and therefore parents are exempted from paying school fees due to the fact that a majority of these parents are unemployed or because those employed earn a lower income as per the guidelines provided in the Norms and Standards for funding of Schools. According to these guidelines, a parent whose income was ten times lower than the annual school fees was exempted from paying school fees. Thus, a majority of learners attending these schools were exempted from paying school fees. The Department of Basic Education provided financial support to these schools and also required the SGB to raise additional funds through donations or sponsorships (Department of Basic Education, 2016).

Focus group members were familiar with one another because they were members of the Teenagers Against Drug Abuse (TADA) and participating in substance abuse prevention initiatives in their schools as well as the community settings. They also shared certain characteristics relevant to the study's question (Marshall & Rossman, 2011). Focus group discussion sessions lasted for three hours. Focus group discussions were appropriate because the goal of this study was to explore perceptions regarding substance abuse prevention programmes implemented in the Ramotshere Moiloa Municipality among adolescents. The focus groups were effective, as participants were from a socially marginalised population. These participants were socially marginalised due to both individual and environmental factors (Berk, 2007; Mokwena, 2015; Seggie, 2012). Individual factors included aspects such

as the developmental stage of adolescence which brought challenges such as identity confusion, low self-esteem, and exposure to risk factors such as substance abuse and violence (Griffin & Botvin, 2011; Li et al., 2013; Pressly & McCormick, 2007; United Nations Office on Drugs and Crime, 2015).

Environmental factors included aspects such as poverty, unemployment, poor living conditions, and a low socio-economic position of their families (Statistics South Africa, 2011). In addition, environmental factors included fear of rejection by peer groups as a result of not conforming to group norms, racial discrimination, attending inferior schools, inadequate services, limited access to social support services available within their rural community, as well as other youth services that were available in urban areas (Bonner, 2007). Furthermore, focus group discussions facilitated comfort among participants since the substance abuse prevention topic was a sensitive and intimate topic. In addition, focus group discussions relied on interactions among group members to widen the range of responses, activate forgotten details of individual experiences, or release inhibitions that otherwise discouraged participants from disclosing information (Romm, 2015).

The strength of the focus group discussions was that since it was socially oriented, it enabled me to conduct this study in an atmosphere that was more natural and relaxed than a one-to-one interview. The focus group was useful in gaining access, focussing site selection, and for even checking tentative conclusions (Marshall & Rossman, 2011). As with other types of interviews, focus group discussions allowed me the flexibility to explore unanticipated issues as they arose in the discussions (Berg, 2009). Results were dependable because the method was readily understood. Furthermore, the cost of the focus group discussions was relatively low. Focus groups provided quick results, and they increased the number of participants in this qualitative study by permitting more adolescents to be interviewed at one time (Berg, 2009; Krueger & Casey, 2008).

Focus groups were useful in exploring perceptions regarding substance abuse prevention programmes. In addition, adolescents in two focus groups identified substance abuse prevention programmes that were implemented for adolescents in the Ramotshere Moiloa Municipality. They indicated the mode of delivery of these programmes, identified challenges encountered in implementing these programmes, and provided input on how these programmes might be improved to address substance abuse problems among adolescents.

The interview guide consisting of research questions mentioned in the previous section on interviews was used to stimulate a discussion on substance abuse prevention programmes that were implemented for adolescents in Ramotshere Moiloa Local Municipality.

As the interviewer, I was guiding the discussion while permitting free exchange of views and ensuring that participants felt comfortable in expressing different views. I ensured that the group composition did not inhibit members from speaking, so that the discussion generated comprehensive information that reflected the full spectrum of opinions and experiences. In addition, I ensured that all members had an opportunity to share their views during the discussion. Prompts such as *let me hear from you* were used to ensure that all members of the focus group shared their views. During the course of the focus group, I took copious notes (Berg, 2009). These notes provided a complete record of the discussion that unfolded during the focus group discussions and assisted in data analysis that is presented later in this chapter.

I acknowledged some of the challenges that I experienced with the focus groups. The quality of the data was deeply influenced by my skills as the facilitator to encourage reserved participants to share their views during the discussions. This was done by using sentences and phrases such as *let us hear from you;* or *any additional information* during my interaction with focus group members (Berg, 2009; Marshall & Rossman, 2011). However, dominant personalities tended to overpower and steer the group's responses. I intervened and ensured that all participants expressed their views. As noted earlier in this section, primary ethical issues that arose in conducting focus group discussions were centred on the dynamics of power and influence that played out during focus group discussions (Marshall & Rossman, 2011). Berg (2009) argued that the length of the focus group discussion has to be brief; that is 60 minutes. However in this study, this was dependent on my interaction with the focus group members. The discussions were not brief. The focus group discussions lasted for three hours and were conducted in both Setswana and English. Setswana was used to clarify questions that participants did not understand and participants were allowed to respond in both English and Setswana.

After individual and focus group discussions, I summarised the main points of the interview, clarified inconsistencies and allowed feedback from the participants. This was done during the interviews through clarity seeking questions to confirm answers obtained from the participants. In addition, interview transcripts were discussed with the participants during

follow-up sessions so that they could verify if correct responses were captured. This was done to ensure that responses captured were a true reflection of responses provided by participants and to avoid reporting incorrect information. I closed off the sessions by thanking the participants for taking part in the interview and informing them that their contribution had assisted the investigation. After each interview I took 15 minute intervals to check whether the digital recorder was working properly and to note data discussed with the participants. Preparing notes immediately after each interview session enabled me to recall a great deal of information discussed with participants (Liamputtong & Ezzy, 2005). In addition, these notes helped me to remember and explore the process of the interviews (De Vos et al., 2002).

Through interviews I managed to get background information about the participants. I followed up immediately when something was omitted or to clarify something. This assisted me in discovering complex interconnections in social relationships (FluidSurveys, 2014; Greenfield, 2002; Nardi, 2016). I was aware of the disadvantages of the interviews, namely that they were open to misinterpretation and difficult to replicate. Interview procedures were not explicit and were dependent on the researcher's characteristics and on the honesty of those providing data (Greenfield, 2002). I overcame these weaknesses of interviews by asking questions where clarity was required during the interview sessions. For the sake of credibility, data were kept safely in the event of possible queries at a later stage. Also, the data were triangulated through the use of multiple data sources, multiple methods, and data analysis. The reliability of the data will be discussed later in this chapter. The next section provides a discussion on how data analysis occurred.

DATA ANALYSIS

Document review

As defined in Chapter 1, document review is a systematic procedure for reviewing or evaluating primary and secondary documents in an electronic or printed format. Like other analytical methods in qualitative research, document review required that data be examined and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge (Bowen, 2009; Buckland, 2013; Evans, 2012; Mogalakwe, 2006; Perry et al., 2016). The following questions, as adapted from Evans (2012), were considered when reviewing documents: *Who wrote the document? Who was the intended audience? What is*

the story line? What was its purpose? Was the document credible? What can we learn from the document?, What does it mean for the research question? These questions and qualitative criteria were considered in order to ensure that the documents provided data required for the research question, while at the same time maximising the trustworthiness of data obtained from these documents.

As proposed by Evans (2012), the following steps were considered in reviewing documents: I read background information about these documents, scanned entire documents, reviewed documents focussing on research questions of the study, and compiled a summary of each document focussing on research questions of this study. Research questions assisted me to stay focussed as I engaged with documents and did not lose track of the aim of the study. Thus, in line with Schreirer (2012), document review in this study was limited to those aspects that were relevant to the research question. In addition, the focus in these documents was on how adolescent substance abuse prevention was considered, gaps identified, and recommendations made regarding the implementation of substance abuse prevention programmes.

Documents as methods of obtaining study data were employed in studies such as those by Burden and Roodt (2007), Cho and Lee (2014), and Perry et al. (2016). Data obtained from analysed documents provided background information and historical insight in the context within which the study was conducted. In addition, reviewed documents provided a clearer explanation about some of the responses provided by participants. Furthermore, previous studies used documents to gather data about events that could no longer be observed or when informants forgot details and to verify findings (Angrosino & Mays de Pérez, 2000). In this study, documents reviewed were aimed at complementing, validating, and corroborating data obtained from individual and focus group discussions (Bowen, 2009; Onwuegbuzie, Leech, & Collins, 2012).

Analysis of interview data

Various methods are employed to analyse qualitative data that includes, among others, content analysis, grounded analysis, thematic data analysis, social network analysis, discourse analysis, conversation analysis, and narrative analysis (Aronson, 1994; Attride-Stirling, 2001; Braun & Clarke, 2006; Brikci & Green, 2007; Cho & Lee, 2014; Creswell, 2014; Hennink et

al., 2011; Marshall & Rossman, 2011). Furthermore, the following computer software might be used to analyse qualitative data: ATLAS.ti; Cassandre, CATMA, Compendium, Computer Aided Textual Mark-up and Analysis, ELAN, NUD*IST, and NVivo. Researchers reported using computer software to support three phases of the research process, namely data collection or creation, data analysis or management, and data display or representation of findings (Anderson, 2010; Wikipedia, 2016; Wood, Paulus, Atkins & Macklin, 2015). Since face-to-face individual interviews, focus groups, and document reviews were employed in this study, thematic content analysis was appropriate for analysing interview data. Works of Aronson (1994), Attride-Stirling (2001), Braun and Clarke (2006), Brikci and Green (2007), Cho and Lee (2014), Hennink et al. (2011), Marshall and Rossman (2011), Mosimege (2006), and Segrott et al. (2014) were used to assist in analysing the data.

Thematic analysis enabled me to identify, analyse, and report patterns and themes within the data. I analysed the data in a systematic way. First, audiotapes of individual interviews and focus group discussions were transcribed verbatim. I transcribed the tapes with the assistance of a transcription specialist. Through the assistance of a transcription specialist, I had a better understanding of the data (Berg, 2009; Segrott et al., 2014). Second, I checked the transcripts against the original audiotapes for accuracy (Braun & Clark, 2006). Third, I ensured that all data collected were complete, and that no parts of detailed field notes were left out. Finally, after checking the quality of the data and filling in any missing gaps, I made copies of all data collected.

In order to manage the data obtained from the participants, the interview transcripts were numbered as follows:

- Transcript number 1 for focus group number 1 (Participants 1 to 7);
- Transcript 2 for focus group number 2 (Participants 8 to 22);
- Transcript number 3 to 4 for individual interviews with two learners who were referred for substance abuse rehabilitation (Participants 23 to 24);
- Transcript 5 to 8 for individual interviews with the four educators (Participants 25 to 28);
- Transcript number 9, for individual interview with the social worker (Participant 29);
- Transcript number 10, for individual interview with the traditional healer, (Participant 30);

- Transcript number 11, for individual interview with the traditional leader (Participant 31);

- Transcript number 12, for individual interview with the clinical psychologist (Participant 32);

- Transcipt number 13, for individual interview with the mental health nurse (Participant 33),

- Transcripts numbers 14 to 15, for individual interviews with parents (Participants 34 to-35).

With regard to the documents analysed, the names of documents instead of numbers were used to identify documents from which summaries were drawn. However, to protect participants and to enable me to identify data obtained from them, transcripts were numbered. This assisted me a lot when I presented the results of this study, as I was able to easily locate where information was collected from these data sources.

Transcripts and summaries of documents were analysed one by one. Data were entered into one of the several software programmes for the management and analysis of qualitative data (Bryman & Burghess, 1999). For the purpose of this study, the NUD*IST programme was used. The programme works with textual documents and facilitates indexing of components of these documents. This enabled me to search for words and phrases very quickly (Willig, 2009). In addition, the use of the NUD*IST programme made it easy for me to analyse data and saved time (Berg, 2009).

Data were coded inductively and deductively (Cho & Lee, 2014; Hennink et al., 2011). Inductive codes were developed by reading the data to become familiar with it and extracting issues that arose from all transcripts and from the summaries of documents analysed. Deductive codes were developed by using questions posed in the interview guide. Coding was done by writing notes on transcripts and summaries of documents analysed using different markers to identify segments of the data (Braun & Clark, 2006). The most salient constructs in summaries of documents were reviewed. Transcripts were identified and shaped into a finite set of codes that were discrete enough to avoid redundancy and global enough to be meaningful. An inclusion criterion for codes was that they had to be relevant to the research question, useful for this study, and raised repeatedly in interview transcripts and

summaries of documents analysed. In addition, in vivo codes from transcripts and documents analysed were also included. Code development stopped when no other issue emerged from the data and when I was satisfied that the process of data collection and analysis was complete (Bowen, 2009; Hennink et al., 2011).

Codes that were relevant to the research question were highlighted and then recorded in a journal. These codes were clustered as per the research question. Later on, they were moved to one table. The table consisted of two columns which identified global and organising themes and interview extracts, which served as basic themes supporting organising themes. These themes were presented in a diagram. Diagrams and discussions on global and organising themes are provided in Chapter 4 under thematic data analysis. When writing up the report, only themes that made a meaningful contribution to answering the research question and subquestions were included. In addition, organising themes were used as topics that responded to research questions in this study.

These themes were supported by extracts of statements from both participants and documents analysed to support views and arguments presented. The research questions guided the analysis in this study. In order to increase dependability, a dialogue regarding each theme was presented through a rich description of results. Thus, the report contained enough evidence that themes within the data were relevant and included a narrative to capture the full meaning of points in the analysis. This was in support of the research question. I received assistance from a co-coder to help analyse data as it seemed that when more than one person analyses data, important insights can emerge from the different ways in which two people look at the same set of data. This is a form of analytical triangulation (See Appendix 11 for the co-coder certificate). I presented all sets of data analysed to the expert in co-coding. The co-coder assisted with the development and naming of global themes, organising themes, and basic themes. Therefore, providing quality assurance on data analysis processes followed. The study by Cho and Lee (2014) affirmed the importance of using experts in data analysis.

Advantages and disadvantages of thematic analysis

The following advantages and disadvantages of thematic analysis were noted:

Advantages: Thematic analysis was easy to learn and apply in this study (Braun & Clark, 2006). It enabled me to extract basic themes and develop organising and global themes. It also helped me to highlight similarities and differences across the data set. Furthermore, it generated unanticipated insights. The method allowed for social and psychological interpretations of data (Braun & Clark, 2006).

Disadvantages: After data analysis, I had many interview quotes which were relevant for research questions and discussions of the findings in this study. It was difficult to decide which interview quotes to use in discussions. Keeping in mind that large portions of interview quotes were not necessary and might be tedious for readers, I selected the quotes that were representative of research findings (Anderson, 2010). In addition, I ensured that quotes selected represented the views of adolescents, parents and professionals who participated in this study.

As mentioned in the preceding section, data were kept safely in the event of queries at a later date. Electronic data about participants and summaries of documents analysed were protected by a password. Paper records such as informed consent forms and notes taken during interviews were secured in a locked cabinet at home. For back-up purposes, I scanned them and saved electronic versions of the transcripts. I also ensured that I did not travel within research sites with identifiable information and research records. Participants were assured that data obtained from them would not be disclosed to any criminal, legislative, or other proceedings (Centers for Disease Control and Prevention, 2017). Furthermore, precautions were undertaken to ensure that research-related information was not carelessly discussed. At the end of the process, all documents will be shredded (Berg, 2009; Walliman, 2006). In addition, as mentioned in the previous section, data will only be destroyed after completion of the degree and publication. The next section provides a discussion on trustworthiness and authenticity of findings.

TRUSTWORTHINESS AND AUTHENTICITY

Various scholars contended that trustworthiness and credibility of study findings were attained through audit trails, negative case analysis, triangulation of data sources, prolonged engagement with informants, sharing with participants their individual interview transcripts, emerging concepts, categories, and having peers review the process (Brikci & Green, 2007;

Cho & Lee, 2014; Marshall & Rossman, 2011; Nichter et al, 2004; Onwuegbuzie et al., 2012; Patton, 2015; Roller, 2014; Sutton & Austin 2015; Tonkin-Crine, et al., 2016). In this study, the following techniques, adapted from Brikci and Green (2007), Creswell (1997), Cho and Lee (2014), Lincoln and Guba (1994), Maxwell, (2013), Segrott et al. (2014), Wesley (2010), and Willig (2009) were employed to ensure that the qualitative data obtained and subsequent data analysis were dependable and credible. A detailed account of the focus of the study, researcher's role, position of respondents, basis for selection, and the context from which data were collected are provided later in the research report.

Triangulation of data using multiple data sources such as individual face-to-face interviews, focus group discussions, and document analysis was considered. The rationale for using multiple sources of data was to corroborate, elaborate or illuminate the research in question (Brikci & Green, 2007; Cho & Lee, 2014; Marshall & Rossman, 2011; Onwuegbuzie et al., 2012; Patton, 2015; Roller, 2014; Tonkin-Crine et al. 2016). This might strengthen the study's usefulness in other settings.

Rich, thick, detailed descriptions: Data collected were presented in the form of short quotations from study participants and summaries of documents analysed. These types of data, known as low-inference data, may allow the reader to determine whether the investigator's interpretations were true to the content and the intent of the data. In addition, they may enable anyone interested in transferability to have a solid framework for comparison.

Member checks: After each interview, member checks were completed by sharing summaries of responses provided by participants. This was done in order to confirm responses captured during individual interviews and focus group discussions. In addition, transcripts of interviews were shared with participants during data verification sessions. Sharing transcripts provided participants an opportunity to provide additional information that was missing from data presented to them (Cho & Lee, 2014; Nichter et al., 2004). Participants were afforded an opportunity to reflect on their views, feelings, and experiences. As indicated earlier, this lessened the risk of participants reporting at a later stage that I misunderstood their contributions or claiming investigative error. Member checks were not without fault, but served to decrease the incidence of incorrect data and the incorrect

interpretation of data (Barbour, 2001; Brikci & Green, 2007; Bygstad & Munkvold, 2007; Maxwell, 2013).

The overall goal of this process was to provide findings that were authentic and original (Bowen, 2009). Data collection and data analysis strategies were reported in detail to provide a clear and accurate picture of the methods used in this study.

Clarification of researcher bias: In the preceding section of this chapter, researcher bias was articulated under the heading "The researcher's role". Engagements and discussions with peers, the doctoral supervisor, two other doctoral supervisors, the qualitative research consultant, the qualitative data analyst, the institutional research integrity manager, and a colleague serving as an institutional researcher experienced in qualitative research methods served as peer examiners of this study before it was finally submitted to external examiners.

In addition, an institutional research integrity manager assisted with ethical considerations for documents analysed and confirmed that ethical considerations included were relevant for this study. Furthermore, one of the institutional research specialists assisted in providing clarity that I was correct by not forcing some of the parents who were not willing to participate in the research. In this regard, participation in the research was voluntary and I had to respect their views. Two additional doctoral supervisors provided advice on the research questions and research method employed in this study. The qualitative research specialist assisted with the compilation of research questions to ensure that rich data were obtained from study participants. Furthermore, she encouraged me to consider including other participants relevant for this study who were initially included in this study, but refused to participate. In addition, she provided advice on the use of qualitative language and concepts throughout this study. The other qualitative data analyst was employed to assist with thematic data analysis, co-coding of the transcripts, and presentation of the findings of this study. As advised by Sutton and Austin (2015), I had a discussion with the co-coder on the resulting sets of codes. This discussion resulted in the revision of the themes that I had initially developed (See Appendix 11 for the co-coder certificate).

My supervisor provided expert input throughout the phases of this study by providing other doctoral research dissertations and research articles for reference purposes. He also referred me to two qualitative research specialists to assist with the study as indicated in the preceding

paragraph. Furthermore, my supervisor encouraged me to consider following up on participants who initially were not willing to participate. In addition, he encouraged me to share my work with other supervisors for their expert input before the study was finally submitted for examination. Trustworthiness of the findings was achieved by providing the supervisor, two doctoral supervisors and qualitative research consultants access to the data. They were also allowed to extract some quotes from the interview transcripts and summaries of the documents analysed (Wesley, 2010). The findings of this study were presented in 2017 for peer review to the South African Community Epidemiology Network on Drug Use, Pretoria Regional Meeting, 8th International Conference on Social Sciences, organised by the North West University and the Social Sciences Research Society, as well as the Southern African Students' Psychology Conference hosted by the University of South Africa.

CONCLUSION

In this chapter, social constructivism and a qualitative research approach were outlined. The research framework for implementing this study was provided to ensure that procedures for a qualitative research approach were adhered to. Personal and professional reflections on my role as a researcher were provided. Challenges encountered in recruiting participants were identified and strategies devised to resolve them. Ethical considerations were adhered to throughout the phases of this study. Thematic analysis was employed to analyse data; its advantages and disadvantages were acknowledged. In addition, techniques were adapted from various scholars to establish this study's trustworthiness. The following chapter provides a discussion of this study's findings.

The worst thing that contemporary qualitative research can imply is that, in this post-modern age, anything goes. The trick is to produce intelligent, disciplined work on the very edge of the abyss. –David Silverman

CHAPTER 4
FINDINGS AND DISCUSSIONS

INTRODUCTION

Chapter 3 provided discussions on the research methodology and research design. In this chapter, I report on the findings and provide discussions of the data collected through individual interviews, focus groups, and document analysis. I introduce participants and provide global and organising themes obtained from these data sources. Participants are introduced by providing summaries of their contexts. These summaries serve as a point of reference when reading quotes extracted from interview transcripts. The experiences and meanings of participants in relation to substance abuse prevention programmes implemented in the Ramotshere Moiloa Municipality are "represented in ways that economically and faithfully capture the common and idiosyncratic themes in the interview data" (Sandelowski, 1988 cited in Livingston, 2014, p 184). Before doing that, it is worth acknowledging three aspects.

First, for ease of reference, participants in this study are referred to as adolescents, which refers to all the learners who participated in the individual and focus groups interviews in this study.

Parents are referred to as parents given their role in the development of adolescents. The other participants, namely the educators, social worker, mental health care workers, traditional healer, and traditional leader are referred to as professionals, given their specific roles in the community in which the study was conducted. Furthermore, pseudonyms are utilised in order to protect participants' real identities (Brikci & Green, 2007; Hennink et al., 2011; Protection of Personal Information Act, 2013). Second, noting that the study was conducted between September 2014 and January 2017, participants are presented as they were by the time data were collected. Finally, presentation of themes is informed by research questions, issues arising from the data obtained from participants, documents analysed, previous studies, advice from other scholars, and my own interpretation, knowledge and experience (Bayliss et al., 2016; Creswell, 2014).

The description of the participants

Thirty-five Black participants were interviewed from September 2014 to January 2017. As indicated in Chapter 3, six professionals and two parents were interviewed at their private residences. The other three professionals were interviewed at their workplace, and 24 adolescents were interviewed at administration offices in their schools. Pseudonyms were used for participants in order to protect their identity and privacy.

Table 2: Biographical information of participants

Participant	Cultural heritage	Family structure	Gender	Developmental stage	Education	Employment status
Adolescents						
Rorisang, adolescent from rehabilitation	Bahurutshe tribe	Extended family	Male	18	Grade 11	Learner in a public school; mother is employed as a domestic worker in Randburg
Modise	Bahurutshe tribe	Nuclear family	Male	17	Grade 11	Learner in a public school, staying with both parents; the mother is employed as a domestic worker and the father is unemployed.
Tshepang	Bahurutshe tribe	Nuclear family	Male	17	Grade 11	Learner in a public school; the mother is unemployed, while the father is employed at a mine in Gauteng.
Kamogelo	Bahurutshe tribe	Nuclear family	Male	17	Grade 11	Learner in a public school; the mother is employed as a domestic worker in Wilbedacht and the father is employed as a public servant in the Department of Public Works in Wilbedacht.
Oarabile,	Bahurutshe	Nuclear family	Male	16	Grade 11	Learner in a public school; mother is

adolescent from rehabilitation	tribe					employed as a domestic worker in Wilbedacht.
Thabo	Bahurutshe tribe	Nuclear family	Male	16	Grade 11	Learner in a public school, staying with both parents employed in retail stores in Zeerust.
Tebogo	Bahurutshe tribe	Single parent	Male	16	Grade 11	Learner in a public school, staying with the mother only; mother employed as a cleaner in one of the government departments.
Nthabiseng	Bahurutshe tribe	Single parent	Female	16	Grade 10	Learner in a public school; mother employed as domestic worker in Zeerust.
Tshimologo	Bahurutshe tribe	Nuclear family	Female	15	Grade 10	Learner; mother employed in a retail store.
Keabetswe	Bahurutshe tribe	Nuclear family	Female	16	Grade 10	Learner in a public school; mother is a domestic worker in Wilbedacht, while the father is employed at a chicken farm in Zeerust.
Tsholofelo	Bahurutshe tribe	Nuclear family	Female	16	Grade 10	Learner in a public school; only the father is employed in one of the retail stores in Zeerust.

Tshiamo	Bahurutshe tribe	Nuclear family	Male	16	Grade 10	Learner in a public school; mother is employed as a cleaner at the police station, while the father is employed at a mine in Gauteng.
Gomolemo	Bahurutshe tribe	Nuclear family	Female	15	Grade 9	Learner in a public school; father is employed at a mine
Lebogang	Bahurutshe tribe	Nuclear family	Female	15	Grade 9	Learner in a public school; the mother is employed in one of the retail stores in Zeerust and the father is employed at a mine in Zeerust.
Lesego	Bahurutshe tribe	Nuclear family	Female	15	Grade 9	Learner in a public school; the mother is employed in a retail store in Zeerust and the father is employed as a security officer in Zeerust.
Mosidi	Bahurutshe tribe	Nuclear family	Female	14	Grade 9	Learner in a public school; both parents are employed in one of the factories in Gauteng.
Reoikantse	Bahurutshe tribe	Single parent	Female	14	Grade 9	Learner in a public school; mother is employed as a domestic worker in Wilbedacht.
Phetogo	Bahurutshe	Nuclear family	Female	15	Grade 9	Learner in a public school; only the

	tribe					father is employed in one of the farms in Zeerust
Amantle	Bahurutshe tribe	Nuclear family	Female	15	Grade 9	Learner in a public school; both parents employed in retail stores in Zeerust.
Mooketsi	Bahurutshe tribe	Nuclear family	Male	15	Grade 9	Learner in a public school; only the mother is employed as a domestic worker in Wilbedacht.
Letlhogonolo	Bahurutshe tribe	Nuclear family	Female	14	Grade 8	Learner in a public school; both parents are employed as domestic workers in Zeerust.
Gaositwe	Bahurutshe tribe	Nuclear family	Female	14	Grade 8	Learner in a public school; both parents are employed in one of the chicken farms in Zeerust.
Moagi	Bahurutshe tribe	Nuclear family	Male	14	Grade 8	Learner in a public school; mother is employed as an administrative clerk at the Ramotshere Moiloa Municipality Offices and the father is employed at a mine in Rustenburg.
Tshepo	Bahurutshe tribe	Nuclear family	Male	14	Grade 8	Learner in a public school; the mother is employed as a cleaner at the police station, while the father is employed at a mine in Gauteng.

Parents							
Keatlaretse	Bahurutshe tribe	Extended family	Female	50	Grade 11	Employed as a domestic worker in Randburg.
Tshepiso	Bahurutshe tribe	Extended family	Female	50	Grade 12	Employed as a domestic worker in Randburg.
Professionals							
Educator, Keitumetse	Bakgatla tribe	Nuclear family	Female	46	Honours Degree in Educational Management, and Advanced Certificate in Education specialising in Life Orientation from Rand Afrikaans University	Employed as an educator in a public school.
Educator, Keneilwe	Bahurutshe tribe	Nuclear family	Female	49	Matric Certificate, Secondary Teachers	Employed as an educator in a public school.

					Diploma, and Higher Diploma in Education	
Educator, Lerato	Bahurutshe tribe	Nuclear family	Female	46	University Diploma in Education and Advanced Certificate in Education specialising in Life Orientation	Employed as an educator in a public school.
Educator, Ontiretse	Bapedi tribe	Nuclear family	Female	44	Secondary Teacher's Diploma and Honours Degree in Education.	Employed as an educator in a public school.
Mphoentle, Clinical Psychologist	Bakwena tribe	Nuclear family	Female	52	Masters in Clinical Psychology	Employed as a psychologist in the Department of Health.
Tumelo, Mental Health	Bahurusthe tribe	Nuclear family	Male	53	Nursing Diploma	Employed as mental health worker in the Department of Health.

Worker						
Motsweledi, Traditional Leader	Bahurutshe tribe	Extended family	Male	38	Grade 12	Serves as a traditional leader and is an entrepreneur, owning a security company.
Mothusi, Traditional Healer	Bahurutshe tribe	Nuclear family	Male	44	Could not complete Grade 11	Serves as a traditional healer, and is also a farm and taxi owner.

The next section provides a discussion of the cultural heritage, family structure, gender, developmental stage, education and employment status of the participants.

Racial Group and Cultural heritage

All adolescents, parents, the traditional leader and traditional healer, two educators, the social worker, and mental health worker participating in this study were Black Africans and reported that they were of the Bahurutshe tribe, born and bred in Lehurutshe: *I was born and bred in Lehurutshe* (Tshiamo, the adolescent). The Bahurutshe tribe is located in Lehurutshe; one of the rural areas of the former Bophuthatswana Homeland (South African History Online, 2017) and part of the Ramotshere Moiloa Local Municipality Reviewed Integrated Development Plan (2014). The Bahurutshe tribe adopted a baboon as their totem (Your Botswana, 2017). The other three professionals (two educators and mental health worker) did not originate from Lehurutshe. One of these educators, Keitumetse, was a granddaughter of the Bakgatla tribe; which comes from the word Kgabo, a velvet monkey that was adopted as a totem for the Bakgatla tribe (Bakgatla-Ba- Kgafela Tribal Administration, 2013; Porsel, 2014). The Bakgatla tribe were located in the Bojanala Platinum District of the North West Province of South Africa.

The other health worker was a granddaughter of the Bakwena tribe: *I was born and bred in one of the villages in Rustenburg (Mphoentle, clinical psychologist).* The Bakwena tribe refers to one of the Batswana speaking tribes, whose totem is kwena or a crocodile in English. The Bakwena tribe was located in Rustenburg; a location of the former Bophuthatswana Homeland (South African History online, 2017). However, one of the educators was from the Bapedi tribe, which was located in the Limpopo Province of South Africa. Their symbolic animal is noko, or a porcupine in English (Trip Down Memory Lane, 2013). Even though her cultural heritage is the Bapedi tribe in Limpopo, she was born in the Gauteng Province of South Africa. Consistent with Statistics South Africa Report (2011) and the Ramotshere Moiloa Local Municipality Reviewed Integrated Development Plan (2014), the home language of people residing in the Ramotshere Moiloa Municipality was Setswana. The home language of all the participants was Setswana except for one of the educators whose home language was Sepedi.

Family structures

Family structures of the adolescents varied from single-parent families, nuclear families, and extended families. In soft-spoken voices, adolescents acknowledged their family structures: *I*

am raised by a single parent; staying with my two siblings, mother, grandmother, grandfather, uncle, aunt, and her daughter (Oarabile, adolescent); *I am raised by a single parent, staying with my aunt, grandmother, sister, and a brother* (Rorisang, adolescent). Mosidi, unlike Oarabile and Rorisang was from a nuclear family structure, raised by both parents: *I am the last born in a family of three children, staying with both parents (*Mosidi, adolescent*)*. Previous studies revealed that a family structure might be a protective or risk factor for adolescent substance abuse (El-Awady, 2017). Two adolescents from single-parent family structures (Oarabile and Rorisang) reported that they were using substances: *I was using substances and referred for rehabilitation*. This is consistent with previous studies (Du & Johnson, 2015; Mothibi, 2014; Rice & Dolgin, 2008) that adolescents from single-parent families were at risk of substance abuse and experienced some mental health issues (British Psychological Society, 2009). However, Hoque and Ghuman (2012) established that a large number of single-parent families did not allow substance abuse among adolescents and this served as a protective factor for the initiation of substance abuse. Corroborating with Hoque and Ghuman (2011), Morojele, Brook, and Brook (2016) established that adolescents who had a non-conflictual, close and supportive relationship with their parents were more likely to internalise their parental values and identify and cooperate with their parents, which may lead to less substance use.

Similar to the family structures of the adolescents, all parents and the traditional leader were from extended families, while one professional was from a single parent family: *I am a single parent, staying with my three children, and other five extended family members (*Keatlaretse, parent*)*; *I am a single mother of two girls (*Tshireletso, social worker). In addition, all educators, the traditional healer, and mental health professional were married and from nuclear families: *I am married and have two children* (Mothusi, traditional healer).

Gender

The demographics of this study revealed that there were 14 female adolescents and ten male adolescents. More female participation was evident among parents and professionals, who were eight in number, compared to three male professionals. As participation in this study was voluntary, it implies that more females than males consented to participate in this study. The higher rate of female participation was also revealed in the study by Chauke, Van der

Heever and Hoque (2015) conducted in a rural high school in South Africa, in which 206 females (53,4%) and 177 males (46, 6 %) participated.

Developmental stage

Participating adolescents were between 13 and 19 years of age. According to Cherry (2017), Erikson (1963), and GoodTherapy.org (2017), these ages form part of the identity and role confusion which is the fifth stage of psychosocial development. Previous studies established that one of the behaviours adolescents engage in during this stage is substance use (Hernandez et al., 2015; Mudavanhu & Schenck, 2014; Royal College of Psychiatrists, 2016). This became evident in this study when one of the parents reported that *My own son is now using dagga and alcohol* (Keatlaretse, parent). The use of substances by adolescents during this stage may lead to them struggling to find a purpose to their lives and encounter difficulties in establishing their identity (GoodTherapy.org, 2017). A further discussion about adolescents' use of substances is provided later in this chapter.

Parents and other professionals in this study were between the ages 37 (young adulthood) and 54 (middle adulthood): *I am 38 years of age* (Motsweledi, traditional leader); *I am 45 years of age* (Tshireletso, social worker); *I am 53 years of age* (Tumelo, mental health worker). Erikson (1963) indicated that it is between 40-64 years of age that one contributes to society and helps guide future generations. Consistent with Erikson (1963), one of the participants, Motsweledi at the age of 38 was already serving as a traditional leader in his village. His passion for serving others and taking care of the wellbeing of adolescents became evident in his report: *They must know that they are future leaders, we need to engage them. They find that they are welcomed by drug lords, who respect them while in their own families and community they are not respected. By respecting them, they will feel valued, and that may assist in stopping substance abuse.*

Educational level

At the time of the study, adolescents in this study were attending secondary school. Two female adolescents and two male adolescents were in Grade 8, while seven female adolescents were in Grade 9. Furthermore, three females were in Grade 10, while three

females and seven male adolescents were in Grade 11. These adolescents were still attending school and in grades that were target groups for substance abuse prevention as established by one of the adolescents: *There is a Life Orientation learning area, implemented from grades 7 to 12 in our schools. In that learning area, they teach us about prevention of substance abuse* (Gomolemo, adolescent).

However, none of adolescents participating in this study was in Grade 12 because by the time the study was conducted in September 2014, Grade 12 learners were occupied in a revision programme for their examinations. Therefore, to protect teaching and learning, they were not recruited to participate in this study.

Concerning parents and professionals participating in this study; one parent completed Grade 12, while the other one ended in Grade 11: *I completed Grade12, but could not further my studies due to financial challenges* (Keatlaretse, parent); *I ended school with Grade11. Due to financial challenges at home, I had to leave school. (*Tshepiso, parent*).* Similar to these parents, two other male professionals completed Grade 12, while Mothusi ended in Grade 11: *I only attended high school up to Grade11. I struggled and was forced to leave school before completing Grade 11. I realised that I was not doing well because of the gift of traditional healing, so I left school* (Mothusi, traditional healer)*; I competed Grade12* (Motsweledi, traditional leader).

Compared to these parents, a traditional healer and a traditional leader, all educators and health professionals completed Grade 12 and furthered their studies: *I have a Grade 12 certificate, Secondary Teachers Diploma and Honours Degree in Education* (Ontiretse, educator)*; I have a Bachelor of Arts in Social Work* (Tshireletso, social worker); *I am a qualified social worker and clinical psychologist* (Mphoentle, professional). The report by Mphoentle that she was a clinical psychologist, contradicted the Census Report (Statistics South Africa, 2011) that the highest educational level of people in the Ramotshere Moiloa Local Municipality was an Honours degree.

Employment status

Consistent with the breakdown of the Black African workforce by skills, 34% of Africans were in low-skilled employment (Statistics South Africa, 2014). Some adolescents reported that their parents were employed as domestic workers: *My mother is employed as a domestic*

worker in Welbedacht (Nthabiseng, adolescent). However, there was evidence of the low-skilled and semi-skilled employment of parents by some adolescents: *My mother is employed as a domestic worker in Welbedacht and my father is employed as a public servant in the Department of Public Works in Welbedacht. My parents are employed in one of the chicken farms in Zeerust* (Gaositwe, adolescent). *My mother is employed in a retail store in Zeerust and my father is employed as a security officer in one of the security companies* (Lesego, adolescent). *My mother is employed as an administrative clerk at the Ramotshere Moiloa Local Municipality offices and my father is employed in a mine at Rustenburg* (Moagi, adolescent).

Similar to the parents of some of the adolescents, parents who participated in this study were employed as domestic workers: *I am employed as a domestic worker in Randburg* (Keatlaretse, parent)*; I am employed as a domestic worker in Welbedacht* (Tshepiso, parent). In contrast to parents and other professionals who participated in this study, two professionals were self-employed: *I have a security company in some areas in South Africa* (Motsweledi, traditional leader)*; I own two farms and taxis* (Mothusi, traditional healer). Other professionals, that is educators and health workers, were employed as public servants: *I have 25 years teaching experience in secondary and high school; currently teaching Life Orientation* (Lerato, educator); *I am currently employed as a mental health worker* (Tumelo, mental health worker)*; I am employed as a clinical psychologist for all the health centres in the Ramotshere Moiloa Municipality* (Mphoentle, clinical psychologist). According to the report of Statistics South Africa (2016), the employment status of these professionals was classified as professional and managerial occupations. These extracts about the employment categories of the parents and professionals in this study was in contrast with the Census Report (Statistics South Africa, 2011), that a majority of the people in the Ramotshere Moiloa Municipality were employed as domestic workers, farm workers, and public servants.

Therefore, the Census Report (Statistics South Africa, 2011) excluded other employment categories such as entrepreneurs, retail, security officials and Africans as farm owners instead of being farm workers as revealed by the findings in this study. However, the employment categories of the parents of some of the adolescents affirmed the provision of the Department of Education (2016) that the majority of learners in those schools were exempted from paying school fees because of the socio-economic status of their families.

Documents analysed

Documents analysed in this study as provided in Chapter 3 under data collection, were not presented separately. Rather, they were incorporated in the analysis of interviews and discussions of the findings of this study. Documents selected were based on research questions of this study and only the information that was complementing interview data were considered.

Themes

As indicated in Chapter 3, thematic analysis was employed to analyse data obtained from interview transcripts and summaries of documents analysed (Aronson, 1994; Attride-Stirling, 2001; Braun & Clarke, 2006; Brikci & Green, 2007; Cho & Lee, 2014; Creswell, 2014; Hennink et al., 2011; Marshall and Rossman, 2011). Four global themes and 15 organising themes were identified. Global themes include: 1. Pushing boundaries of identity; 2. It's hard being a teenager; 3. Deconstructing the false narrative; and 4. Creating new rays of hope.

Organising themes include: 1.1 Substance abuse as a social entrapment – holding the youth to ransom; 1.2 In search of greener pastures; 1.3 You can't tell me, I do as I see; 2.1 Substance abuse as an escape route to oblivion; 2.2 Substance abuse as creating work for young idle minds; 2.3 Hardship as a way of life; 2.4 A sense of stagnation; 2.5 A sense of helplessness; 3.1 Going back to our roots – reinvigorating our moral fibre; 3.2 Pulling all strings together; 3.3 A need for creative and innovative interventions; 3.4 A need for a holistic and wider stakeholder participation; 3.5 Broken beyond imagination; 4.1 Communities as intervening agents; and 4.2 Going round and round in circles.

See Figure 3 below for a presentation of the global themes and organising themes. Global themes and organising themes are presented and their brief descriptions are provided. According to Neuman (2009), the presentation of direct quotes is common in the qualitative research processes and illustrates the themes described.

The structure and style for presenting the global themes and organising themes, unless stated otherwise, is to: (a) provide a brief description of key concepts or themes as they emerged from the findings, (b) provide evidence through the use of verbatim quotes; and (c) provide

an interpretation of the meaning derived from the quotes driven by a holistic orientation, with reference to theory and previous research (Livingston, 2014).

Figure 3: Overall global themes and organising themes

PUSHING THE BOUNDARIES OF IDENTITY

The global theme *pushing boundaries of identity* refers to acts that adolescents engage in, which are often contrary to expectations of parents, and have negative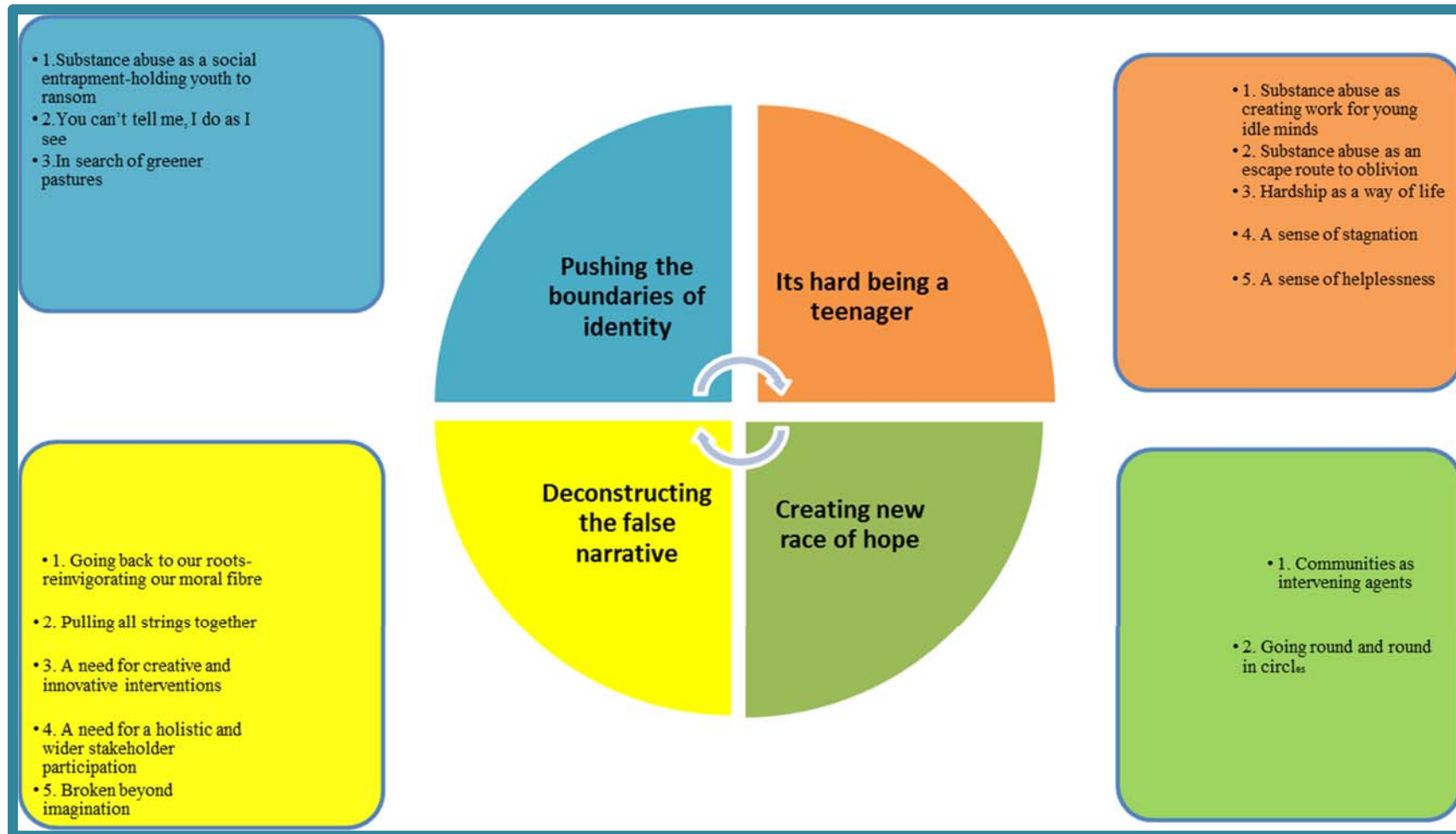 implications to their development (Klindt, 2014). It consists of the following organising themes: *Substance abuse as a social entrapment – holding youth to ransom, in search of greener pastures, and you can't tell me, I do as I see*. See Figure 4 below for the global themes and organising themes.
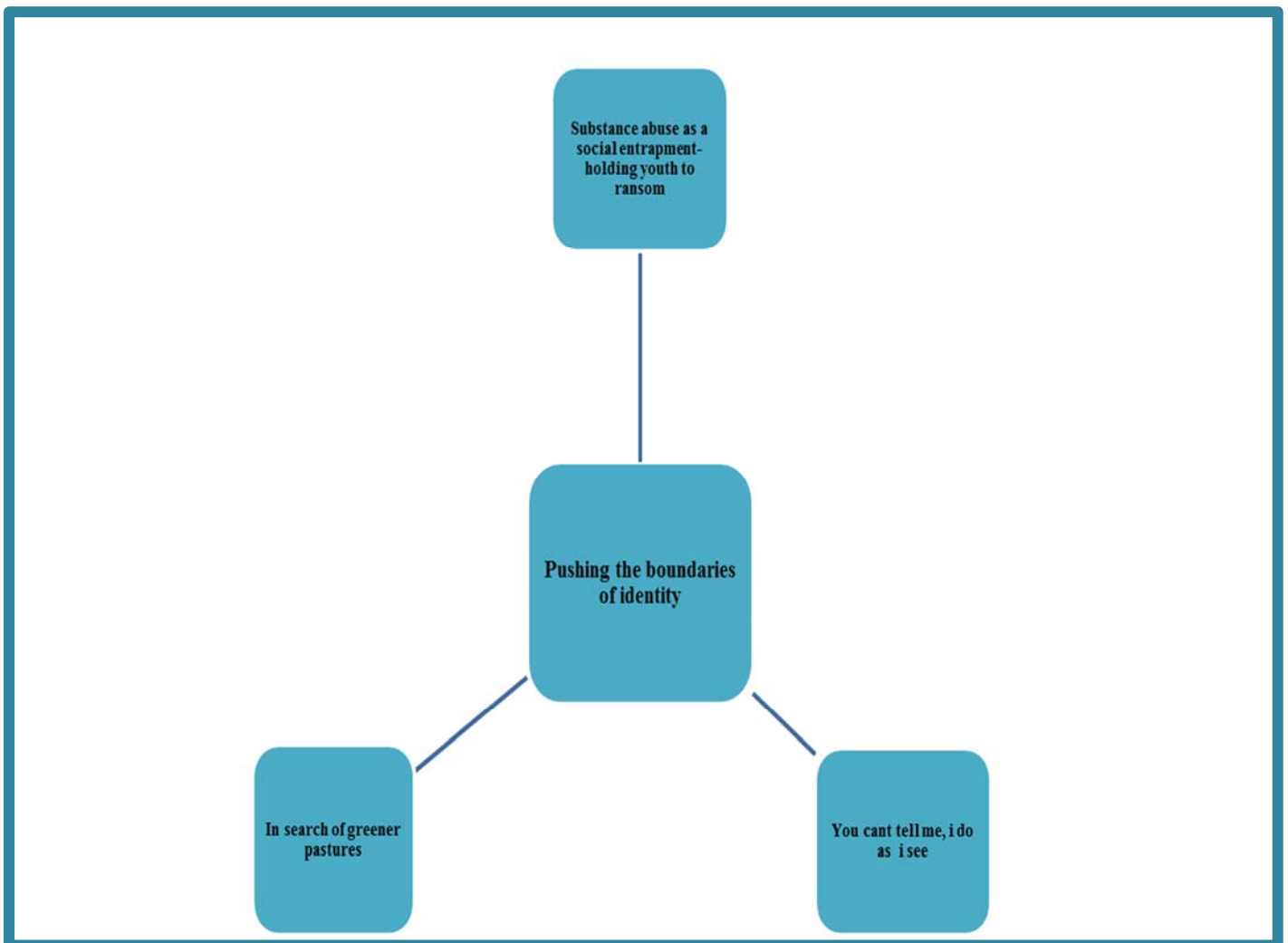
Figure 4: Global theme pushing the boundaries of identity

Substance abuse as a social entrapment – holding the youth to ransom

The organising theme *substance abuse as a social entrapment – holding youth to ransom* refers to adolescents being lured into the act of using substances (Royal College of Psychiatrist, 2016). Previous studies established that adolescents were socially entrapped into the use and abuse of legal and illegal substances such as alcohol, tobacco, cannabis, cocaine, glue and heroin (Balogun et al., 2013; Dada et al., 2016; Department of Basic Education, 2013; Griffin & Botvin, 2010; Lakhanpal & Agnihotri 2007; Mothibi, 2014; Mudavanhu & Schenck, 2014; North, 2012). The United Nations Office on Drugs and Crime (2016) also reported that substance abuse varies over time, across regions and sociodemographic sectors. Furthermore, other studies reported that substance use and abuse was a male rather than female phenomenon and occurred in urban rather than rural areas (Dada et al., 2012; Peltzer et al., 2010).

Adolescents and professionals provided the following similar and differing views about legal and illegal substances abused by male and female adolescents:

> *They use dagga, nyaope, glue, and cigarette.* (Thabo, adolescent)*; Adolescents use glue, cocaine, dagga, tobacco, nyaope, alcohol, brandy, black label, tlokwe, and Amstel* (Mosidi, Tebogo, Lebogang, adolescents)*; Adolescents in our rural area use alcohol, tobacco, and dagga. Girls and boys use these substances (*Lerato, educator)*; Adolescents abuse alcohol, dagga, tobacco, snuff* (Tshireletso, social worker)*; Teenagers from Zeerust also use substances. Dagga is the number one substance of abuse, and then alcohol, and glue. Hard drugs, we do not hear about them. Adolescents mainly use dagga* (Tumelo, mental health worker)*; They use alcohol and dagga. Alcohol is the most common substance abused by adolescents* (Motsweledi, traditional leader).

These extracts suggest that alcohol, cannabis (dagga) and tobacco were extensively used substances among adolescents and corroborate with reports of previous studies about substances used by adolescents in various provinces within South Africa (Dada et al., 2015; Department of Social Development, 2014; Mothibi, 2014) and in other countries (United Nations Office on Drugs and Crime, 2016). These extracts further show that male and female

adolescents in the rural area where the study was conducted abused substances, which was in contrast with previous studies that substance abuse was a male rather than female phenomenon and occurred in urban areas (Dada et al., 2012; Peltzer et al., 2010). In the following extracts some of the adolescents and professionals also reported on the usage of cocaine, methylated spirit, snuff, and tlokwe (sorghum beer):

> *Adolescents use cocaine (*Modise*, adolescent); They use methylated spirit* (Motsweledi, traditional leader)*; Adolescents abuse snuff* (Tshireletso, social worker)*; Adolescents use tlokwe* (Amantle, adolescents).

The extracts pointed to limited reporting on the usage of snuff, which was also established in the study conducted among adolescents in the rural communities of Limpopo Province of South Africa (Mothibi, 2014). However, the limited usage of tlokwe came unexpectedly given that it was reported as a substance of abuse in the rural areas because it was cheap and readily available (Makindara, Hella, Erbaugh & Larson, 2013). Even though these extracts proposed the usage of methylated spirits, snuff, tlokwe and tobacco among adolescents, these substances were not reported in any of the substance abuse treatment centres of South Africa as the substances of abuse from January to June 2016 (Dada et al., 2016). The extracts also pointed to the limited reporting on the usage of cocaine, which was consistent with the findings of Dada et al. (2016), that only 2% of those admitted in substance abuse treatment centres in the Central regions of South Africa (that includes the Free State, North West, and Northern Cape Provinces) used cocaine. However, these findings contradicted the findings of a study conducted in the rural areas of Limpopo Province of South Africa which established that 47% of adolescents abused cocaine (Mothibi, 2014).

The limited usage of cocaine as reported by adolescents in this study implied that it might be costly, not easily accessible, and constituting a criminal offence (Osman et al., 2016; South African Police Service, 2016). In addition, the limited usage of methylated spirits may be because according to provisions of the Liquor Act (2003), no person may sell or supply liquor or methylated spirits to a minor. Furthermore, a person must take reasonable measures to determine accurately whether a person was a minor before selling or supplying methylated spirits to that person. In addition, the limited usage of the methylated spirits was because adolescents had to sign for it before it was sold to them as reported by one of the professionals as follows:

> *In shops, you no longer find spirits on the shelves; you get it at a counter*
> *where they sell cigarettes. Before they sell it to you, you must first sign*
> *for it. This is to avoid teenagers from abusing it* (Motsweledi, traditional
> leader).

One of the adolescents and a professional also reported that adolescents in their village abused *segonyamatlho* (a type of traditional beer). However, the following extracts show that they had differing views about its contents:

> *Adolescents also use segonyamatlho meaning eye plucker. This is a*
> *homemade ginger beer and acid of a car battery is added* (Kamogelo,
> adolescent)*; Adolescents use a concoction of traditional beer called*
> *segonyamahlo. It means eye plucker. It is made up of cake flour, ginger*
> *beer, battery acid. Fermentation process is not the same. Once a person*
> *uses it, he or she will sleep over two days and mostly at risk of rape. Both*
> *males and females use it.* (Tshireletso, social worker).

The extracts suggest that adolescents created a concoction of homemade ginger beer by adding non-harmful substances such as cake flour and harmful substances such as battery acid to create a substance of abuse and enhance the desired effect of the substance referred to as *segonyamahlo,* meaning eye plucker. The creation and usage of *segonyamatlho* by adolescents was in contravention of the Liquor Act (2003, p15), which stipulated that no person may manufacture or distribute liquor, or even sell liquor to minors. *Segonyamahlo* was not reported as a substance of abuse in the documents analysed in this study and previous studies conducted in South Africa and other countries (Dada et al., 2016; Department of Basic Education, 2013; Mothibi, 2014; National Drug Master Plan, 2013; United Nations Office on Drugs and Crime, 2016). Instead, previous studies reported on the use of African homemade sorghum beer which was used for various cultural activities including welcoming of initiates (Davis, 2011), grooms and brides (Collins, 2016) in families, and for *Badimo* (Allen & Saunders, 2014).

In this study, none of the participants referred to the use of homemade beer for traditional purposes as was reported by previous studies. The other substance of abuse identified by

adolescents and some of the professionals was nyaope, as reported by the participants in the following extracts:

> *They use nyaope* (Tshepo, adolescent)*; Adolescents abuse substances such as nyaope* (Ontiretse, educator); *I heard that in Welbedacht they use nyaope. Both males and females use nyaope* (Mothusi, mental health worker).

These extracts supported the notion that nyaope was a commonly used substance among adolescents as was reported in previous studies (Dada et al., 2014; Health 24). In contrast to previous studies about the substances used to create nyaope, adolescents in this study reported other substances used to create nyaope as follows:

> *The other one is hubbly bubbly. Adolescents use a container or lantern with two pipes; they will add dagga or even alcohol and burn it. They also add flavourants and inhale it using the pipes. Normally two teenagers will share it. I have seen males using it* (Tshepang, adolescent).

Adolescents in this study provided information about the contents of nyaope and the mode of usage as compared to professionals who only indicated its usage without providing details of the mode of use and ingredients.

In addition, the ingredients for nyaope and its mode of usage as indicated by these extracts differ from reports of previous studies that the mixture of nyaope consisted of low-grade heroin and cannabis. In some instances, others used anti-retroviral drugs (Dada et al., 2014; Health 24; Home Detox South Africa, 2014; Hugo, 2015). These findings lend support to previous studies that the contents of nyaope may vary from place to place (Home Detox South Africa, 2014; Hugo, 2015). Furthermore, the usage of nyaope in the Ramotshere Moiloa Local Municipality was consistent with the previous South African studies that it was readily available, not costly (Mokwena, 2015), and prevalent among young Blacks living in socio-economically depressed areas (Venter, 2014).

Extracts pointed to the use of more than one substance of abuse among adolescents, in which adolescents combined alcohol and cannabis to create nyaope, as well as the combination of

African ginger beer, battery acid and cake flour to create *segonyamahlo*. This implies polysubstance use, which was reported in previous studies as a growing phenomenon among adolescents (Connor et al., 2014; Griffin & Botvin, 2011; Promises Treatment Centre, 2009). Furthermore, these findings were consistent with the report of the United Nations Office on Drugs and Crime (2016), that polysubstance use encompassed wide variations in patterns of substance use. However, these findings differed with the reports of previous studies about substances that were combined with alcohol (Connor et al., 2014; Griffin & Botvin, 2011; Promises Treatment Centre, 2009; United Nations Office on Drugs and Crime, 2016).

Previous studies also reported on the usage of heroin, opiates and stimulants (Dada et al., 2016; Mothibi, 2014; United Nations Office on Drugs and Crime, 2016). However, the usage of these substances that was reported in the National Drug Master Plan (Department of Social Development, 2013) was not reported by any of participants in this study.. These findings lend support to The Partnership at drugfree.org (2014) that these substances were moderately used substances. According to the United Nations Office on Drugs and Crime (2016), adolescents found it difficult to obtain these substances as they were costly. The use thereof was regarded as a criminal activity, where one may be arrested (Osman et al., 2016; South African Police Service, 2016).

Availability theorists held that adolescents use substances because they were readily available (Carson et al., 2000; Liddle & Rowe, 2006; Mokwena, 2015; Peltzer et al., 2010; Venter, 2014). Previous researchers also established that schoolgoing youth found it easy to buy alcohol from bottle stores, supermarkets, bars and shebeens (a shebeen is an informal licenced drinking place in a township) (Department of Trade and Industry, 2015; Seggie, 2012).

Substances were available in their community, as reported by some adolescents, parents and professionals in the following extracts:

> *The shop where they spent most of the time, they also buy cigarettes. I once went to this foreigner who owns the shop and asked him why he is selling cigarette to our children and he just looked at me without responding. I wondered why he is selling cigarettes to minors. I sometimes wish the police could raid this shop. The other day I went*

home for leave, and out of anger, I removed the table, which they use to play dice and throw it next to the cattle kraal. I thought by doing that they would stop playing dice. They continue gambling next to that shop, and the owner seem not to be worried. There are so many taverns in our village (Keatlaretse, parent)*; In some schools, there are learners selling substances like cigarette and dagga to other learners. Some get out of the school during break and buy at the neighbouring shops. Sometimes, you will see a former student standing by the fence and selling to those in the school. When you find out what is it they sell, you will find that they sell cigarettes. There is a new trend; they will save their transport and pocket money and use it at the tavern* (Lerato, educator).

The other reason is that we have many taverns in our community. Therefore, young people will get it there. Cigarette is also used because we have tuck shops owned by... [Referring to Foreign Nationals] *who sell to young people. They do not care whether these are young people or not. They sell to them.* (Mothusi, traditional healer)*; The other challenge is that when young people go to tuck shops and buy for example cigarette or go to the taverns and buy alcohol, they sell to them because sometimes parents send their children to buy cigarette or alcohol for them* (Mosweledi, traditional leader)*; These substances are easily available and easily accessed in any of the shops around and shebeens. I feel that the government is opening gates for foreign nationals who are selling drugs in saloons and tuck-shops. These foreign nationals are even saying that buying substances from their tuck shop is a choice. Our government has no proper control of influx of foreigners. The problem is sky rocketing. There is a plantation of dagga in yards and the field. However, if they get hold of anyone planting dagga, they will arrest that person* (Mphoentle, clinical psychologist).

These findings indicate that parents send minors to buy cigarettes for them at tuck shops, which was in contrast with the Tobacco Products Control Act (1993) and Tobacco Products Control Amendment Bill B24 (2006) that prohibited the sale of tobacco products to minors.

In addition, these findings pointed to availability of liquor and easy access to taverns which was in contrast to the provisions of the Liquor Act (2003, p.15) which stipulated that

> *a person must not sell or supply liquor or methylated spirits to a minor; a person must take reasonable measures to determine accurately whether or not a person is a minor, before selling or supplying liquor or methylated spirits to that person; a minor must not make a false claim about age in order to induce a person to sell or supply liquor or methylated spirits to him or her; a person must not make a false claim about the age of a minor in order to induce a person to sell or supply liquor or methylated spirits to the minor; the Minister may cancel a registration if the registrant does not comply with the provisions of this Act; the minister may review, and propose new conditions on registration if the registrant; has not met its commitments or complied with its plans concerning combating alcohol abuse, or has breached an approved code of conduct, and cannot provide adequate reasons for failing to do so.*

The question then arose if the minors have access to taverns despite the provisions of this Act. In addition, why were licences of these tavern owners renewed if they allowed minors in their premises and did not honour provisions of the Act and commitments made regarding plans to combat alcohol abuse? Furthermore, these extracts were in contrast with what was expected of the role of inspectors who, according to their functions as stipulated in the Liquor Act (2003, p.28), were expected to:

> *investigate complaints submitted to the inspector in the prescribed manner and format; monitor and enforce compliance with this act; seize any liquor that appears to have been manufactured contrary to section 4 (2).*

These extracts also contravened the provisions of the South African Police Service Programme of Action, which provided for the appointment of Designated Police Officials (DPO) at Police Stations responsible for addressing transgressions of the liquor legislation (Parliamentary Monitoring Group, 2013). It seemed as if there was no monitoring by inspectors. Non-compliance with the Liquor Act (2003) and Tobacco Products Control

Amendment Bill B24 (2006) by some owners of taverns and tuck shops seemed to defeat the purpose of preventing substance abuse among adolescents. These extracts corroborated with the availability theorists and previous studies that availability and easy access to substances was a risk factor for substance abuse by adolescents (Liddle & Rowe, 2006; Mothibi, 2014; Peltzer et al., 2010; Seggie, 2012).

These extracts from participants also indicated that there were locals and foreign nationals selling substances in tuck shops and saloons, which were easily accessed by adolescents. Extracts from participants lend support to previous studies that the decrease in local controls following the collapse of apartheid, increased travel to South Africa which made it vulnerable to drug trafficking and the use of these substances (Brook et al., 2006; Parry, 1998; Peltzer et al., 2010; Seggie, 2012). In addition, the extracts by participants state that there was no monitoring of businesses of foreign nationals such as tuck shops and saloons to stop the sale of substances and protect adolescents from buying substances since they were minors. Furthermore, these extracts from participants were in contrast to the report by the South African Police Services that raids were done on a daily basis in areas considered as *hot spots* for drugs. In addition, these raids were conducted based on identified concerns and information from the community (Parliamentary Monitoring Group, 2013).

This extract by one of the participants also suggested that there were adolescents gambling next to the shop in their community. This pointed to engaging in a criminal act, which was consistent with the United Nations Office on Drugs and Crime (2012) that the use of substances led to engagement in various criminal activities to sustain substance abuse behaviour. However, it was interesting to note that there were efforts to address the challenge of selling alcoholic beverages and tobacco to minors, as indicated by one of the professionals in the following extract:

> *We had discussions with the provincial office and public works to assist*
> *us in deploying people from Justice to help us in developing by-laws for*
> *our village and community resolutions so that actions taken are within*
> *the law and in line with the SA Constitution; we are still awaiting their*
> *assistance. There are NGOs that are established to create awareness*
> *about substance abuse, but they do not play their part. Their other role is*
> *that when taverns are opened, the tavern owner must make them aware*

> *because all tavern owners are supposed to contribute 10% of their profit to these NGOs. In turn, these NGOs will issue a certificate to tavern owners, which they present when they renew their licences. The 10% contributed by tavern owners assist NGOs to raise awareness about substance abuse. Again, these NGOs are supposed to report to the Liquor Board when these tavern owners do not comply with the requirements of the Liquor Act* (Motsweledi, traditional leader).

These extracts show that efforts were made to develop strategies to address parents sending their children to buy alcoholic beverages and cigarette for them as well as tavern owners and tuck shops selling to minors. In addition, these findings pointed to NGOs that were established to monitor taverns and report to the Liquor Board. In addition, these findings lend support to the Constitution of the Republic of South Africa (1996) regarding protection of children's rights, provisions of the Liquor Act (2003), and Tobacco Product Control Amendment Bill B24 (2006) regarding protection of minors from accessing alcohol and tobacco products. Furthermore, these findings were consistent with the recommendations of Bower et al., (2015) that restrictions on underage drinking needed to be enforced. In addition, social control theorists posited that parents who guide and monitor their children regarding appropriate behaviour resulted in less drug use by adolescents (Griffin & Botvin, 2011; Hernandez et al., 2015; Liddle & Rowe, 2006).

Some adolescents saved pocket and transport money and used it to buy alcohol at the tavern during weekends, as indicated by some adolescents and one professionals in the following extracts:

> *Parents give their children more money to buy food at school during break (*Letlhogonolo, adolescent)*; There is a new trend; they will save their transport and pocket money and use it at the tavern. They prefer hiking and not pay for a taxi or bus when coming to school or going home after school. When you ask them why are they hiking and not using a bus or taxi; they will tell you that they are saving money for use during the weekend at the tavern. So they save money to spend it at the tavern with alcohol* (Lerato, adolescent).

Consistent with Essau (2014), Liddle and Rowe (2006), Louw (1998), as well as Rice and Dolgin (2008), these findings demonstrate that the lack of monitoring by parents on how their children spent money provided for lunch and transport costs led them to use it for substances. However, the use of transport money by adolescents for substances seemed to be a finding that had not yet been discovered in previous studies.

You can't tell me; I do as I see

You can't tell me, I do as I see refers to the use of substances by adolescents because they had seen significant others such as family members and peers using substances. This was evident from the disease or biological theorists and previous scholars who argued that adolescents with family members abusing substances were vulnerable to developing problems relating to substance abuse and that substance abuse ran in families (Alcohol and drug abuse module, n.d.; Griffin & Botvin, 2010; Liddle & Rowe, 2006; Manning et al., 2009; NHS Information Centre, 2011; Substance Abuse and Mental Health Services, 2015; United Nations Office on Drugs and Crime, 2015).

Parents, uncles and cousins abuse substances in their families, as cited by some of the adolescents and professionals in the following extracts:

> *Most of the parents are working in neighbouring farms. After work, some of them will drink alcohol.* (Motsweledi, traditional leader)*; My own uncle use substances* (Gomolemo, adolescent); *My own cousin used drugs* (Lebogang, adolescent).

These findings corroborate with the learning theorists that substance abuse was a learned behaviour from parents and significant others (Burger, 2008; Griffin & Botvin, 2011; Ramlagan et al., 2010; Simmons-Morton & Farhat, 2010). Findings further revealed that uncles and cousins were significant family members who use substances. This was consistent with learning theorists who argued that interaction between an individual and the environment shaped patterns of substance use (Burger, 2008; Department of Basic Education, 2013; Donald et al., 2007; Gabriel et al., 2016; Griffin & Botvin, 2010; Lakhanpal &

Agnihotri, 2007; Mothibi, 2014; Osman et al., 2016; Pressley & McCormick, 2007; Rice & Dolgin, 2008; Simmons-Morton & Farhat, 2010; Trobisch, 2016).

Furthermore, one of the professionals reported the following:

> *Some parents did not teach them what was right and wrong. Some parents are even drinking alcohol or even smoking; so they cannot tell their children anything* (Mothusi, traditional leader).

This extract shows a lack of guidance on appropriate behaviour and the inability of parents to reprimand their children from using substances. This seemed to be a risk factor for use of substances by adolescents and was in keeping with findings from previous studies (Brook et al., 2006; Burger, 2008; Donald et al., 2007; Griffin & Botvin, 2010; North, 2012; Pressley & McCormick, 2007; Reddy et al., 2010; Rice & Dolgin, 2008; Trobisch, 2016).

Some adolescents used substances because of fear of rejection by their friends who provided financial support, as reported by one of the professionals in the following extract:

> *They do not provide for their children; they end up relying on their friends for support. So they will be forced to do what their friends are doing. If their friends use drugs because of the financial support they may get, they will use drugs. For example, if a child does not have pocket money, he or she will rely on friends. They use drugs because of their friends. They want to be part of the group and do not want to be rejected by their friends* (Mothusi, mental health worker).

Furthermore, the inability of the parents to provide for the needs of their children was a risk factor for substance abuse. One of the parents and two professionals acknowledged this as follows:

> *Due to financial challenges, some parents are not able to provide for the needs of their children and their children end up using drugs* (Tshireletso, social worker); *Some parents are not responsible for their children* (Mothusi, traditional healer); *Some parents are not able to*

provide for the needs of their children (Keatlaretse, parent). *These adolescents get frustrated and will drink alcohol and smoke cigarette* (Tshepiso, parent).

However, one of the professionals had a different view: *There are some children who are taken care of but still use drugs* (Lerato, educator). These extracts pointed to adolescents relying on their friends for financial support when their parents were unable to provide for them, thus posing a risk for substance abuse. Furthermore, these extracts mention that these adolescents seemed to be unaware of social grants available to assist adolescents from destitute families (Kelly, 2016; South African Social Security Agency, 2016). Information about social grants might have served as a protective factor against adolescent substance abuse because they would have had an alternative for their financial support requirements, instead of relying on friends. The findings further indicated that adolescents abused substances even though they were taken care of by their families. This seemed to be a new finding, which was not discovered in the literature reviewed in this study.

Consistent with previous studies (Liddle & Rowe, 2006; Rice & Dolgin, 2008; Trobisch, 2016) regarding peer influence, one of the professionals identified adopting lifestyles of other teenagers in the Gauteng Province by teenagers in the Ramotshere Moiloa Municipality as a risk factor for substance abuse. He reported as follows:

Teenagers in Zeerust used to be disciplined and respect their parents. Now, they have changed. They now adopted the lifestyle of teenagers growing in towns like Gauteng. Those from Johannesburg are the ones influencing them. Most of the parents are working in Johannesburg as domestic servants; some are working in factories and mines, so I think when visiting them, they copy some of the bad behaviour from teenagers in Gauteng. For instance, in the past in our village, when a child was not behaving in a proper way, our parents would beat him or her. If they cannot, they would refer them to the traditional leaders to discipline them. We had those who were responsible for order and discipline in the community. Now, because of rights, parents are not able to reprimand their children because they will report them. Educators also used to help with discipline, but now they are powerless, they cannot use corporal

> *punishment because of the rights learners have. Right now, males and females are the same. They behave in a bad manner.* (Mothusi, mental health worker).

These extracts imply that adolescents were influenced by their peers from other regions, including Gauteng Province to use substances. This seemed to be new data, which was not reported in previous South African studies (Mothibi, 2014; Setlalentoa et al., 2015) and international studies (Liddle & Rowe, 2006; Rice & Dolgin, 2008; Trobisch, 2016). None of these studies referred to peers in Gauteng influencing adolescents to use substances. Instead, previous studies acknowledged that adolescents were more likely to be influenced by peers to use substances (Mothibi, 2014; Setlalentoa et al., 2015), which, in turn, increased the chances of the adolescents maintaining or increasing their drug involvement (Liddle & Rowe, 2006; Rice & Dolgin, 2008; Trobisch, 2016).

The findings also pointed to acculturation; in which adolescents adopted lifestyles of others in an urban area such as Gauteng, lending support to Abbot and Chase (2008) that once people left their protective home environments, they were faced with new cultural norms and values. In addition, these findings corroborated with the Department of Education and Communities, State of the New South Wales, (2011) and Ntozini (2015) that young people tend to adapt to the values and customs of their old culture. They do this while striving to adopt the norms of the new culture in order to fit in with their peers. Furthermore, these findings pointed to a lack of protective factors such as initiation rituals in which adolescents were guided about what was expected of them during the next phase of their lives. This included, among others, problem- solving, rules and taboos of the society, social responsibility, what was considered appropriate behaviour for them, as well as clarification of their purpose or life mission (Davis, 2011; Johanson, 2013).

However, Davison et al., (2004) indicated that although peer influence was significant in the decisions adolescents made about using substances, those who had a high sense of self-efficacy were influenced less by their peers. The findings from one of the participants suggested that parents and educators lost control over children, and that they were no longer able to reprimand them. This pointed to challenges encountered by parents and educators in handling adolescents. In addition, this was in contrast to the provisions of the National Drug Master Plan (2013) and the National Strategy for the prevention and management of alcohol

and drug use among learners in schools (Department of Basic Education, 2013) that parents and educators were required stakeholders for substance abuse prevention programmes.

The above indicates that if parents and educators were undermined, they would not be able to fulfil their role in substance abuse prevention. This finding also implies the referral of children to traditional leaders by their parents in the past, suggesting that traditional leaders served as protective factors for addressing unbecoming behaviour such as substance abuse by adolescents. However, one of the professionals reported the following:

> *parents no longer report unbecoming behaviour such as substance abuse*
> *to traditional leaders as was the case in the past. The law does not allow*
> *us. Such issues are now referred to the social workers for intervention*
> (Motsweledi, traditional leader).

This extract pointed to the role of social workers in addressing matters relating to substance abuse as per the provisions of the National Drug Master Plan (Department of Social Development, 2013). However, these extracts indicate that traditional leaders were excluded from addressing substance abuse challenges encountered by their community members. Addressing these challenges might require specifying the role of traditional leaders in referring substance abuse problems to social workers. This might also assist in ensuring their inclusion as stakeholders required for addressing substance abuse problems as provided in the National Drug Master Plan (Department of Social Development, 2013) and resolutions of the Anti-Substance Abuse Prevention Programme of Action (Department of Social Development, 2011).

Westermeyer (2004 cited in Dalla, Antoniou & Matsa, 2009) established that initiation into excessive substance use might also occur during periods of rapid social change, often among cultural groups who had little exposure to a drug and had not developed protective normative behaviour. One of the professionals reported that relatives brought substances such as nyaope and cannabis into their village and sold them to adolescents. This contributed to crime, as reported in the following extracts:

> *Yes, in rural areas in the past we never had such problems. Now, you will*
> *have teenagers from here, going to Gauteng to visit either their parents*

or relatives staying in Gauteng. There, they will see how other teenagers behave or even see those using drugs. When they come back, they will bring some of these drugs like nyaope. Sometimes their own relatives from Gauteng will bring such drugs to our village. Some even end up coming here to sell. As I said, those from cities like Gauteng are the ones bringing drugs like nyaope and dagga in our village. We now have housebreaking by teenagers because of bad influence they get from people in Gauteng. Some of these criminals come to our town because they realised that we are still far behind with civilisation and they take advantage of us and even do house breaking, theft, armed robberies and even searching people in town. Crime is high in our village because of the use of drugs by teenagers (Mothusi, mental health worker).

This extract shows that when participating rural adolescents visit their parents and relatives in an urban area such as Gauteng, they are influenced to use substances. In addition, these findings support previous studies such as Osman et al. (2016) regarding the sources of supply for substance use. This points to a the need to consider sources of supply for substance abuse when developing substance abuse prevention programmes for adolescents.

In search of greener pastures

In search of greener pastures refers to parents from rural areas migrating to urban areas to seek employment to enable them to provide for their families (Wrathall & Suckall, 2015). According to About the partnership – the partnership for a drug-free America (n.d.); Kumpfer, (2014); and Lakhanpal and Agnihotri (2007), some adolescents were left alone because their parents were always busy or away due to demanding jobs. Rice and Dolgin (2008) also posited that an unstable family environment with an absent father, or a family environment where one or both parents had emigrated, or where parents had died, were associated with substance abuse.

Lending support to previous studies, two professionals reported in the following extracts that parental negligence and child-headed families were some of the reasons for the abuse of substances by adolescents:

Mostly, parental negligence. Parents do not have time for their children. Child-headed families, stress is high and they end up using substances. No one to tell them it is wrong. Some are orphans, and use their social grants on substances (Tshireletso, social worker)*; Some adolescents are depressed because they are from child-headed families* (Mooketsi, adolescent)*; Most of our learners are orphans, without anyone taking care of them. No support from their own relatives or other members of the community. Some community members are self-centred and do not care about these orphans. They will be frustrated and use drugs* (Lerato, educator).

These extracts point to some adolescents as orphans heading families, which corroborates with previous studies that child-headed families were risk factors for substance abuse. (Setlhare, Wood, & Meyer, 2016). These adolescents were at a stage in which they were vulnerable to experimenting with substances since there was no one providing support and monitoring them during this challenging stage of adolescence due to the fact that their parents had passed on (About the partnership – the partnership for a drug free America, n.d.; Kumpfer, 2014; Lakhanpal & Agnihotri, 2007; Rice & Dolgin, 2008). Additionally, these extracts lend support to the psychological theories that adolescents used substances to temporarily get rid of unwanted emotions such as loneliness and depression (Maryland University Medical Centre, 2016; Mothibi, 2014; Osman et al., 2016).

Previous studies (Bilyeu, 2017; Langosch, 2012; Mohale, 2013) acknowledged that grandparents played an important role in raising grandchildren when their parents were away. This may be due to, among others, employment requirements, homelessness, divorce, financial struggles, incarceration, domestic violence, substance abuse, and the death of parents. When grandparents assumed the role of caring for their grandchildren when their parents were unable to do so, grandparents were at a point in their lives where they were a generation older than their grandchildren, and were at times encountering health problems (Langosch, 2012).

Furthermore, a study by Mohale (2013), consisting of ten female grandparents caring for their AIDS-orphaned grandchildren in Lephalale, one of the rural areas in Limpopo Province of South Africa, established that in raising their grandchildren, among some of the challenges

encountered by grandparents in the rural areas were behavioural problems by their grandchildren, such as smoking cigarettes, dagga and other illegal substances. Furthermore, some of the grandchildren were impulsive and hyperactive, thus resulting in stress to their grandparents who were unable to manage such behaviours.

In the current study, one of the professionals reported as follows:

> *Most of the parents die between the ages 30-45. Children were left with*
> *their grannies who cannot control them (Tshireletso, social worker).*

Consistent with previous studies as indicated in this section, this extract suggested that grandparents took care of their grandchildren after the passing of their parents. However, they were unable to control them. Social control theorists argued that where there were insufficient controls, adolescents were at risk of substance abuse (Griffin & Botvin, 2010; Peltzer et al., 2010). This highlighted the need to provide grandparents with skills that would enable them to communicate, establish good relations, set rules, and provide care and support to their developing grandchildren (Goyer, 2010; North, 2012; Nsamenang & Tchombe, 2011). In addition, providing grandparents with information about managing adolescents and instilling self-control will assist and protect their grandchildren from some of the risky behaviours such as substance abuse (Griffin & Botvin, 2010).

The findings of the current study also indicate that some of the adolescents used social grants to buy substances. This points to the abuse of social grants and contradicted its purpose as provided by the South African Social Security Agency (2016). One of the professionals further reported as follows about child-headed families and challenges encountered in identifying them:

> *Most of these children will behave in an unbecoming manner. They will*
> *be disrespectful to educators and other learners. When you call them to*
> *find out who they are, where they are staying, and with whom, that is*
> *when you will realise that they are heading families. They do not share*
> *that information easily. Only when you assure them that you want to*
> *assist them. Sometimes you end up asking their friends who will also not*
> *be ready to provide such information immediately. You have to be patient*

with them and come up with a strategy of making them aware that you value them and they are important to you. We also see it through absenteeism. Such learners will not come to school and when we ask them why they did not come to school, that is when they will tell us they are staying alone. Some are staying alone because their parents are working as domestic workers in neighbouring locations or in Gauteng. Some of them are orphans; both parents passed on or their mother passed on and they do not know their fathers. Some will even tell you that they never heard anything about their father (Lerato, educator).

These extracts point to child-headed families and reasons why children were heading families; which included aspects such as parents as migrant labourers and the passing on of one or both parents. This corroborated with the findings of Setlhare et al. (2016). In addition, these extracts highlighted challenges encountered in identifying such children, which implies a gap in strategies required to assist educators to identify such children. One of the parents reported the following with regard to her employment:

I am employed in Randburg, Gauteng, as a domestic worker. My children are taken care of by my younger sister (Keatlaretse, parent).

These extracts specify that some of the parents were migrant labourers in areas such as Randburg far away from home, and their children were taken care of by some extended family members. This finding confirms the findings of previous studies that uninvolved parents were disconnected from their children and may not meet their children's needs (Bukakto & Daehler, 2011; Shaffer, 2009). This may lead to experimentation with substances.

IT'S HARD BEING A TEENAGER

The global theme *its hard being a teenager*, refers to the turbulent process of coming of age, which was unpredictable and sometimes not easy for the adolescents, families and society to manage (Butaumocho, 2017). It consists of the following organising themes: substance abuse as creating work for idle minds, substance abuse as an escape route to oblivion, hardship as a

way of life, a sense of stagnation, and a sense of helplessness. See Figure 5 for Global theme and organising themes.
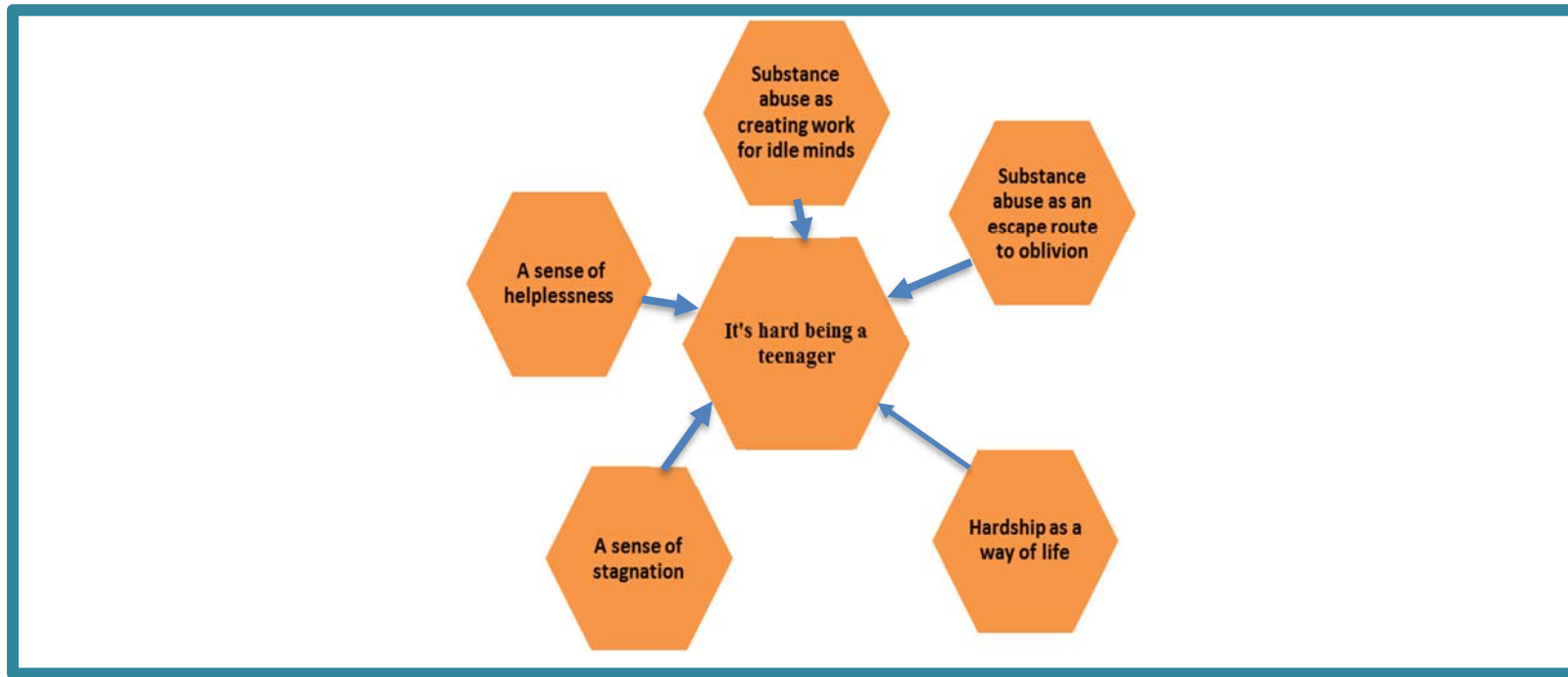
Figure 5: Global theme It's hard being a teenager

Substance abuse as creating work for idle minds

Substance abuse as creating work for idle minds refers to the unpleasant mental state of not being engaged in any activity, which led adolescents to crave for substances (Koerth-Baker, 2016). Compared to previous studies reporting on the preceding section that viewed substance use as a difficulty confronting adolescents, Mohasoa (2010) and Osman et al. (2016), established that adolescents used substances to be happy and for entertainment. Corroborating with these studies, some of the adolescents used substances to be happy, for entertainment, and associated substance use with status. Some adolescents and professionals reported as follows:

> *A need to be happy and for entertainment* (Moagi, adolescent)*; They also use substances due to lack of entertainment centres* (Mphoentle, clinical psychologist)*; Most of the times I think some abuse substances because they want to make joy in their struggle* (Oarabile, adolescent)*; There is no specific reason. They use substances for fun, for enjoyment, and to keep themselves busy* (Tumelo, Mental Health Worker)*; For them it is fancy, they associate smoking and drinking with status and how much money you have* (Lerato, educator).

Extracts indicating that substance use was fancy, associated with status and how much one had, seemed to be newly captured information in the Ramotshere Moiloa Municipality which was not reported in the literature reviewed in this study. These extracts further imply that adolescents had a low self-esteem and as a result engaged in the use of these substances to cope with negative feelings and escape from stressors (Mothibi, 2014; Wu et al., 2014). This contributes information to the developmental (Li et al., 2013; Liddle & Rowe, 2006; Mudavanhu & Schenck, 2014; Royal College of Psychiatrists, 2016) and psychological theorists (Gonzales et al., 2014; Karen Lesly, 2008; Rice & Dolgin, 2008; Zastrow, 2004) about individual factors contributing to substance abuse among adolescents, which addresses the research question on the reasons for substance abuse.

Furthermore, these extracts point to a gap in activities that were required to increase the self-esteem of adolescents, empower parents to establish warm relationships with their children, reduce their emotional pressure, motivate them and promote positive mental attitudes

(Khajehdaluee et al., 2013). These extracts also mention that substance abuse prevention programmes implemented did not emphasise identification and clarification of myths such as *substances make one happy and can be used for entertainment*. One of the professionals indicated that adolescents abused substances because of idle minds: *Most of the things are happening to our youth because of idling minds. If they could be kept busy, they will not use substances* (Motsweledi, traditional leader). This extract was consistent with the previous study conducted in the rural areas of Limpopo, in which it was reported that 57% of adolescents abused substances because of boredom (Mothibi, 2014). Furthermore, these extracts point to a lack of awareness about other extramural activities that adolescents may engage in, which would make them happy and where they would be entertained rather than engage in substances, which were addictive and had adverse effects on their lives. Examples of such activities included, among others, indigenous games, improvised sports, poetry and drama, as outlined in the Ke Moja Integrated Strategy (Department of Social Development, 2003), as alternative leisure pursuits.

Substance abuse as an escape route to oblivion

Substance abuse as an escape route to oblivion refers to use of substances by adolescents to forget the challenges confronting them such as loneliness, depression and cyberbullying (Pullen et al., 2016). Psychological theories considered adolescent substance abuse as an escape route from the underlying psychological distress (Balogun et al., 2013; Mancini & Roberto, 2009; Oldman et al., 2005; Rice & Dolgin, 2008). In addition, previous studies reported that adolescents turned to alcohol and other substances as a way to self-medicate and cope with their emotions (Gonzales et al., 2014; Karen Lesley; 2008; Mothibi, 2014). Furthermore, other studies discovered an association between cyberbullying, and psychiatric and psychosomatic problems among adolescents (Durand et al., 2013; Nixon, 2014; Promises Treatment Centre, 2016; Sourander et al., 2010).

According to these studies, many bullied adolescents felt embarrassed and powerless to stop it. This was also consistent with findings of the previous studies, which reported that adolescents abused substances to deal with the painful experience of bullying (Partnership for Drug Free Kids, 2013; Promises Treatment Centre, 2016).

In addition, the Partnership for Drug Free Kids (2013) established that bullied victims abused alcohol, cannabis and cigarettes. Furthermore, the use of these substances by bullied victims led to even more substance abuse to ease the depressive symptoms. According to the Addictions Research Report (2013), cyberbullying put a strain on mental health which included problems of processing emotions, disruptions in socially appropriate behaviour, and impaired ability to interact successfully with others, and to concentrate. This pattern may become a vicious cycle that may be very difficult to break, especially without professional help (Promises Treatment Centre, 2016).

In the following extract, one of the adolescents reported cyberbullying as a risk factor for substance abuse:

> *There is cyberbullying by other learners using cell phone applications such as WhatsApp messages, Facebook and sms's where a person will just insult and even bully you through sms messages* (Modise, adolescent).

These findings indicate that mobile phone applications such as WhatsApp messages, Facebook and sms's were used to insult and bully others. Consistent with previous studies as indicated in the preceding section, these findings imply that those who were bullied and insulted resorted to substance abuse as a coping mechanism. However, in this study, no specific substance was reported to be used to cope with bullying as compared to the Partnership for Drug Free Kids (2013), where bullied victims used alcohol, cannabis and cigarettes. Cyberbullying seemed to be a new finding, which was not reported as a risk factor for substance abuse among adolescents in the Ramotshere Moiloa Local Municipality.

Hardship as a way of life

Hardship as a way of life refers to the state in which adolescents accepted challenges confronting them as part of their lives. Poverty as one of the hardships in the lives of the adolescents was identified as a risk factor for substance abuse in previous studies (Berk, 2007; Harrison, 2017; Mothibi, 2014; Ramlagan et al., 2010; Setlalentoa et al., 2015; United Nations Office on Drugs and Crime, 2016). Adolescents and some of the professionals

supported the notion that poverty was a risk factor for substance abuse among adolescents. They provided the following causes of poverty in families:

> *Life in Zeerust is tough because Zeerust is a developing town. Hunger is killing us. It is not worth it living here because sometimes you find that no one is working at home yet the family is big like a soccer team* (Oarabile, adolescent); *They are faced with poverty and they think it is the end of the world; and they cannot do anything with it* (Lerato, educator)*; The other reason is that because of poverty at home, some teenagers because of frustration will use drugs* (Mothusi)*; No one is employed in their families. Some children drink alcohol, smoke cigarette and dagga because of poverty at home* (Keatlaretse, parent).

In the following extract, one of the professionals reported that some teenagers were involved in housebreaking and sold what they stole to buy drugs:

> *Some will even be involved in housebreaking so that they can sell whatever they steal to buy what they want and even drugs* (Mothusi)*.*

This extract was consistent with the previous studies, which established that adolescents engaged in criminal acts to sustain their drug-taking habits (Mothibi, 2014; United Nations Office on Drugs and Crime, 2012). However, these extracts contradicted the role of the South African Police Services in reducing the supply of illegal substances and combating crime as per the provisions of their five-year programme of action developed in response to the resolutions of the second Biennial Anti-Substance Abuse Summit (Department of Social Development, 2011; Parliamentary Monitoring Group, 2013).

Learning theorists posited that family conflict and parents who were not emotionally supportive were associated with a higher risk for substance use (Liddle & Rowe, 2006). Consistent with the learning theorists, some adolescents and professionals cited family conflicts and other challenges within the family as responsible for the use of substances by adolescents. The participants said the following:

My younger sister ill-treats my son (Tshepiso, parent); *The other reason is violence in families. Most of the parents are working in neighbouring farms. After work, some of them will drink alcohol and when they arrive at home, they will fight with family members; their wives and children* (Motsweledi, traditional leader)*; teenagers growing in such families get frustrated and abuse substances* (Tshimologo, adolescent).

Lending support to these extracts, Moran et al. (2004) cited in Mudavanhu and Schenck (2014), established that all forms of ill-treatment of children were regarded as possible influences leading to substance abuse. Furthermore, these extracts pointed to violence in families as a risk factor for substance use and corroborates with the findings of psychological theorists that adolescents used substances in order to temporarily deal with the lack of comfort in social situations and to ease their pain (Gonzales et al., 2014; Karen Lesley, 2008; Rice & Dolgin, 2008).

Choices Recovery (2015) reported that adolescents found it difficult to understand that their parents no longer loved each other, blamed themselves for the divorce and ended up experimenting with substances. Mothibi (2014) contended that for adolescents, divorce could become the most stressful life event and could lead to substance abuse. However, Divorcehelper.net (2013) argued that there was no possible connection between the use of substances by adolescents and their parents going through a divorce. On the contrary, two professionals in this study cited divorce as a risk factor for substance abuse among adolescents. They said the following:

Divorce in families has a negative impact on children, which is one of the reasons why some young people engage in risky behaviours. Families where one of the parents is absent, makes children to be vulnerable to substance abuse. Parents are not able to cope with substance-abusing teenagers; some parents tend to protect their children instead of going out and seeking assistance; some parents or even teenagers are not able to speak out about substance abuse within families. If some of the family problems are not resolved in families, they tend to impact negatively on teenagers and they end up using drugs (Tshireletso, social worker)*;*

> *Disruptions, instability in the family, divorce* (Mphoentle, clinical psychologist).

These extracts show the inability of parents to provide for their children's needs and to cope with substance-abusing adolescents as a result of divorce, absence of one parent, overprotective parents, and the inability to speak about substance abuse in families. The fact that if these challenges were not resolved, led to substance abuse by adolescents. This was also reported in previous South African and international studies (Berk, 2007; Chie et al., 2015; Mothibi, 2014; Rice & Dolgin, 2008; Schafer, 2011).

A sense of stagnation

A sense of stagnation refers to the state in which adolescents do not make progress with their studies because of substance abuse (Department of Basic Education, 2013). Previous studies established that substance abuse was linked to poor academic performance (Mothibi, 2014; Setlalentoa et al., 2015). Consistent with the previous South African studies, one of the reasons why adolescents abuse substances is because they do not progress well in their studies. In this regard, an educator shared the following:

> *There is no progress with their studies. You will find a learner not progressing academically. As such, they repeat grades, doing same subjects, which they struggle to pass. They are not aware of other opportunities that may be available for them; where they can do other subjects, which they will be able to pass. They get frustrated and then use drugs* (Keitumetse, Educator).

These extract pointed to low academic performance by adolescents, which led them to abuse substances to deal with their failure to perform. Furthermore, the extract implies that some of the adolescents seem not to have been provided with the required support for not performing well in the mainstream schools (Garner, 2014; Harrison, 2017). In addition, the extract implies a need for ongoing training and support to educators to provide high quality education to enable them to meet the diverse needs of learners in their classrooms as per the provisions of the South African Schools Act (1996), White Paper 6 on inclusive education

(Department of Education, 2001) and recommendations of previous studies (Mader, 2017; South African Council for Educators, 2017).

Substance abuse can affect the academic performance of adolescents. In this regard, one of the parents cites the following reason for the fact that his son had to repeat a grade twice:

> *His use of substances led to him repeat the grades. He is supposed to be in Grade12 this year; unfortunately, he repeated Grade10 twice. When I asked why he is not promoted to Grade11, educators told me that he only wrote three subjects last year because he was suspended. He is a very brilliant boy. Now because of substances, he is not doing well at school* (Keatlaretse, parent).

This extract demonstrates how the use of substances led to low academic performance and caused him to be suspended from school and repeat the grades.

In addition, the extract lends support to the previous local studies in the Limpopo and North West Province of South Africa as indicated in the preceding section that substance abuse among adolescents led to poor academic performance (Mothibi, 2014; Setlalentoa et al., 2015). This was also established in some of the studies conducted among secondary schools in Nigeria and European Countries (Chukwu, et al., 2017; Recovery First, 2012). However, the extract that an adolescent only wrote three subjects and was suspended from the school because of his use of substances, demonstrated gaps in the application of principles of restorative discipline that disciplinary responses to behaviour should not be punitive. Instead, they should combine strict control and strong support for adolescents. Furthermore, they should adopt an educational approach focus on education and hone proper social skills in adolescents in order for them to become productive members of society (Pitsoe & Letseka, 2014; Winfield, 2015).

Some adolescents, parents and professionals reported that adolescents used substances because of a lack of opportunities. In this regard, they said the following:

> *They use substances because we don't have more opportunities* (Tshepang, adolescent); *teenagers in Zeerust are not exposed. They do*

not have opportunities like teenagers in developed areas. We only have two universities in the province. When they complete matric, they must leave the province to proceed with their studies in other provinces. (Keitumetse, educator)*; For those in Zeerust, their doors are closed. They are also discouraged. After completing matric, most of their brothers and sisters will not be able to further studies because of financial challenges. Most of the parents do not afford to pay fees. Instead, after completing Grade12 they will get employment in food and clothing shops in Zeerust* (Ontiretse, educator)*; They are underdeveloped, with limited opportunities; no opportunities for advanced technologies, very few internet facilities, no good quality educational institution, most of the teenagers will leave the town to get better education elsewhere. The only tertiary institution is Taletso FET College* (Mphoentle, psychologists)*; We see development and changes in areas like Gauteng. Our village does not change. No development like in Gauteng* (Tshepiso, parent).

These extracts point to a lack of development, limited educational opportunities, and poor educational outcomes as risk factors for adolescent substance abuse. Furthermore, these extracts suggested that there were limited tertiary educational institutions available. This implies that those who could not access tertiary educational institutions were at home and out of frustration, they would be at risk of substance abuse. These extracts corroborated with previous studies (Department of Basic Education, 2013; United Nations Office on Drugs and Crime, 2016) that adolescents become trapped in a cycle of substance use, as opposed to being engaged in legitimate and educational opportunities.

Adolescents and some of professionals further reported about the lack of recreational facilities, libraries and entertainment in their community. They said the following:

There is a lack of recreational facilities for young people in the community (Tshepo, adolescent); *There is no library in the community except at school. There is no community hall for youth activities where young people can participate in activities that will protect them from risky behaviours. There is no entertainment* (Modise, adolescent)*; There*

is no entertainment for young people. They only have football grounds. We have Mmabana Recreational Centre; unfortunately, it is located in Wilbedacht and is not accessible to all the villages. The other challenge is that those who may want to use Mmabana have to pay to access it. It is not free. Is just that I am not sure of the amount they pay per month (Tumelo, mental health worker); There is no gym, no sport facilities, no libraries, and no Wi-Fi connection. I think if we had such facilities, they could take advantage of them instead of falling trap of substance abuse (Motsweledi, traditional leader)*; Life of a teenager in Zeerust differs a lot from a teenager living in Johannesburg because they have some activities that keep them busy. They use substances because they have fewer programmes that keep them busy* (Phetogo, adolescent)*; The challenge is that the town is less developed; you have to drive out of town to other areas such as Johannesburg for essential services and entertainment* (Mphoentle, clinical psychologist)*;They will sit next to the shop where they play dice. There are no sports fields where our children can play games like in other areas such as Gauteng* (Keatlaretse, parent)

These extracts lend support to previous studies and policies that a lack of recreational facilities and entertainment made adolescents vulnerable to the use and abuse of substances (Ames & Cunradie, n.d.; Department of Social Development, 2013; Ramlagan et al., 2010; Setlalentoa et al., 2015; Substance Abuse and Mental Health Services Administration, 2014). Furthermore, these extracts point to male adolescents playing dice as entertainment because there were no entertainment facilities. Consistent with this extract, a study by the Ohio Department of Alcohol and Drug Addiction Services (2012) established that playing dice was considered a primary type of gambling occurring among male friends and it was linked to substance abuse. However, unlike the findings of this study that adolescents played dice at the shops, findings of the Ohio Department of Alcohol and Drug Addiction Services (2012) revealed that male friends played dice either on the street or in a residence.

A sense of helplessness

A sense of helplessness refers to a painful or unpleasant state in which an individual feels that he or she cannot control the situation (Nolen, 2017). Adolescents, parents, and some of the professionals expressed their sense of helplessness as follows:

> *It is not worth living here because sometimes you find that no one is working at home, yet the family is big like a soccer team* (Oarabile, adolescent)*; We need help... we do not know what to do. It is difficult* (Keatlaretse, parent)*; Youth are perishing, and we are not doing enough* (Tshireletso, social worker)*; For those in Zeerust, their doors are closed. They are also discouraged. After completing Grade 12, most of their brothers and sisters will not be able to further studies because of financial challenges* (Lerato, educator)*; teenagers in Zeerust are not exposed...they do not have opportunities like teenagers in developed areas. They are faced with poverty and think it is the end of the world. They cannot do anything with it* (Keitumetse, educator)*.*

These extracts describe how participating adolescents were faced with a socio-economic challenge such as unemployment. This was consistent with Ramotshere Moiloa Local Municipality Reviewed Integrated Development Plan (2014) and the Census Report (Statistics South Africa, 2011) that a majority of people in Ramotshere Moiloa Municipality were unemployed and discouraged job seekers. In addition, in his State of the Province Address, Premier Supra Mahumapelo acknowledged the socio-economic challenges in the North West Province of South Africa. Furthermore, he reminded citizens that as they lead the second transition of the national democratic revolution, their focus would be on dismantling apartheid and its remaining legacy (*makwati*) of poverty, inequality, and unemployment which afflicted Blacks in general and Africans in particular (Bokone Bophirima Provincial Government, 2017).

The extracts also point to a lack of exposure to opportunities after completing Grade 12. This contradicted the provisions of the Life Orientation Curriculum Statement (Department of Basic Education, 2012) regarding information provided about careers, tertiary institutions, and financial institutions providing financial support to needy students in tertiary institutions (Department of Basic Education, 2012; National Student Financial Aid Scheme, 2015; Ralarala, 2007).

One of the adolescents and some of professionals revealed the following:

> *We need help, do not know what to do; police officers are corrupt* (Mphoentle, clinical psychologist); *Some people are selling drugs, nyaope, dagga (*Mothusi, traditional healer); *People are helpless and do not know where to report, doors are closed* (Lerato, educator); *My grandmother saw a plantation of cannabis not far from her house, and she was afraid to report to the police because of fear of being attacked and killed by those who planted it* (Lebogang, adolescent).

The extract about the cannabis plantation did not come as a surprise, given that adolescents and professionals participating in this study reported that cannabis was one of the most abused substances by adolescents in the Ramotshere Moiloa Municipality. This extract states that they are afraid to report to the police about those who planted cannabis and others selling substances. The reference to a cannabis plantation further affirmed previous reports that it was available in many rural areas of South Africa and a source of income. Mdibi (2015) established that in a village of Bulawo in the Eastern Cape Province of South Africa, the community grew cannabis to earn some money to send their children to school. Martin (2017) established that some people grew cannabis out of desperation to feed their families. The extract about the cannabis plantation pointed to gaps in the National Drug Master Plan (Department of Social Development, 2013) that cannabis crops in fields needed to be destroyed. This extract also indicate to gaps in the provisions of the Back to Basics Approach and the Rural Safety Strategy (South African Police Service, 2016) which provided for an appointment of rural safety coordinators to interact, consult and implement appropriate measures to address drug-related crime in rural areas.

In addition, the aspects that were mentioned in this extract came as a surprise; because according to the Reviewed Integrated Development Plan for Ramotshere Moiloa Local Municipality (2014), all villages in the Ramotshere Moiloa Local Municipality were under the control of traditional leaders who are taking care of them and attending to their concerns. Fawcett and Rabinowitz (2017) established that if one wants to prevent or find a long-term solution to a problem, there was a need to address its causes. They further recommended a need to conduct a community assessment and understand socio-economic factors contributing

to health. Topline Research Solutions (2016) argued that authorities may use enforcement through legislation. However, that would not assist in addressing encountered challenges.

Therefore, within the context of this study, the reference to the plantating and sale of cannabis indicates a need to consider the socio-economic challenges confronting those planting cannabis in the rural community where the study was conducted. Furthermore, these challenges should be addressed. This can be done without being combative or having to arrest the people who are responsible for planting and selling cannabis; this seems not to be effective. This implies working together with communities to address the problem of the planting of cannabis instead of imposing legislation that may not be effective in addressing this problem in the rural area where the study was conducted.

In the following extracts some professionals supported the notion that their village was under the control of a traditional leader:

> *Our town is surrounded by villages such as Dinokana, Moshana, Gopane, Motswedi, Ntsweletsoku, Lekubu, and Supingstad, which is next to the border of Botswana. These villages were under the leadership of the former President Lucas Mangope of Bophuthatswana before 1994. Now, they under the authority of the Ramotshere Moiloa Municipality, which is in Zeerust town. We also have ward councillors and traditional leaders managing communities in each village* (Mothusi, traditional healer)*; As traditional leaders, we take care of our villages.* (Motsweledi, traditional leader).

Similarly, one of the professionals made mention of other assistants of their traditional leader, translated into Setswana as *Dikgosana* who were also taking care of areas falling under their authority: *They are also able to use Dikgosana that is the assistants of our traditional leader to take care of the areas falling under their authority* (Lerato, educator).

Furthermore, one of the professionals reported that police arrested those selling substances. However, because of corruption, among other reasons, some people did not report it to the police. The professional conveyed the following about police members:

The police also keep law and order and arrest people who sell drugs or if they find a person in possession of dagga or nyaope. If they get a tip-off, they will come and assist with arresting those selling drugs. We also have Community Police Forum in our community. They work with our traditional leaders about any crime-related matter. The problem with some police officers is that they are corrupt. For example, if they know someone selling drugs like nyaope and dagga, they will not arrest the person even if they are informed. People become helpless and do not know where to report. Our traditional leaders will then report this to station commander so that such police officers are addressed (Mphoentle, clinical psychologist).

The above extracts suggest that police members arrested those selling or are in possession of substances. This also pointed to the police as a protective factor for substance abuse. However, it seems that those community members became helpless and did not know where to report it, as they perceived some of police members as corrupt, and did not trust them to arrest those selling or are in possession of substances. This clearly seemed to be a risk factor for the prevention of substance abuse. The perceptions by community members of police members as corrupt and the fact that they did not trust the police to provide services was also established in a study by Vilakazi (2015). This study examined the impact of police corruption on service delivery in the Gauteng Province of South Africa in the Pretoria Central Policing Precinct. These extracts further pointed to traditional leaders escalating the report about police members who were not arresting those in possession of substances to the station commander. This served as a protective factor for substance abuse.

However, these extracts seem to denote deficiencies in the implementation of provisions of the Constitution of the Republic of South Africa (1996) that police members must prevent, combat and investigate crime. This implies that there is a need to understand the challenges encountered by police members, which impeded them from providing their service to the rural community as outlined in the Constitution of the Republic of South Africa (1996). Furthermore, these extracts are in contravention of the Back to Basics Approach and the Rural Safety Strategy which provide for safety awareness and take responsibility for safety by implementing safety measures, adopting sound safety habits, community crime prevention initiatives as well as effective investigation and conviction (Parliamentary Monitoring Group,

2013; South African Police Service, 2016). These extracts further point to the effects of substance abuse as a threat to safety and security in the rural area where the study was conducted; which was not the case in the past.

The extracts also suggest limited efforts by the police members, community policing forums, and traditional leaders in raising awareness about the link between substance abuse and criminal acts among adolescents and other community members. In addition, this finding implies that some of the police members did not combat criminal acts according to the provisions of the Constitution of the Republic of South Africa (1996), the National Drug Master Plan (Department of Social Development, 2013), as well as the Parliamentary Monitoring Group Report (2013), and South African Police Service (2016). Furthermore, these extracts point to a decrease in local controls following the collapse of apartheid (Brook et al., 2006; Parry, 1998; Peltzer et al., 2010; Seggie, 2012). Therefore, this indicates to a need to consider Batho Pele-People First Principles as outlined in the White Paper on transforming public service delivery (Department of Public Service and Administration, 1997). This also suggests the use of principles of community psychology (South African College of Applied Psychology, 2017) in addressing perceptions that community members hold regarding the service obtained from some of the police members. This includes, among others, consulting with community members where the study was conducted, allowing them to identify problems encountered with regard to the service offered by police members, and affording them an opportunity to figure out how best to resolve those problems (South African College of Applied Psychology, 2017). Meares (2017) asserted that people care a lot about having an opportunity to share their side of the story and providing input into priorities and strategies of law enforcement agencies.

In his 2016 budget speech, former Minister of the South African Police Services, Nkosinathi Nhleko further underscored community-centred policing with sustained community participation, to enable South African Police Service to reflect on the views of ordinary citizens and to ensure that voices of the electorate were represented (South African Police Service, 2016). The South African Police Service may, in turn, provide information about services they offer through parent meetings in schools, tribal community meetings, and community policing forum meetings. Where senior officials of the South African Police Service discover that community members are not satisfied with the services provided, they should investigate the matter, hold those who were acting contrary to their roles and

responsibilities accountable, and provide feedback to community members on how their concerns were addressed.

Furthermore, there is a need for police members to treat community members with dignity, respect and protect their rights (Meares, 2017). This may assist in changing community perceptions about police members, restoring the lost trust among community members about the police members and restoring the dignity of police members. According to DeVan (2016), police members cannot deal with all the crime. They need help and support from the community they serve. Corroborating with DeVan (2016), Minister of the South African Police Service, Fikile Mbalula in 2017, emphasised that the fight against crime cannot be won without involvement of the communities (South African Police Service, 2017). There was a need to strengthen strategic partnerships with communities through the establishment of community policing forums (South African Police Service, 2017) in each tribal *Kgotla* (translated as a community council), under the leadership of the headman who reports to the traditional leader. However, these tribal *Kgotlas* need to include parents, adolescents and other community members. Furthermore, they should create a conducive environment for each community member to share their views with regard to addressing criminal acts in their communities.

DECONSTRUCTING THE FALSE NARRATIVE

The global theme, deconstructing the false narrative, refers to the analysis of perceptions about substance abuse among adolescents, which may be incorrect due to insufficient or inaccurate information (Phillips, 2013). It consists of the following organising themes: broken beyond imagination, a need for creative and innovative interventions, a need for holistic and wider stakeholder participation, going back to our roots – reinvigorating our moral fibre and pulling all strings together. See Figure 6.
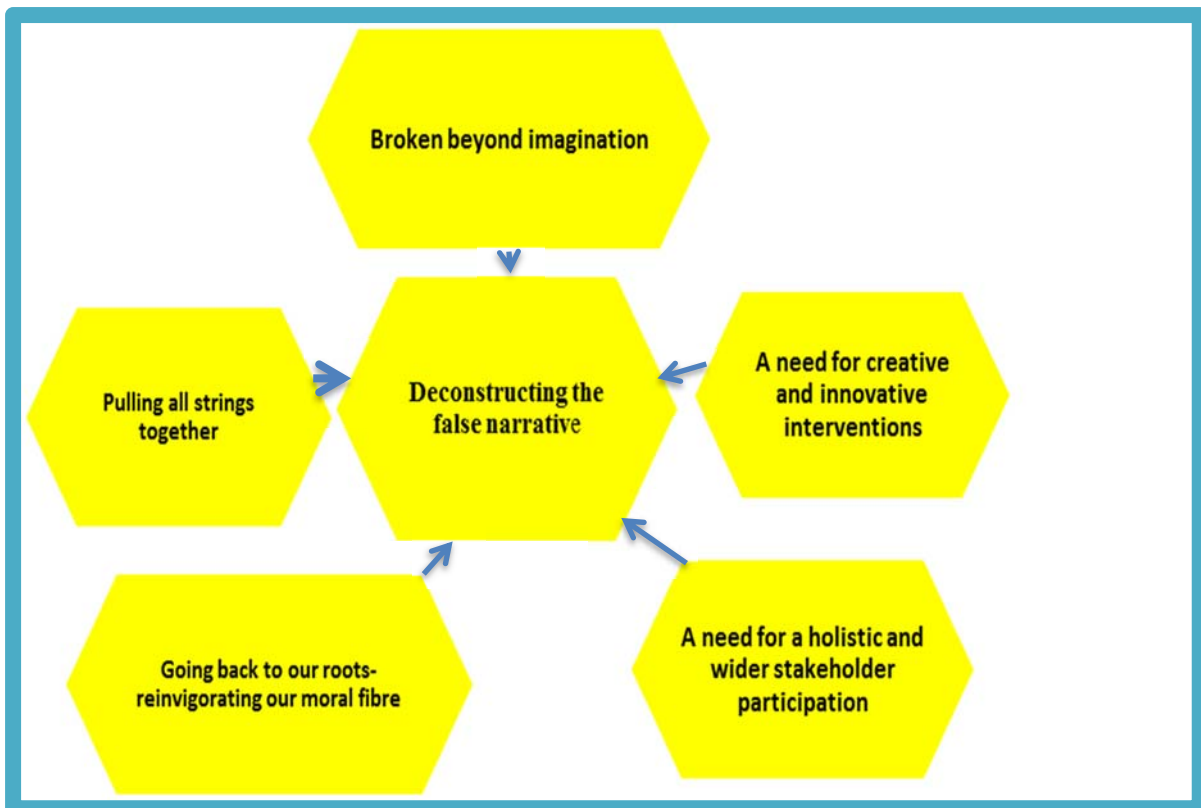
Figure 6: Global theme: Deconstructing the false narrative

Broken beyond imagination

Broken beyond imagination refers to the pain endured by parents for witnessing adolescents abusing substances. The painful effect of substance abuse was established by previous studies (Daley, 2013; Kalantarkousheh et al., 2014; Setlalentoa et al., 2015). Previous studies also revealed that adolescents were aware of the effects of substances, but continued using them (Gabriel et al., 2016). Consistent with these findings, some adolescents, parents and professionals in this study expanded as follows on the painful effects of substance abuse:

> *Parents are crying about their children using drugs (Tshiamo); It is painful to see our children using substances like this. It is also not good to be called at school because your child is using substances. This affects their studies because it means they don't attend classes, smoking cigarette at the toilet. They miss classes and may end up failing. Again when they start using substances, they will not respect you, thinking that they are now adults. The use of drugs is painful and is killing our children (Keatlaretse, parent); Drug abuse is a problem. It is painful to see effects of drug abuse on teenagers (Ontiretse); We need assistance in our village. Our children must be assisted to stop using substances* (Tshepiso, parent).

These findings point to the lack of respect shown by adolescents to ignore the advice of their parents not to use substances because of the effects it had on them (Csikszentmihalyi, 2016; Royal College of Psychiatrists, 2016). In addition, consistent with the previous substance abuse prevention strategies (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015), and previous studies (Setlalentoa et al., 2015), these findings revealed the health and psychological impact of substance abuse on adolescents and their parents.

Furthermore, the findings lend support to the National Strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013) that substance abuse is linked to academic difficulties and absenteeism. Cherry (2017) further cautioned that the inability of adolescents to manage the conflict of either exploring the use of substances or not using them would lead to personal failure instead

of personal growth. These findings further point to parental concerns about the use of substances by adolescents and a need for intervention to assist parents to address substance abuse problems. This was consistent with the recommendations of previous studies that challenges relating to substance abuse among adolescents required intervention (Mohasoa, 2010). Mudavanhu and Schenck (2014) also recommended that the focus should be on the wellbeing of youths, but in particular on parents who are in need of the physical and emotional energy to be involved in their children's lives. The preceding sections discussed reasons for substance abuse among adolescents. They included, among others, the availability and affordability of substances, learning the use of substances from parents and peers, parental negligence, loneliness, depression, boredom, poverty, and the absence of parents. The next section provides interventions for substance abuse challenges.

A need for creative and innovative interventions

A need for creative and innovative interventions refers to new user-friendly approaches to address challenges relating to substance abuse among adolescents (Department of Social Development, 2003). Creative and innovative approaches such as education and training on substance abuse was one of the strategies employed in countries such as Australia, Canada, the Netherlands, Portugal, Switzerland, the United Kingdom and the United States of America. These approaches were reported as effective in addressing these challenges (International Centre for the Prevention of Crime, 2015). In South Africa, the National Drug Master Plan (Department of Social Development, 2013) provided for the education and training on substance abuse in schools, through the learning area Life Orientation. Furthermore, national guidelines for the prevention of drug use and abuse in all public schools and Further Education Tertiary Institutions (2002) provided for the training of all educators on substance use, misuse and dependency management. The guidelines also provided information about the dangers of the use of substances and encouraged those experiencing problems to get the help they needed. According to these guidelines, preventive education was presented through the Life Orientation Curriculum and Assessment Policy Statement (Department of Basic Education, 2012).

Furthermore, the national strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013) required that school-based prevention programmes should be developmental, and locally and culturally relevant.

Some of the adolescents and professionals indicated that educators and adolescents have been trained. The focus of substance abuse training programmes was on providing information about substances. Education on substance abuse was included in the Life Orientation Revised National Curriculum Statement for grades R to 9 and grades 10 to 12:

> *There is a Life Orientation learning area. This is implemented from grades 7 to 12 in our schools. In that learning area, they teach us about prevention of substance abuse* (Letlhogonolo, adolescent)*; There are various programmes. Life Orientation: Information on substance abuse is also presented in a formal manner through Life Orientation learning area. This is done by grades 7 to 12. Educators compile lesson plans and different forms of assessment are conducted* (Ontiretse, educator)*; I know that in primary and secondary schools, teachers teach children about the dangers of drugs. When I was in primary and high school, they taught us about the dangers of substance abuse* (Mothusi, traditional healer).

These extracts were consistent with the substance abuse prevention strategies of various countries that the school context was one of the areas in which information about substance abuse prevention might be shared (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015). These extracts also lend support to the recommendations of the Department of Basic Education (2013) and the National Drug Master Plan (Department of Social Development, 2013) that information about substance abuse should be provided through Life Orientation lessons. Adolescents and professionals reported as follows on substance abuse education provided through creative and innovative co-curricular programmes such as Love Life, RADS, TADA and the Bakwena N4 Project:

> *We also have a RADS Programme. It stands for Radically Different Species. The programme also differentiates between RADS and RATS. It focusses on different problems facing young people and provides solutions for risky behaviour among young people including disease. One of the campaigns is South Africans against Drunken Driving. Learners are also requested to read the reports on the number of accidents in the N4 Road passing Zeerust. The aim of this activity is to make learners aware of the number of people dying due to alcohol-related deaths. Love life*

Programme: There is someone from Love Life who also comes and conducts lessons on substance abuse. She also assesses the learners and works closely with LO Teachers to avoid providing conflicting information (Ontiretse, educator)*; We also went for substance abuse training at Ramosa (This is a guesthouse in Zeerust) during holidays* (Moagi, adolescent)*; We have Bakwena N4 Project and we are provided with Road Safety Manuals. Focus is on road safety; the link between substance abuse and road accidents. Information-sharing is through drama; also focus on life skills; effects of substance abuse on driving skills; and drunken driving.*

In our community, sometimes social workers will come and teach people about drugs in community meetings (Mothusi)*; Other health nurses from the Department of Health, also teach learners about substance abuse and other health challenges facing learners such as teenage pregnancy, HIV/AIDS, and any other health-related problem. We focus on health in general. Other members are NGOs such as MAMORVICK. They also raise awareness about substance abuse among the learners. We conduct awareness campaigns in schools. As a department, we work with other members of the substance abuse forum and develop programmes to be implemented in schools. We are normally accompanied by a representative from SAPS, Ramotshere Moiloa Municipality, other members of the forum; that is a representative of churches, youth organisations funded by the Department of Social Development such as MAMORVICK as well as one youth organisation from Khunotswane, one of the villages in Zeerust. They also raise awareness about substance abuse in schools. We are able to assist with transport as and when we visit schools* (Mothusi, traditional healer).

These extracts point to the provision of information about substance abuse and its effects to adolescents through co-curricular programmes offered by the departments of Education, Health, Social Development, and NGOs such as the Bakwena N4 Project and youth organisations such as Love Life. Furthermore, these extracts lend support to the SAPS report that the Safe Schools Programme was used to raise awareness about substance abuse among

secondary schools (Parliamentary Monitoring Group, 2013). These extracts also reveal that adolescents were provided with reports on the number of accidents due to drunken driving and road accidents. However, previous studies established that even though education and information-based programmes were useful in certain situations, they did not necessarily meet the criteria for best practice interventions (Harker et al., 2008).

According to the National Adolescent and Young Adult Health Information Centre (2014), for these programmes to be effective, they required a commitment to improving adolescent health. One of the professionals reported the following:

> *Some of the educators were not committed to substance abuse prevention programmes. Therefore, they needed to be encouraged to take their responsibility so that learners could know that they had adults who cared for them during school hours. Learners and young people needed to take charge of their lives. Life is too fast; if proper foundation was not laid for teenagers, then young people tend to engage in risky behaviours (Tshireletso, social worker).*

These extracts indicate that some educators were not committed to substance abuse prevention programmes, which imply a risk factor for the success of those programmes. These extracts also contradict the provisions of the National Drug Master Plan (Department of Social Development, 2013), the National Strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013), and the Life Orientation Curriculum and Assessment Policy Statement (Department of Basic Education, 2012). They require educators in schools to teach Life Orientation as a compulsory learning area in which matters relating to substance abuse can be addressed. In addition, the Department of Basic Education is one of the critical stakeholders in substance abuse prevention programmes in accordance with the provisions of the National Drug Master Plan (Department of Social Development, 2013).

Furthermore, the extract that indicates that some of the educators were not committed to substance abuse prevention programmes was in contrast with the information obtained from one of the professionals who reported the following:

Life Orientation was one of the learning areas through which we implemented substance abuse prevention programmes (Ontiretse, educator).

The national strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013) also provided for the implementation of creative co-curricular activities such as peer education clubs. Adolescents and some of the professionals reported in the following extracts that information gained in a formal learning context about substance abuse prevention was complemented through co-curricular activities on substance abuse:

Teenagers Against Drug Abuse. TADA is a programme that awake or alert young ones and teenagers of the danger they putting their lives on. The main activities of the programme are to keep teenagers away from drugs for about the whole day because they do activities such as dramas, poems, storytelling based on true story. (Gomolemo, adolescent).

There is Teenagers Against Drug Abuse at our school. Yizo and Gazilam; I saw them on TV. TADA is a programme that is done by other learners in our school. Our Life Orientation educators were trained on substance abuse so that they come share that information with us. They do that at assembly through drama, poetry and information about dangers of drug abuse. Gazilam and Yizo are programmes that I saw on TV; they are dramas that showed information about young people using drugs and effects. For example, some of the teenagers using drugs were unruly and violent to their peers (Oarabile, adolescent).

Teenagers Against Drug Abuse (TADA) is done by Department of Social Development in collaboration with our school and other schools in Zeerust. In that programme, the following topics regarding substance abuse are discussed with the learners: What is substance abuse, types of drugs, what influences young people to use drug; how to help themselves in case they use drugs, how to identify someone using drugs. Learners

*identified to serve in the programme are trained on these topics so that they can teach other learners in the school (*Keitumetse, educator*).*

The other one is MAMORVICK. The target group is learners abusing substances and is done through a workshop. Learners are taken to a camp during holidays for one week. Once-off camp. There is also TADA: That is Teenagers Against Drug Abuse. This is done by the Department of Basic Education through collaboration with social workers. That is Department of Social Development. Through this programme, groups of learners are identified by educators to participate. They are taken to training for a week and come back to implement in the school. They are trained on substance abuse, what causes learners to abuse substances and its effects. The other programme is RADS/RATS Training workshop. The focus is on training of Life Orientation educators; providing motivational talks on substance abuse and presentations on other life skills. The target group is all grades (Keneilwe, educator).

That is grades 7-12. Trained educators will then select students to participate in the programme. The learners will develop programmes for other learners and present these during assembly. Mmabana recreational centre is also coordinating substance abuse prevention programmes. Their focus is on providing information about drugs through art and culture. Learners present information to other learners through drama and group discussions. The role of educators is to facilitate such sessions and provide guidance to learners. Learners are the ones composing these dramas (Ontiretse, educator).

We have TADA, RADS and MAMORVICK, which focus on awareness about substance abuse, its effects and information about rehabilitation. Learners participating in these programmes attend workshops during holidays and are trained so that they share information about substances with other learners. After training, they will do drama, speeches, and sports activities. Our school will be participating in the final district competition. We also have Keeping girls in school programme. The target

for this programme is girls only. This programme assists girls with pads. In addition, those who fall pregnant are given support so that they get back to school after giving birth. The programme also addresses substance abuse related information. Identified female learners of the keeping girls in school are trained. After training, they do presentations in assembly raising awareness about healthy lifestyles for female learners. They also support other female learners (Ontiretse, educator).

There is TADA groups, facilitated by social workers in schools. Through these TADA groups, learners are motivated against the use of substances (Mphoentle)*; There is an NGO at Ramosa not far from Zeerust town. This NGO raises awareness about substance abuse. They also assist our youth with applications for tertiary institutions and employment, as well as how to write Curriculum Vitae (*Motsweledi, traditional leader).

We also have a camp that we hold during holidays for the learners. This is a peer-to-peer programme. It normally takes 3-5 days and is funded by Department of Social Development and done in collaboration with the Department of Education. During the three days, we provide information about substances abused; reasons for use of substances and its effects. We also share information about treatment centres available in the province as well as aftercare support provided. We also have life skills programmes such as Teenagers against Drug Abuse (TADA) and Youth against Drug Abuse (YADA). TADA is implemented in schools; whilst YADA is targeting Youth out of School. We also have outreach programmes for young people and adults in the communities within Ramotshere Moiloa Municipality (Tshireletso, social worker).

Previous studies and substance abuse prevention strategies of various countries including South Africa (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015; Setlalentoa et al., 2015; United Nations Office on Drugs and Crime, 2016) indicated that there were various programmes implemented to address substance abuse prevention programmes. Consistent with these studies, extracts from this study indicate that there were creative co-curricular substance abuse prevention programmes

implemented by government and NGOs. This corroborated with the findings of previous scholars (Setlalentoa et al., 2015) and the provisions of the National Drug Master Plan (Department of Social Development, 2013) regarding collaboration among government and NGOs when implementing substance abuse prevention programmes. These extracts also pointed to targeted prevention programmes focusing on female adolescents only lending support to previous studies about targeted intervention programmes (United Nations Office on Drugs and Crime, 2016).

Furthermore, these extracts describe how evidence-based strategies such as projects; essay writing, speeches, tests, presentations, drama, and the use of role models were employed to prevent substance abuse. The use of the various strategies to raise awareness about substance abuse corroborated with a study by Chie et al. (2015) which reported that substance abuse prevention programmes should be presented to students in a creative manner using theatre and music performances. In addition, these extracts lend support to the Ke Moja Integrated Strategy (Department of Social Development, 2003) which sought to bring awareness of and discourage substance abuse among young people using a range of media such as posters, radio clips, television clips and drama.

These extracts indicated that adolescents, youth out of school, youth at risk, parents, and community members were the target group for substance abuse prevention programmes. This was similar to the substance abuse prevention strategies that were applied in other countries and the rest of South Africa (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015). Consistent with the recommendations of previous studies (Morojele, Knott, Myburg, & Finkelstein, 2008), it was exciting to note that these extracts signify that substance prevention programmes were targeting previously disadvantaged rural communities. In addition, one of the professionals reported that a*ctivities are tailor-made to suit the needs of their target groups in Zeerust.*

This view was consistent with the recommendation made by the International Centre for the Prevention of Crime (2015) and Setlalentoa et al. (2015) that there was a need to determine the communities' needs regarding substance abuse problems confronting them. However, one of the professionals reported that Grade 12 learners were excluded from substance abuse prevention programmes:

> *Grade 12 learners are not exposed to these programmes because focus is*
> *at ensuring that they pass. Therefore, focus is on using available time to*
> *teach Grade12 subjects and to assist them so that they obtain good marks.*
> *The school does not want Grade12 learners to fail because the school will*
> *be classified as a trapped school. Grade 12 learners are excluded from*
> *these additional activities.*

These findings denote exclusion of some of the Grade 12 learners from substance abuse prevention programmes which contradicted the provisions of the national strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013). The strategy stipulated that the Curriculum Assessment Policy for Life Orientation should allow for the infusion of lessons on drugs and substance use. These lessons should be repeated in all the grades up to Grade 12. Additionally, excluding Grade 12 learners from participating in substance abuse prevention programmes could be a risk factor for substance abuse, influencing their academic success negatively. Furthermore, this finding implies inconsistencies in the implementation of substance abuse prevention programmes in the schools.

Despite all the substance abuse prevention programmes implemented, adolescents continued to abuse substances. The question is: Why do adolescents continue abusing substances despite all the abovementioned guidelines and information provided to them through Life Orientation lessons and co-curricular programmes? This could be because information provided is about the dangers of substance abuse instead of addressing issues such as self-control, emotional awareness, communication skills, problem-solving skills, self-efficacy, assertiveness and drug resistance skills as recommended by the national guidelines for the management and prevention of drug use and abuse in all public schools and further education tertiary institutions (Department of Basic Education, 2013). Previous studies (National Institute on Drug Abuse, 2003; Perform well, n.d.; Setlalentoa et al., 2015) also established that providing information about the dangers of substance abuse does not address substance abuse challenges effectively.

In addition, a study by Alavi (2011) aimed at investigating the role of self-esteem in the individual's tendency to addiction, theft and prostitution, established that low self-esteem correlated to substance abuse, theft and prostitution. Lending support to Alavi (2011),

Lawrence (2017) established that low self-esteem might lead to a lack of development and a tendency towards substance use. Furthermore, it is congruent with previous studies (Department of Education and Communities, 2011; Goliath & Pretorius, 2016; Sun & Shek, 2010) that point to the importance of considering positive constructs such as self-control, emotional awareness, communication skills, problem-solving skills, self-efficacy, and assertiveness. These positive constructs may contribute to positive adolescent development and mitigate against the use of substance abuse before it occurs when implementing substance abuse prevention programmes. Corroborating with previous scholars, Ruiz and Strain (2011) argued that more emphasis should be on increasing self-understanding and acceptance . This could be done through activities such as value clarification and responsible decision-making, improving interpersonal relations by fostering effective communication, assertiveness training, and increasing the adolescent's abilities to fulfil their needs during the adolescent stage. Browne (2014) asserted that consideration of these positive constructs in substance abuse prevention programmes might also improve the lives of adolescents in rural areas and enhance their health and wellbeing.

In the following extract some adolescents and professionals recommended aspects to be included in substance abuse prevention programmes:

> *As teenagers, we face many challenges as we develop from childhood to adulthood* (Moagi); *There is a need for parents to establish good relations with their children to enable them to express the problems they have with their parents* (Tshireletso); *Violence in the community; peer group pressure; and cyberbullying through cell phones* (Tshiamo, adolescent; Keneilwe, educator; Keitumetse, educator; Tshireletso, social worker)*; Youth at school are at risk of challenges such as Satanism. There is a need to revise religious policy. There is a need for prayer meetings or assembly where pastors can pray for learners as was the case in the past. Parents seem not to be committed to religious matters and children are left out. There is a need for collaboration with churches and communities. Important stakeholders such as the family, school, church, ward councillors, traditional leaders, and Department of Health need to work together and not in silos. Activities should focus on challenges facing teenagers; put systems in place to address these*

challenges; a plan to address social ills; all sectors to take responsibility. Currently, Department of Social Development is in charge of all these challenges (Tshireletso, social worker).

In addition, in the following extract some of educators and professionals proposed stakeholders and aspects that might be included in substance abuse prevention programmes to address challenges encountered by adolescents:

Self-concept, who am I, and then identify the general challenges facing young people; Young people need to understand who they are because they can be able to address any problem around them. The next step would be to teach them to accept themselves. Tell them they are the only people who can accept themselves and know that they have potential to address any problem coming their way. Affirming them is very important. I would also use peer support programmes before going for professionals to participate in the programme. Focus on improving self-image and instilling confidence among learners. Most of the learners face problems with courage (Lerato, educator)*; Topics such as identification and definition of drugs, types of drugs, effects of drugs, why young people use drugs, how to handle someone abusing drugs, how to support such people and where to get assistance". If this approach does not work, I will identify challenges and address them working with adolescents participating in the programme* (Keneilwe, educator)*; I would include awareness, counselling and rehabilitation about substance abuse* (Keitumetse, educator).

We need to get experienced community members to come and talk about drugs. We can also call someone in the community who is respected to talk about drugs (Ontiretse, educator)*; They are not enough. Our hands are full. My wish is for our government to support these initiatives. Substance abuse is rife and we need more services. (1) Survival of substance abuse: enable those abusing substances to share their experiences and achieve sobriety. (2) Churches (3) School (4) Family (5) Client (6) Community need to be empowered. I will include those without substance abuse*

problem because the teenagers using substances need to be integrated in the community. The community needs to understand the substance abuse problem. Professionals are required. I would use multidisciplinary approach; including social workers, psychologists, occupational therapists, police, teachers, and pastors. I would use these professionals for their expert knowledge, which is required for substance abuse prevention. Occupational therapists will assist in creating goals for these teenagers. I would raise awareness about substance abuse in communities because that is where substance abuse problems are encountered. I will also establish substance abuse support groups so that those who are rehabilitated can share their stories and assist others who may be addicted (Mphoentle, clinical psychologist).

These extracts point to the use of available resources within the community to address substance abuse challenges. This resonates with recommendations of previous studies (Harrison, 2017; Radin et al., 2015; Setlalentoa et al., 2015) as well as principles of community psychology (South African College of Applied Psychology, 2017), which acknowledged collaboration with community members, groups and organisations to solve social issues such as substance abuse. In addition, where there was a need to build capacity to enable community members to address substance abuse problems (Setlalentoa et al., 2015; South African College of Applied Psychology, 2017).

These extracts were also consistent with proposals of previous studies about the inclusion of aspects such as the types of substances abused (North, 2012; Poole, 2005; Royal College of Psychiatrist, 2016), and reasons for their use (Mudavanhu & Schenck, 2014). These findings also point to the inclusion of aspects relating to the self-concept as was recommended in previous studies (Khajehdalee et al., 2013). More aspects were mentioned, such as the family as a place where substance abuse prevention should start, the community where substance abuse was encountered (Griffin & Botvin, 2010; Mudavanhu & Schenck, 2014; Setlalentoa et al., 2015), substance abuse rehabilitation, survival of substance abuse, sobriety, establishment of substance abuse support groups, integration into the community (Brody, 2013; National Institute on Drug Abuse, 2009; The Prevention of and Treatment for Substance Abuse Act, 2008; Sussman, 2011), and the multidisciplinary approach to substance abuse (Department of

Basic Education, 2013; Department of Social Development, 2003; Department of Social Development, 2013).

Furthermore, recommendations about aspects to be included in addressing substance abuse prevention programmes were consistent with those that were proposed by other policy makers and in previous studies (Brody, 2013; Department of Basic Education, 2013; Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015; National Institute on Drug Abuse, 2009; Sussman, 2011; The Prevention of and Treatment for Substance Abuse Act, 2008). The extracts also pointed to the inclusion of churches and the revision of religious policies to ensure that prayer meetings conducted by pastors in schools were resuscitated as was the case in the past. The extracts also lend support to the National Drug Master Plan (Department of Social Development, 2013) about the role of religious leaders in substance abuse prevention programmes.

Adolescents and some of professionals recommended in the following extracts that information sessions, speeches and debates should be included in substance abuse prevention programmes:

> *Substance abuse prevention programmes must provide information that will help learners stay away from drugs* (Kamogelo, Lebogang, adolescents; Keneilwe, educator and Tshireletso, social worker); *First, I will start with a message to all teenagers that they must not use drugs. I will teach them the dangers of using drugs and what to do to stop using drugs. I will also tell them about the rehabilitation centre and how it assists those abusing drugs. I will include them because when you teach someone something, he or she will understand the dangers of drug abuse. Again telling them about rehabilitation centre, those who are using drugs will know about a place where to go for assistance. I think to guide them about the dangers of drug abuse and show them how they can assist other teenagers* (Oarabile, adolescent); *Keeping them busy with debates and speeches. I will also do awareness about substance abuse in the community. Our community needs to be aware of substance abuse and its effects on adolescents. I will also do awareness on those adolescents who dropped out from school* (Tshepang, adolescent); *More information on*

substances abused, its causes, and effects is required for our children (Keatlaretse, parent).

These extracts on information sessions, speeches and debates to raise awareness on substance abuse and provide information about where people would get assistance was consistent with the substance abuse prevention strategies of various countries (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015), and the recommendations of previous studies (Griffin & Botvin, 2010; Setlalentoa et al., 2015).

In the following extracts, some of the adolescents, parents and professionals recommended the inclusion of sporting activities in substance abuse prevention programmes:

> *We do not have sports grounds where they could play. We need sports grounds to keep them busy with sports activities* (Tshepiso, parent); *We need sports grounds for our adolescents* (Keatlaretse, parent); *Keep them busy with sporting activities* (Reoikantse, adolescent); *We need to keep them busy with sports but with focus on substance information. Department of Sports must also be involved. Through sports and recreational activities, adolescents can be kept busy and avoid boredom which leads them to using drugs. Through sports, they will understand the importance of keeping healthy and fit. That will have a positive effect on their studies. They will be able to concentrate in class* (Lerato, educator); *Include sporting activities and competitions* (Keabetswe and Tsholofelo, adolescents; Ontiretse, educator and Tshireletso, social worker); *First, I will start with a camp activity that will take about 4-5 weeks at the game reserve. Do activities such as swimming, mountain biking, and marathons. I will include them so that I can make all teenagers to come and join us so that they can start to decrease their drug-abusing rate time because it's tough to leave drugs. I think to encourage adolescents in developing programmes there has to be a payout afterwards because adolescent stage is understandable when one can say I don't go there in a group; they all will say me too. Therefore, when they hear that there is payout they will not be influenced by one. They will all come* (Rorisang, adolescent).

These extracts recommend the inclusion of various sporting activities in substance abuse prevention programmes. These findings also propose the inclusion of activities such as swimming, mountain biking and marathons that could be implemented in rural areas where these activities might not be available. The extracts indicate the importance of recreational facilities for substance abuse prevention and lend support to the provisions of the Ke Moja Integrated Strategy (Department of Social Development, 2003), National Drug Master Plan (Department of Social Development, 2013), and The Prevention of and Treatment for Substance Abuse Act (2008) regarding the importance of recreational facilities as a protective factor for substance abuse. One of the professionals recommended a need for a multipurpose centre as follows:

> *Multipurpose centre for teenagers and a gym to keep them busy.*
> *Any opportunity available would assist to empower and keep them busy*
> *(Keneilwe, educator).*

Similarly, some of the adolescents, parents, and the professionals indicated that there were no recreational facilities in their rural area. See the following:

> *We do not have recreational facilities; young people do have talents. If they had sporting facilities, they would polish their talents. In Zeerust, we have Mmabana Recreational Centre, but it is not accessible to rural communities. These resources need to be decentralised. By availing this recreational centre to all villages, we should be able to combat substance abuse. Young people have so much time but do not know where to channel their behaviour. I always pray that God must help me address the challenges facing young people in rural areas* (Lerato, educator); *There is a lack of recreational facilities for young people in the community* (Tshimologo, adolescent); *We do not have sports grounds where they could play various sports like in Gauteng* (Keatlaretse, adolescent); *We do not have developed football grounds like in other developed areas. We have Mmabana Recreational Centre, which is not accessible to all the villages. It is not free; people must pay to use recreational resources in that centre* (Tumelo, Mental Health Worker).

These extracts suggest inequalities regarding the establishment of recreational facilities in rural areas and affirmed what was established by previous studies and other policy makers (Department of Social Development, 2013) that the Department of Sports and Recreation needs to provide sports and recreation facilities. Extracts also pointed to limitations encountered by the Department of Sports and Recreation to transform the delivery of sport and recreation by ensuring equitable access by the citizens of South Africa as well as an integrated system of enablers supporting the delivery of sports and recreation (Department of Sports and Recreation, 2012).

An address by Thulas Nxesi, Minister of Sports and Recreation in South Africa during the budget vote for 2017/2018 in parliament, indicated that they needed to cooperate with Cooperative Governance and Traditional Authorities (COGTA) and municipalities for the sharing of sports and recreational facilities. He further reported that from 2016, a certain percentage of the Municipal Infrastructure Grant would be ring-fenced to build community sports facilities. The minister further reported that the Rural Sports Development Programme was already underway across all provinces in South Africa (Polity, 2017). Furthermore, these findings point to a lack of recreational facilities, which would be a risk factor for substance abuse as was discovered by previous scholars (Setlalentoa et al., 2015).

In addition to recreation facilities, Motsweledi (traditional leader) pointed to a need for entrepreneurship opportunities for young people. He said the following:

> *We have old houses that were owned by white people in town and are no longer in use. Young people can use them for business. For example, backpacker. Backpackers serve as guesthouses, which are reasonable. For example, people pay R180, 00 per night. The rooms are differentiated according to their gender. You will have an area allocated for males and another one for females. Young people can start their own business by establishing Backpackers. These Backpackers will create employment opportunities where young people can be employed.*

These extracts point to the inclusion of activities such as entrepreneurship opportunities to create employment for adolescents, to keep them busy and avoid substance abuse, lending support to previous scholars who also recommended the creation of employment

opportunities for adolescents (Setlalentoa et al., 2015). Molelemane (2014) also argued that through entrepreneurship, adolescents in underprivileged areas could become empowered to contribute to a more sustainable economy, a better society and to reach their goals.

A need for a holistic and wider stakeholder participation

A need for a holistic and wider stakeholder participation refers to the inclusion of multidisciplinary stakeholders for the prevention of substance abuse. Substance abuse prevention strategies of various countries (Department of Basic Education, 2013; Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015; South African Police Service, 2016), and previous studies (Deb & Gupta, 2017; Setlalentoa et al., 2015) recommended the importance of a multidisciplinary team of professionals to address substance abuse challenges. Additionally, the National Drug Master Plan (Department of Social Development, 2013) and the national strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013) identified government departments, non-government organisations (NGOs), Community-Based Organisations (CBOs), research institutions, and universities as essential for ensuring the pooling and rational use of resources.

Furthermore, according to the Ke Moja Integrated Strategy (Department of Social Development, 2003), collaboration among different stakeholders did not only strengthen the effectiveness of the strategy, but it also guaranteed buy-in and ownership by various stakeholders. Additionally, it ensured that various experts from different departments or institutions brought their skills to address the substance abuse problem and that with proper coordination, the programme would be sustained in various departments that were involved.

In the following extracts the participants identified and acknowledged the role of stakeholders such as role models, parents, government departments, and NGOs for addressing challenges relating to substance abuse among adolescents:

> *Bakwena N4 substance abuse prevention project; Department of Health, MAMORVICK, Mmabana Recreational Centre, parents, SAPS, social workers* (Ontiretse)*; Department of Social Development, Public Works through EPWP Programme, our Municipality, Community Proprietary*

> *Associations, Local banks, community members, and traditional leaders.*
> *I include local banks because for any youth development programme*
> *they benefit as the youth are the future (*Motsweledi, traditional leader).

These extracts lend support to previous studies about stakeholders required for substance abuse prevention programmes. They further pointed to the Bakwena N4 substance abuse prevention project, Community Proprietary Associations, local banks, and MAMORVICK which were additional stakeholders that were not specified in the substance abuse prevention strategies of other countries (International Centre for the Prevention of Crime, 2015) and the National Drug Master Plan (Department of Social Development, 2013). Furthermore, even though one of the professionals identified Mmabana Recreational Centre as one of the stakeholders for substance abuse prevention, the other professional indicated in the following extract that there were no facilities similar to Mmabana Recreational Centre in their village:

> *We have Mmabana Recreational Centre; unfortunately, it is located in*
> *Wilbedacht and is not accessible to all the villages* (Mothusi, traditional
> healer).

The following extracts obtained from some of the adolescents and professionals further proposed recommendations to use professionals such as educators, clinical psychologists, health nurses, occupational therapists, psychologists, social workers, medical doctors, pastors, police members, traditional leaders, and ward counsellors to prevent the use of substances among adolescents:

> *Professionals are required. I would use multidisciplinary approach;*
> *including social workers, psychologists, occupational therapists, police,*
> *teachers, and pastors. I would use these professionals for their expert*
> *knowledge, which is required for substance abuse prevention.*
> *Occupational therapists will assist in creating goals for these teenagers*
> (Mphoentle, clinical psychologist)*; Our educators, police, nurses, and*
> *social workers. Our educators are at school with us the whole day. They*
> *must teach us about the dangers of drugs. They must know how to help*
> *those using drugs and refer them for rehabilitation. The police must*
> *arrest those abusing drugs. The nurses must treat learners who use*

drugs in the clinic or hospital. They must also come to our school and teach us about the dangers of drugs and what they do when a person is sent for rehabilitation. Social workers assisted me by referring me to the rehabilitation centre in Klerksdorp so they must also assist other learners and refer them to rehabilitation centres to help them stop using drugs (Oarabile, adolescent)*; People who are respected in the community; ward councillors and traditional leaders* (Keneilwe, educator)*; Pastors must teach about drugs in church; TV and Radio presenters must speak about drugs through various media channels* (Keitumetse, educator).

We parents, educators, our adolescents, social workers, nurses, pastors, police officers, our councillors, and traditional leaders. Parents must raise children in a proper way. **Lore le ojwa lesale metsi**, *translated as children, must be taught to behave well at an early age. Educators and social workers must teach our children about substance abuse. Police will help with Community Policing Forum where we can be taught about substances. We need pastors to preach and pray for our children against use of substances. Traditional leaders and councillors must talk to parents and children about the negative effects of substances* (Tshepiso, parent).

These extracts reveal the inclusion of stakeholders such as adolescents, councillors, doctors, educators, nurses, occupational therapists, parents, pastors, social workers, traditional leaders, traditional healers, and police members in substance abuse prevention. These findings also highlight information about non-government organisations such as Love Life, the Bakwena N4 substance abuse prevention project, MAYETO and MAMORVICK. These extracts also proposed roles of these stakeholders in substance abuse prevention programmes, which were similar to those provided in the National Drug Master Plan (2013). These findings supported previous studies about the importance of a multidisciplinary team to address challenges related to substance abuse as indicated in the preceding section. However, stakeholders such as traditional leaders and traditional healers were not included in the substance abuse prevention strategies of countries such as Australia, Canada, the Netherlands, Portugal, Switzerland, the United Kingdom and the United States of America (International Centre for the Prevention of Crime, 2015).

In the following some professionals had similar views on the importance of involving traditional leaders in substance abuse prevention programmes:

Traditional leaders and their assistants need to work together with us (Mothusi, traditional healer)*; I think traditional leaders must also be involved because they are our leaders. When they speak, most of the time community members will respect what they say. Even young people will listen to them. They are also able to use Dikgosana, that is the assistants of our traditional leader to take care of the areas falling under their authority. They can call Makgotla that is community meetings where substance abuse matters can be discussed during such meetings. Through such meetings, information about substance abuse can be shared with parents in a language that they understand. Assistants of traditional leaders can assist families when they are encountering challenges with adolescents using drugs. In our village, people respect instructions of the traditional leaders. I believe these adolescents will respect them because they know that instructions from the traditional leader must be respected, translated in Setswana as* **Lefoko la Kgosi leagelwa mosako** (Lerato, educator)*; If they were involved, they could assist those families. 80% of such families could be assisted* (Motsweledi, traditional leader).

These extracts emphasise the importance of including traditional leaders in the wellbeing of its community members lending support to the recommendations of previous studies (Mathonsi & Sithole, 2017), provisions of the National Drug Master Plan (Department of Social Development, 2013) and the Traditional Leadership and Governance Framework Act (2003).

However, one of the professionals was reluctant about the inclusion of traditional healers in substance abuse prevention programmes: *No, I do not have any further information. I think I shared everything about required stakeholders for the substance abuse prevention programme* (Lerato, educator). This extract suggests that traditional healers were not viewed as stakeholders to be considered for substance abuse prevention programmes. That would be

because Lerato held a different religious perspective and was educated in Western medical treatment (Sorsdahl, Flisher, Wilson, Stein, 2010).

Furthermore, this extract contradicts the provisions of the World Health Organisation (2013) and the Traditional Healers Act (2004) for greater collaboration with traditional healers. However, in the following extract one of the professionals acknowledged the importance of all stakeholders irrespective of their religious orientation:

> *Kgetsi ya tsie e kgona ke go tshwaraganelwa, translated as together, we can do more. We need parents, teenagers, traditional leaders, traditional healers, doctors, social workers, educators and police officers to assist us with this problem. Other people like us as traditional healers must participate in these programmes. We can share information on how we treat such problems (Mothusi, traditional healer).*

These findings suggest a collaboration of all the stakeholders and lend support to the provisions of the National Drug Master Plan (Department of Social Development, 2013) and recommendations from strategies of other countries (International Centre for the Prevention of Crime, 2015).

Even though police officers were considered as essential stakeholders for substance abuse prevention programmes by the provisions of the National Drug Master Plan (Department of Social Development, 2013) and the recommendations of previous studies (International Centre for the Prevention of Crime, 2015), one of the professionals raised a concern about the capability of some of police members in dealing with adolescents. See the following extract:

> *I will also go to the police stations even though they are not equipped to deal with young people. I will ensure that they are trained on how to relate to young people. They need to understand young people. They need to have an approach of addressing young people. They need to know how to bring young people closer to them. They need to be friendly to young people. Due to their status, they are sometimes arrogant and if they change their approach, young people will respect them. SAPS must also be involved. They will assist with maintaining law and order and*

> *assist with arresting people selling drugs to young people. The police*
> *officers must also make adolescents aware that their role is to ensure*
> *their protection not to harass them as they may think. They need to*
> *change perceptions of adolescents about them. Adolescents must know*
> *that they are there for their safety. They should work closely with*
> *adolescents because adolescents know the people selling drugs* (Lerato,
> educator).

These extracts demonstrate that some police members were unable to relate to adolescents as expected and that they required training. These extracts were inconsistent with their role of serving, protecting and building communities in a way that is responsive to their needs (Constitution of the Republic of South Africa, 1996; Lantigua-Williams, 2016; South African Police Service, 2016). Furthermore, this denoted limitations in the provisions of the South African Police Service Strategy (2014) regarding the training of police members and their role in substance abuse prevention programmes (Department of Social Development, 2013). Furthermore, the extracts point to gaps about the role of the police members in educating adolescents about skills required for responsible citizenship (Raymond, 2010).

Even though the substance abuse prevention strategies of South Africa and Switzerland indicated that police members were trained on appropriate ways of interacting with adolescents in South Africa and Switzerland (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015), the extracts dealing with the inability of the police members to interact with adolescents indicate to a need for continued training of the police members. Thurau (2009) advised that police members need to be trained on adolescent development and the etiology of antisocial behaviours, as well as relationship building. In addition, parents and youth need to be empowered to work with police members to improve the quality of police and youth interactions. Dacchille and Thurau (2013) maintained that if police members were trained on youth development, they would be in a position to better serve adolescents. The appropriate training of police members to deliver on the policing mandate was underscored in the Strategic Plan of the South African Police Service (2014).

Some of the adolescents and professionals reported that they were involved in the development and implementation of substance abuse prevention programmes. See the following:

> *We prepare speeches, dramas, and presentations* (Mosidi, adolescent*); We prepare lessons on substance abuse* (Keneilwe); *As a coordinator for substance abuse I was involved. That is why I conducted counselling, provided information, and referrals regarding substance abuse related matters for the learners. TADA is a ready-made programme developed by the Department of Social Development. RADS and MAMORVICK programmes were developed by the service providers, not me or the school* (Ontiretse, educator*); Yes, we are involved in the development of these programmes. We have national and provincial programmes. For both the National and Provincial programmes we have an opportunity to provide inputs to the programmes before implementation, and we also customise these programmes to suit the needs of the community we are serving* (Tshireletso, social worker*); We are involved in the development of substance abuse policy, for example, mental health policy. We are notified about amendments to the policy and afforded an opportunity to provide inputs. We also plan other activities as members of the substance abuse forum* (Mothusi, Mental Health Worker).

These extracts suggest that adolescents as the target group for these programmes were involved in the development and implementation of substance abuse prevention programmes. In addition, these extracts point to the involvement of some professionals in providing input to the development and review of the Mental Health Policy as well as the National and Provincial substance abuse prevention programmes. This lends support to the Department of Health (2013), Department of Social Development (2013), International Centre for the prevention of Crime (2015), as well as the National Strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013) about the importance of involving stakeholders in the development of substance abuse prevention programmes.

Furthermore, the extracts indicate the involvement of mental health professionals in providing inputs to the Mental Health Policy. This was in line with the provisions of the National Mental Health Policy Framework and Strategic Plan (Department of Health, 2013) for capacity development of mental health workers in policy development. The role of mental health workers in providing inputs to the policy was also acknowledged in the National Adolescent and Youth Health Policy (Department of Health, 2017) and previous studies (Draper et al., 2009; Ssebunnya, Kigozi & Ndyanabangi, 2012). Draper et al. (2009) further provided the following policy development process in the Department of Health which includes:

- identifying a need for and purpose of the policy,
- identifyng and tasking the relevant section and official(s) within the department to drive the development of the policy,
- establishing a working group to compile the policy and inform the provincial stakeholders of the new policy development process,
- consulting representatives of the discipline(s) and other stakeholders involved in the policy area,
- working group developing a draft document,
- conducting a literature search on the policy issues and reviewing similar policies in other countries,
- circulating the draft policy to a broader range of stakeholders for further comments and development until saturation is reached,
- coordinating input by provincial stakeholders and consulting with provincial and district stakeholders, and
- finalising and costing the policy, and submitting it for approval within the department.

Some of the professionals also emphasised the importance of involving adolescents in the development of substance abuse prevention programmes. See the following extracts:

We need to take them on board; request them to brainstorm on challenges they are encountering as young people and allow them to provide responses on what can work. Once we engage them, they will own up the programme, and proceed with meetings even if the

coordinator is not around. They want to be appreciated and involved in programmes (Lerato, educator)*; It is always important to involve the people affected, have knowledge of their experiences and share knowledge of things we may not be aware of. They will be able to offer support to the programmes we intend developing* (Mphoentle, clinical psychologist)*; Our own community must support them. They must know that they are future leaders, we need to engage them. They find that they are welcomed by drug lords, who respect them while in their own families and community they are not respected. By respecting them, they will feel valued and that may assist in stopping substance abuse. The other challenge that we have is that when young people go to tuck shops and buy for example cigarette or go to taverns and buy alcohol, they sell to them because sometimes parents send their children to buy cigarette or alcohol for them* (Motsweledi, traditional leader).

These extracts propose that the involvement of adolescents in the development of substance abuse prevention programmes would make them feel valued and respected. The extracts also point to providing an opportunity for the adolescents to share their knowledge and experience on which programmes would be effective in addressing substance abuse problems. Making them feel valued and respected and promoting their buy-in will instil in adolescents a sense of ownership of the programmes implemented.

Furthermore, these findings lend support to the provisions of the National Drug Master Plan (Department of Social Development, 2013), the national strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013), and the Ke Moja Integrated Strategy (Department of Social Development, 2003) about the involvement of adolescents as stakeholders in substance abuse prevention. However, in the following some of the adolescents and professionals reported that they were not involved in the development of substance abuse programmes:

No. Members of the TADA are the ones planning this programme for us. I only participated in TADA programmes at our school. At the rehabilitation centre, we participated in counselling sessions organised by the rehabilitation centre. Yizo and Gazilam are TV programmes and I

was not involved in their development (Oarabile, adolescent)*; I was not involved. The TADA Programme is developed by the Department of Social Development* (Mphoentle, clinical psychologist)*; As traditional leaders, we are not involved in issues of substance abuse. We only take care of our villages. If we were involved, we could assist those families. 80% of such families could be assisted* (Motsweledi, traditional leader).

These extracts show that not all stakeholders were involved in the development of substance abuse prevention programmes.

This contradicted the recommendations of the International Centre for the Prevention of Crime (2015), the provisions of the National Drug Master Plan (Department of Social Development, 2013), the national strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013), and Ke Moja Integrated Strategy (Department of Social Development, 2003) about the stakeholders required for addressing challenges related to substance abuse. Furthermore, non-involvement of traditional leaders contradicted the recommendation made by Thandi Modise, former Premier of the North West Province of South Africa, at the official opening of the house of traditional leaders that *Dikgosi,* meaning traditional leaders, must be part of the fight and play an important role in mobilising communities against substance abuse (Kgwele, 2012).

Going back to our roots – reinvigorating our moral fibre

Going back to our roots – reinvigorating our moral fibre refers to the ability of the parents and older adults to instil in adolescents the appreciation of appropriate behaviour (Winsor, 2013). Some of the adolescents, parent and professionals expressed the notion of mutual respect between parents and their children as follows:

*In the past, we respected our parents. Our children do not respect us (*Tshepiso*, parent); Young people must be taught respect and how to respect each other* (Phetogo, adolescent; Lerato, educator; Tshireletso, social worker)*; The role of the parents should be to treat their children with respect* (Motsweledi, traditional leader).

This extract suggests a concern regarding children who no longer respect their parents and a need for parents to teach their children to respect and in turn respect them. This resonates with an African Setswana proverb ***Lore lo ojwa lesale metsi***, meaning that parents must teach their children to respect at an early age (Motshwane, 2016). Steve Biko also argued that a lack of respect for the elders, in the African tradition, was an unforgivable sin (Mangcu, 2017). However, Bottomly (2014) reminded us that young people were hesitant to show respect to adults if the adults also disrespected them. According to Bottomly (2014), mutual respect was a building block for any relationship, and adults therefore needed to earn the respect of young people. Lending support to Bottomly (2014), the *Journal for International Students* (2017) also emphasised a need for parents to provide their children with proper education, nurturing and a solid foundation. In turn, children were to show respect and appreciate their parents through obedience and service to them.

Some of the professionals emphasised the need for parents to command respect by reprimanding their children to use the correct language and working with other stakeholders:

> *They need to be encouraged to use correct language when communicating with their children. They should not be punitive and judgemental (Mphoentle, clinical psychologist)*; *Parents must be involved, implement what is recommended for their children, even take responsibility for the upbringing of their own children, and address challenges facing them. They need to be empowered on parenting skills where there is a lack. They must not spoil their children; they need to learn to reprimand their children for unbecoming behaviour; work with other stakeholders to support their children. It is difficult* (Tshireletso, social worker).

These findings support the views of Davis (2011) and Johanson (2013) about the importance of African initiation rituals in which adolescents were prepared for adulthood through teaching them about societal traditions and expectations, rules, appropriate behaviour and problem-solving. In addition, these findings supported Western perspectives such as those by social control theorists who argued that parental control patterns that involved setting clear requirements for mature and responsible behaviour, in contrast to power-assertive or authoritarian techniques of discipline, resulted in less drug use (Liddle & Rowe, 2006; Louw,

1998; Rice, 1992). Furthermore, Sussman (2011) reminded parents to share matters related to substance abuse with their children in a non-judgemental manner.

One of the professionals also highlighted the importance of the family in substance abuse prevention as follows:

> *I believe prevention starts from home. Family structure is important; it need to be strengthened* (Tshireletso, social worker).

This extract is consistent with the findings of Rice and Dolgin (2008) as well as Mothibi (2014) that the family structure where both biological parents were available served as a protective factor for substance abuse. However, in instances where one of the parents was unavailable, adolescents were at risk of substance abuse.

In the following extracts parents and professionals recommended that traditional leaders assist parents in addressing adolescent substance abuse problems:

> W*e also need traditional leaders to assist with substance abuse* (Tshepiso, parent); *Traditional leaders must talk to parents and children about the negative effects of substances* (Keatlaretse, parent); *Traditional leaders because they are influential among the community members. We also need to involve them so that when we implement substance abuse prevention programmes in their villages or wards, they can send a representative; That representative can share that information with other members of the community during community meetings* (Mothusi, traditional healer).

However, in the following one of the professionals reported that traditional leaders were no longer able to assist parents with such problems as they were now referred to social workers:

> *The law does not allow us. Such issues are now referred to the social workers for intervention* (Motsweledi, traditional leader).

These extracts indicate that traditional leaders assisted the parents to address behavioural challenges with their children in the past. However, they were no longer assisting. This corroborated with Augustine (2016) who established that traditional leaders were stripped of some of their roles, which contradicted the importance of traditional leaders in taking care of their communities as recognised in the Census Report (Statistics South Africa, 2011), the Constitution of the Republic of South Africa (2003), the Ramotshere Moiloa Local Municipality Reviewed Integrated Plan (2015), the Traditional Leadership and Governance Framework Amendment Act (2003) and as custodians of customs, culture and values (Augustine, 2016). The findings underscore the role of the social workers in assisting parents to address behavioural challenges as well as challenges relating to substance abuse. This confirms the provisions of the National Drug Master Plan (Department of Social Development, 2013) about the role of the social workers in substance abuse prevention and pointed to a gap in the role of traditional leaders in substance abuse prevention.

Pulling all strings together

Pulling all strings together refers to the involvement of parents in addressing substance abuse challenges among adolescents (Sussman, 2011).The acting MEC for the Department of Social Development in the North West Province, Galaletsang Fenny Gaolaolwe, emphasised the importance of parental involvement in substance abuse prevention during her presentation of the budget (Department of Social Development, 2017). In addition, the South African Police Services (2016) recommended that parents could play an important role in preventing substance abuse among their children by speaking openly and honestly about substance use without being judgemental or punishing them. Consistent with these recommendations, all the adolescents, parents and professionals agreed that parents need to be involved in substance abuse prevention programmes and their reasons varied. See the following:

> *Yes, guardians or parents should be involved because they are important people who can guide their children about dangers of drugs. Again they must know where to report or get assistance when their children use drugs. Our parents in our villages may not know these things. So, they must be involved so that they can know how to help their children. Parents must be given information about drugs and how they can be dangerous to their children and even kill them* (Amantle, adolescent)*; Yes, parents need*

to be brought on board. They are primary caregivers. Mostly children become who they are because of their parents. Generation gap between children: through interaction with children they will be able to bridge this gap. They must observe their children and know how to support them in case they start abusing substances. They must also be given information about where to go in case their children use drugs. Thus parents must also be trained about substance abuse. Professional people like social workers and nurses must provide information about substance abuse to parents. Some parents do not speak well with their children. They tell them you are useless. They need to be taught how to address their children. They need to know that if they are stressed, they should not release stress on their children but treat them with respect (Keneilwe, educator).

Yes, for support. Parents could be precipitating factors for substance abuse; therefore, they need to be involved. They know their children better. Parents need to pledge their support to provide emotional support. They need to be helped in understanding the situation of their children and know that their children have a reason for substance abuse. Treatment and prevention will be easy. If they judge and punish their children, their children become defensive and oppose anything they do (Mphoentle, clinical psychologist)*; Yes, we should be involved. That will help us know how to identify a child using substances, where to get assistance, and who to contact in case we encounter such a challenge. Again, we need to know how to support our children because these drugs are affecting their performance at school. Right now my son is repeating a grade. We also need to know about places where children can be sent for rehabilitation. So, if we are involved, I think we will be able to assist our children. As parents in rural areas we must know about the types of drugs that our children are using and places where they normally buy them. As parents we must know where to report when we see people selling alcohol, cigarette and other drugs to our children. We can be assisted on how to handle our children. It is not easy to raise our children especially when you are working far away from home like me. We need to know how to support our children even when we are far from home. Those taking care*

of our children must also be taught how to support our children while
their parents are away because of work (Keatlaretse, parent).

These extracts recommend that parents should be involved in order for them to acquire information about matters relating to substance abuse, handle adolescents who abuse substances and assist them to cope with challenges relating to substance abuse. These extracts lend support to previous studies (South African Police Service, 2016; Sussman, 2011) as well as to the evidence-based substance abuse prevention strategies employed in the United Kingdom and the Netherlands (International Centre for the Prevention of Crime, 2015) about the importance of providing support to families and adolescents on the harmful effects of substances. The extracts also point to a need to empower parents with parenting skills in case they lack such skills. Parents should take full responsibility in the upbringing of their children to minimise the risk of substance abuse. The findings further signify that parents needed to work with other stakeholders to support their children. The importance of parental involvement and appropriate parental monitoring was found to be effective in reducing delinquency and substance use in other studies (Griffin & Botvin, 2010; Liddle & Rowe, 2006; Setlalentoa et al., 2015).

Furthermore, previous studies also recommended empowerment programmes that offered early childhood education, social support for parents, parenting skills training and parent-child communication skills, building healthy child relationships and resource acquisition instruction or networking as a way of reducing or preventing substance abuse among adolescents (Griffin & Botvin, 2010; Prevention of and Treatment for Substance Abuse Act, 2008; Setlalentoa et al., 2015; Spoth, et al., 2012). However, the limitation of these empowerment programmes was the difficulty of obtaining parental buy-in or parental participation, particularly parents of adolescents most at risk for drug abuse (Sussman, 2011).

CREATING NEW RAYS OF HOPE

The global theme, creating new rays of hope refers to the regeneration of substance abuse prevention programmes, which were customised to meet the unique needs of adolescents (Psychology Today, 2017). It consists of the organising themes communities as intervening agents and going round and round in circles. See Figure 7 below.
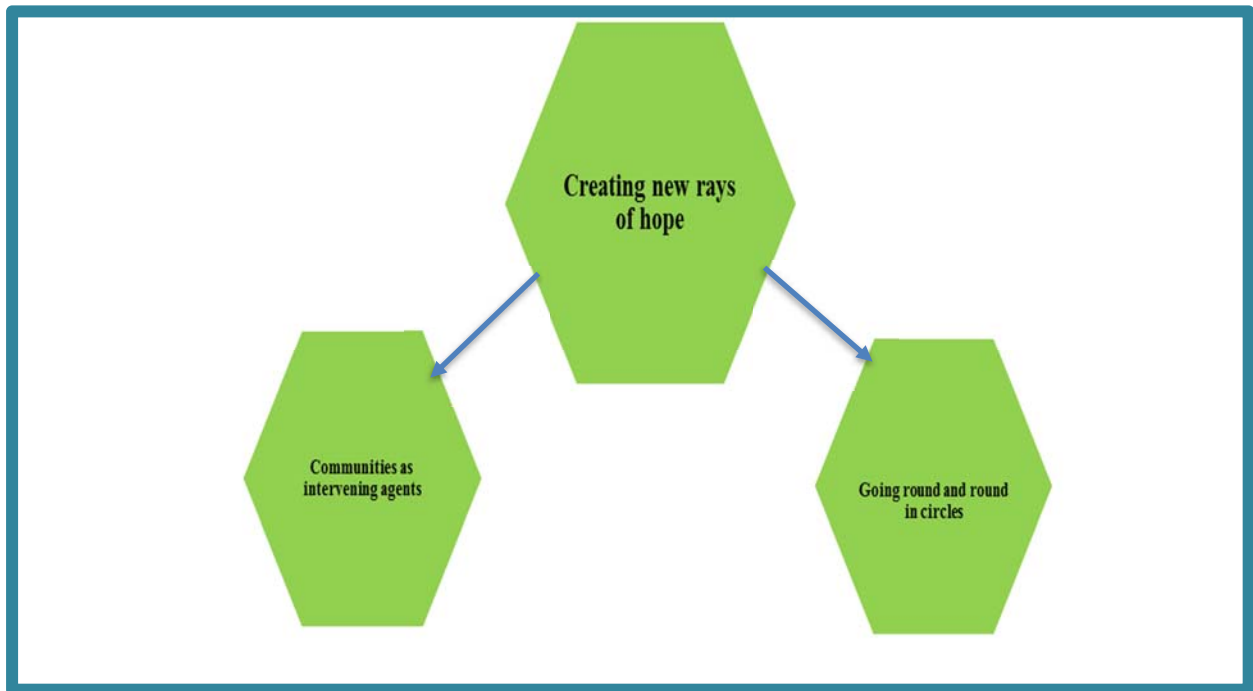
Figure 7: Global theme creating new rays of hope

Communities as intervening agents

Communities as intervening agents refer to the committees and facilities that were established within communities to address problems associated with substance abuse (Setlalentoa et al., 2015). Communities as intervening agents were emphasised in the substance abuse prevention strategies of other countries (International Centre for the Prevention of Crime, 2015) and within the South African context. The National Drug Master Plan (Department of Social Development, 2013) and The Prevention of and Treatment for Substance Abuse Act (2008) required the establishment of a Local Drug Action Committee within each municipality in all the provinces of South Africa. In addition, substance abuse prevention strategies developed in the provinces of South Africa pointed to the availability of a Local Drug Action Committee in communities (Department of Social Development, 2011).

Furthermore, the Minister of Social Development in South Africa, Bathabile Dlamini, reported that provincial substance abuse forums, as well as local drug action committees, were established (South African Government News Agency, 2015). Likewise, a study by Setlalentoa et al. (2015) established that there was a Local Drug Action Committee in Ikageng in the Dr Kenneth Kaunda District Municipality of the North West Province of South Africa. It was also established that substance abuse prevention committees exist in other countries such as Billerica and the United States of America (Galdston et al., 2013). These committees have increased awareness, promoted education, and provided resources in particular to the Billerica community to reduce community-wide substance abuse problems.

Two professionals indicated in the following that there was a Local Drug Action Committee in the Ramotshere Moiloa Local Municipality:

> *There is a Local Drug Action Committee in Ramotshere Moiloa Municipality and substance-abuse activities are aligned to both the Provincial Drug Action Committee and Central Drug Action Committee. We compile substance abuse prevention reports for submission to both the Provincial Drug Action Committee and Central Drug Action Committee as and when required* (Tshireletso, social worker)*; I have more than ten years serving in the substance abuse forum. First, we*

develop an annual plan. In that plan, we have programmes such as the commemoration of the World Drug Day (Tumelo, mental health worker).

These extracts point to the existence of the Local Drug Action Committee in the Ramotshere Moiloa Local Municipality. Its activities were aligned to the Provincial and Central Drug Action Committee. In addition, these extracts recommend that members of the substance abuse forum develop an annual plan. These extracts lend support to the provisions of the Anti-Substance Abuse Programme of Action (Department of Social Development, 2011), the National Drug Master Plan (Department of Social Development, 2013), and The Prevention of and Treatment for Substance Abuse Act (2008) about the establishment of the Local Drug Action Committee. The extracts were also consistent with the previous study that established the existence of the Local Drug Action Committee in other areas of the North West Province of South Africa (Setlalentoa et al., 2015).

In the following extract one of the adolescents and professional further reported that they compiled reports and submitted to the social worker:

We compile reports and present them at the annual substance abuse prevention camp (Lesego, adolescent)*; We compile reports and submit to the coordinator for the Local Drug Action Committee* (Ontiretse, educator).

In line with previous studies (Setlalentoa et al., 2015) and the National Drug Master Plan (Department of Social Development, 2013), these extracts indicate that the Local Drug Action Committee had a coordinator who was responsible for coordinating activities of the Local Drug Action Committee such as convening meetings and inviting stakeholders to serve in the Local Drug Action Committee. Other activities include coordinating the training of the members of the Local Drug Action Committee, facilitating the development of the mini drug master plan and substance abuse prevention programmes, monitoring and reflecting on programmes implemented, consolidating reports compiled by various stakeholders, and submitting reports to the Provincial Drug Action Committee (Department of Social Development, 2013).

Previous studies reported that adolescent themselves for treatment, or they were referred by other sources for admission to substance abuse treatment centres. The sources that referred them include the family, social workers, schools, community organisations, alcohol or substance abuse care providers, other healthcare providers, and the statutory and the criminal justice system (Center for Behavioral Health Statistics and Quality, 2013; Dada et al., 2015; Department of Health, 2016; The Prevention of and Treatment for Substance Abuse Act, 2008). One of the adolescents and some of the professionals reported that referrals to treatment centres were done by the adolescents themselves during presentations or substance abuse awareness activities, or by educators, parents, health nurses and social workers. In addition, it transpires from the following that parents were notified, and a motivation compiled and approved before the patient was admitted:

Through substance abuse prevention programmes, identified leaders also assist in referring those abusing substances to us. As their mentor, as soon as I receive information about learners abusing substances, I will notify parents and the social worker allocated to our school. The social worker will then have a session with the learner and the parents. If the learner requires rehabilitation, the social worker will assist in referring such learners to the rehabilitation centre (Keitumetse, educator); *We normally refer learners to rehabilitation centres. This is based on self-referral by learners themselves; educators in collaboration with parents or guardian. Self-referrals by learners normally occur during presentations or substance abuse awareness campaigns after our campaigns. Once we receive a request for referral to a rehabilitation centre, we compile a motivation for such a referral. The two centres where we normally refer our learners is Sunpark, which is in Klerksdorp and Witrand, which is in Potchefstroom. These organisations are private institutions funded by Department of Social Development (DSD). DSD has a Memorandum of Understanding with these rehabilitation Centres and is allocated ten beds per month and once the application is approved; the patient is admitted for three to four weeks* (Tshireletso, social worker); *I was admitted at Klerksdorp rehabilitation centre. I was using drugs and one of the Life Orientation educators referred me there* (Oarabile, adolescent).

These extracts from the interviews indicate that treatment centres were available. Those abusing substances were either referred for rehabilitation by educators and social workers in collaboration with parents, or they did self-referrals. These extracts were consistent with previous studies (Center for Behavioral Health Statistics and Quality, 2013; South African Community Epidemiology Network on Drug Use, 2013), which established that the admission of adolescents to substance abuse treatment was through self-referral or referral from other individuals, or by schools, community organisations, alcohol or substance abuse care providers, and other healthcare providers. However, the above extracts indicating that adolescents did self-referrals during presentations or after substance abuse awareness campaigns seems to be a new finding that was not reported in previous studies. This finding suggests the importance of substance abuse presentations and awareness campaigns in encouraging adolescents to indicate their need for referral to the substance abuse treatment centres.

Furthermore, in this study, none of the adolescents, parents, and professionals reported about referrals by the statutory and the criminal justice system, as reported in previous studies (Centre for Behavioral Health Statistics and Quality, 2013). In addition, these extracts show that there was no discrimination in respect of referrals and admissions to treatment centres. In fact, those rehabilitative services were made available to those who required them. The above extracts support the provisions of the National Drug Master Plan (Department of Social Development, 2013) about collaborations among stakeholders regarding referrals for matters relating to substance abuse and were consistent with the provisions of The Prevention of and Treatment for Substance Abuse Act (2008) regarding referrals for substance abuse treatment.

The requirement for preparation of a motivation before one is referred for admission raised a concern because one of the professionals indicated in the following extract that due to the vastness of the Ramotshere Moiloa Municipality, they were not able to provide the required support:

> *The vastness of the Ramotshere Municipality makes it difficult for social*
> *workers to provide support* (Tshireletso, social worker).

This extract conveys that it took a while before motivations were prepared for those requiring treatment, which affected the waiting period for the approval of motivations for admission, and led to delays in the provision of substance abuse treatment services to adolescents requiring treatment. This contradicted the provisions of the National Drug Master Plan (Department of Social Development, 2013), the national guidelines for the management and prevention of drug use and abuse in all public schools and further education tertiary institutions (Department of Education, 2002),The Prevention of and Treatment for Substance Abuse (2008), as well as the national strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013) about the treatment for substance abuse.

Different countries applied different substance abuse treatment programmes (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015). Detoxification, if required, was an important feature for successful treatment. In addition, individual and family psychotherapy were often recommended to address the developmental, psychosocial, and family issues that contributed to and resulted from the development of a substance abuse disorder (Brody, 2013; Center for Behavioral Health Statistics and Quality, 2013; Department of Health, 2016; Wexner Medical Centre, n.d.). In the following extract, some of the adolescents and professionals reported on detoxification, individual and family therapy, as well as educational sessions conducted to address problems related to substance abuse:

> *Once admitted at those rehabilitation centres; they do detoxification to remove the substance from the body and educate them about substance abuse. They also do counselling to help them stop abusing substances* (Tumelo)*; As a trained……. (referring to the qualification of one of the mental health professionals), I give individual therapy to manage the disorder. Abstinence is the main goal. We look at the problem in context, the family, social life of the client and factors contributing to this disorder. I also look at the academic performance of the teenager; and check the reasons for low performance. If it is because of performance, which is not satisfactory, I help in coming up with a study timetable, methods of studying, and types of support. I also involve the family and*

> *make them aware of the problem. I do individual psychotherapy and*
> *family therapy sessions* (Mphoentle, clinical psychologist).

These extracts lend support to previous studies about detoxification, individual and family therapy to deal with matters relating to substance abuse. These extracts also recommend outpatient treatment for substance abuse. Furthermore, these extracts indicate that substance abuse problems were treated considering other contextual factors that contribute to substance abuse such as the family and academic performance. This corroborated with previous scholars who recommended the consideration of the developmental, psychosocial and family issues that may have contributed to the development of a substance abuse disorder (Brody, 2013; Centre for Behavioral Health Statistics and Quality, 2013; Department of Health, 2016; Wexner Medical Centre, n.d.). These extracts were also consistent with recommendations of Brannigan and colleagues (2004, cited in Sussman, 2011) that for substance abuse treatment to be effective, programme services should address all areas of the lives of adolescents in the school, home and in public. In addition, parents were supposed to be involved in the treatment of drug use by the youth.

In many traditional African belief systems, mental health problems were perceived to be due to ancestors or bewitchment (Makhanya, 2012; Shirungu, 2016). The traditional healers and religious advisers were considered as having expertise in these areas. Furthermore, these sources of health care were often more accessible than Western forms of mental care (Sorsdahl et al., 2009). Previous studies reported that there was a range of different types of alternative practitioners in South Africa (Melato, 2000; Skuze, 2007). This included herbalists and diviners specialising in the production of herbal medicines, as well as religious and spiritual leaders, including faith healers, who integrate Christian ritual and traditional practices, and belonged to one of the African churches (Traditional Health Practitioners Act, 2007). One of the adolescents and some professionals reported the following extract that there was a substance abuse treatment centre in the Ramotshere Moiloa Local Municipality which is not registered with the Department of Social Development:

> *There is a rehabilitation centre which is not registered with the*
> *Department of Social Development. The focus of the centre is promoting*
> *spiritual fulfilment for patients. It is in one of the wards within the*
> *municipality. They apply religious principles to address substance abuse*

problems (Tshireletso, social worker)*; My uncle is admitted at a centre where they address his substance abuse problems through religious practices. They teach them prayer and reading the bible. Some of the people abusing substances prefer to get assistance from traditional doctors. Community members believe that these interventions are effective and work for them* (Mosidi, adolescent).

These extracts suggest that there were efforts at community level to assist those requiring treatment for substance abuse problems through spiritual interventions. However, the establishment of this centre was in contravention of the Prevention of and Treatment of Substance Abuse Act (2008), which stipulated that no person may provide substance abuse rehabilitation services without registration and approval to render such a service. Furthermore, this Act stipulated that all the people providing substance abuse treatment must have undergone training accredited by the South African Qualifications Authority Act (1995). The extracts further demonstrate a need for the Department of Social Development and Health to raise awareness among those establishing rehabilitation centres about the provisions of The Prevention of and Treatment for Substance Abuse Act (2008). This was to ensure that they are aware of and comply with the procedures for establishing a rehabilitation centre. Information about the procedures for registering a rehabilitation centre might be shared through the established Local Drug Action Committee as well as through traditional leaders and tribal community meetings.

Ngobe (2015) reported that cleansing the patient of evil spirits through washing, steaming, induced vomiting, casting out evil, and herbal medication were some of the methods that were commonly used to treat mental illness. One of the professionals also shared the following information about how he treated those addicted to substances:

I use natural herbs to deal with this. First, you will prepare medicine for that person to drink. That is used to calm a person as some of them are restless. Our medicines takes long, so if the person does not calm down, I will take him or her to the medical doctors because their medication is so fast to calm a person. I will then take the person back for me to provide treatment. Normally, I would keep such people for a month, depending

> *on the problem they have. So I use mixed natural herbs for the person to*
> *drink. I give this to cleanse the blood* (Mothusi, traditional healer).

The above extract indicates the use of mixed natural herbs in treating substance abuse problems in specific cases.

In addition, according to the extract, one month is a sufficient period for treating patients, which is consistent with short-term inpatient programmes that keep patients up to 30 days for substance abuse treatment (Brody, 2013). This extract points to the referral of patients by the traditional healer to medical doctors for intervention when there was a need. This pointed to the importance of collaboration between traditional healers and medical practitioners. Furthermore, this extract supports the provisions of the Traditional Healers Act (2007) and previous study (Melato, 2000) which emphasised collaboration to total integration with the Western practitioners.

Additionally, one of the professionals reported that he was trained in treating diseases. See the following:

> *This traditional healer taught me about other herbal medicines that I did*
> *not know and where to get them as well as how to heal other diseases*
> *(*Mothusi, traditional healer).

This extract recommends training in the usage of African medicine and the use of herbs in treating diseases. This extract also corroborates with the previous study by Kitui (2012) in which it was established that traditional medicine and herbs were applied to accelerate healing. One of the professionals further reported about the importance of a gym when treating patients:

> *Sometimes, I think when people come for treatment especially those who*
> *will stay for a month; one needs to keep them busy. For example, if we*
> *had a gym, it will assist them, keep them busy. That makes it easy for me*
> *to manage them* (Mothusi, traditional leader).

According to this extract it seems that it is important to consider keeping those in treatment busy through facilities such as a gymnasium in addition to the treatment provided.. The Traditional Health Practitioners Act (2007) and previous studies on traditional African perspectives for substance abuse do not provide information about the importance of keeping patients busy through, for example a gym, while in treatment (Kitui, 2012; Ngobe, 2015). However, previous studies (Zschucke, Heinz, & Strohle, 2012) established that exercises were included in many addiction recovery programmes. Corroborating with these studies, Volkow (2011) established that exercise, including active play, outdoor adventure, team sport, martial arts and dance prevent substance abuse by improving tolerance to stress and strengthening resistance to substance abuse. Furthermore, in accordance with Volklow (2011), Bradford Health Services (2016), also asserted that exercise alleviates both physical and psychological stress. According to these authors, the body releases endorphins through exercise, which creates a natural high, similar to the high created when one abuses substances. However, abuse of substances interferes with the person's ability to feel pleasure, happiness and satisfaction.

Going round and round in circles

Going round and round in circles refers to the inability to make progress with the planned substance abuse prevention programmes implemented as a result of various factors (Becker-Phelps, 2009). Some weaknesses were identified in respect of the substance abuse prevention programmes that were implemented. For instance, some of the prevention programmes were implemented on a once-off basis and not followed up due to limited financial resources, as illustrated by the following:

> *Due to limited financial resources, we hold substance abuse training workshops once a year* (Tshireletso, social worker).

The above extract contradicts the requirement that financial resources needed to be provided for effective substance abuse prevention programmes (International Prevention of Crime, 2015) Training workshops should be long-term, and include booster sessions to prevent programme impact from decaying over time as reported by previous studies (Botvin & Griffin, 2003; Department of Basic Education, 2013; National Institute on Drug Abuse,

2003). In addition, adolescents did not respond well to these substance abuse prevention programmes, as indicated by the following:

> *Adolescents do not respond well to the programme because some will not go there because adolescence is a stage whereby you don't want to be told unless you tell others* (Oarabile)*; Those who are willing to participate in the programme may respond by joining the TADA group* (Tshireletso, social worker)*; I think because some are not interested in these programmes* (Mothusi, traditional leader)*; They are enough. The problem is that we are not progressing. One cannot indicate any progress because even after information is shared with our learners about drugs, they continue using them. Those who went for rehabilitation came back motivated that they will not use substances. However, they continue using them* (Keitumetse, educator).

These extracts suggest that participation in these programmes was voluntary and only for those who are interested. This then defeats the purpose of reaching out to all the adolescents as some may not be empowered about substance abuse prevention programmes and may be at risk of abusing substances. This is in contravention of the provisions of the National Drug Master Plan (Department of Social Development, 2013) and the national strategy for the prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013) that substance abuse prevention programmes should reach all the adolescents. These extracts also indicate that substance abuse prevention programmes were ineffective because adolescents continued abusing substances. The above extracts may also imply deficiencies in implementing prevention programmes. Some of the adolescents and professionals indicated that the substance abuse prevention programmes were insufficient:

> *In my opinion, these programmes are not enough because they take place after a while* (Mooketsi); *These programmes are not enough because some of them like **Thaka Moso,** translated as a future peer, is far from our village. Teenagers are not able to access them* (Motsweledi, traditional leader)*; They are not enough because the programmes benefit those attending school. Those who are dropouts are not aware, and they end up influencing those who are at school again. As a result, it seems*

like waste of time and resources. Those abusing substances are not properly reached and addressed (Keitumetse, educator).

They are enough. The only thing is that they need to be user-friendly for adolescents. There is a need to find a way of presenting this in an appealing manner. I think adolescents enjoy listening to poets and watching dramas or even engaging in sports activities. Presentations seem to be boring to them. They also feel comfortable to listen to their peers and ask them questions if they do not understand. We should, therefore, use peers to raise awareness about drug abuse (Lerato, educator).

These extracts demonstrate that the programmes implemented were insufficient, implying that they could be improved to ensure efficiency in addressing substance abuse challenges among adolescents. However, he following report of one of the adolescents indicates that programmes were enough and adolescents responded well to them:

Yes, they are enough. Adolescents respond well because, with TADA, I see learners in our school attending their meetings, dramas or poetry. With Yizo and Gazilam, those are TV programmes that most of the learners enjoy watching on TV and you will hear them talking about them (Oarabile, adolescent).

The above extracts connote different views among some of the adolescents and professionals about the adequacy of substance abuse prevention programmes implemented and how adolescents responded to them. This corroborates with the recommendations of Griffin and Botvin (2010) that substance abuse prevention programmes need to be flexible and responsive to the changing trends in substance abuse.

According to the United States Department of Health and Human Services (2010), Myers et al. (2010), as well as Pullen and Oser (2014), sizeable rural health populations had greater shortages of mental health providers and fewer facilities to provide treatment services. One of the professionals identified the following barriers to treatment:

The two centres where we normally refer our learners are Sunpark, situated in Klerksdorp and Witrand, situated in Potchefstroom. These organisations are private institutions funded by Department of Social Development (DSD). DSD has a Memorandum of Understanding with these rehabilitation centres and is allocated ten beds per month. Once the application is approved; the patient is admitted for 3-4 weeks (Tshireletso, social worker).

These extracts show that those who required treatment for substance abuse and were referred to Sunpark, travelled about 175 kilometres from Dinokana to Klerksdorp; while those referred to Witrand travelled 184 kilometres from Zeerust to Potchefstroom. These extracts further indicate that those treatment centres were nine kilometres apart from each other, which means that community members in Potchefstroom and Klerksdorp had easy access to the two treatment centres. However, in the Ramotshere Moiloa Local Municipality, there was no substance abuse rehabilitation centres. Those who required the service had to travel long distances to access treatment. This pointed to the unequal distribution of substance abuse treatment centres.

These extracts corroborate with the previous study (Myers et al., 2008) that travel costs and lengthy travel distances to the nearest treatment services were some of those logistical barriers in accessing treatment. In addition, this was a risk factor for access to substance abuse treatment and may be an impediment for the treatment of adolescents for substance abuse. Besides, the previous study reported that the longer distance to receive substance abuse treatment often resulted in lower completion rates of substance abuse treatment programmes.

Likewise, a lack of public transportation services could further impede access to ongoing treatment and support groups (Pullen & Oser, 2014). One of the professionals further reported the following about limited beds allocated and limited admission periods:

Department of Social Development is allocated ten beds per month and once the application is approved; the patient is admitted for 3-4 weeks (Tshireletso, social worker).

These extracts point out that the treatment service is not accessible to other adolescents requiring inpatient treatment. These extracts also suggest that those admitted were discharged after three to four weeks . These extracts corroborate with the findings of the previous studies which established that substance abuse treatment far exceeded supply (Bower et al., 2015; Myers et al., 2008). This was in contravention of the provisions of The Prevention of and Treatment for Substance Abuse Prevention Act (2008) that treatment centres needed to ensure that their services were available and accessible to all service users. These extracts also contradict the recommendations of Brody (2013) that treatment need to be offered continuously for as long as the individual requires it, including aftercare. This suggests that there is a need to provide substance abuse treatment facilities that were within easy reach of the adolescents requiring treatment. Treatment should be provided for as long as adolescents require it. However, noting the limitations with regard to substance abuse treatment facilities as acknowledged by Brody (2013), this implies that available community clinics within reach of those adolescents requiring substance abuse treatment, should provide outpatient treatment for substance abuse as well as aftercare support (Department of Social Development, 2013; International Centre for the Prevention of Crime 2015; Morojele & Ramsoomar, 2016; Prevention of and Treatment for Substance Abuse Act, 2008).

However, the needs of the adolescents requiring treatment and the severity of the substance abuse condition should be considered. Potential benefits of outpatient community clinics include lower costs compared to inpatient services, and that adolescents in need of treatment may be able to attend school while receiving treatment in their community. However, the challenge might be that those adolescents may have access to substances in their communities (Condron, 2017). To address relapse challenges, adolescents may utilise support groups or other recovery mentors within their communities (Condron, 2017; National Institute on Drug Abuse, 2012).

Furthermore, according to extensive national studies of tens of thousands of addicts, one-third of those who stay in treatment longer than three months still remain drug-free a year later (Partnership for Drug-Free Kids, 2016). The above challenges to accessing treatment might have discouraged those seeking rehabilitation services to declare their substance-abusing status and even seek help. In turn, this defeats the harm reduction strategy as provided in the National Drug Master Plan (Department of Social Development, 2013) and the provisions of the Prevention of and Treatment of Substance Abuse Act (2008). These extracts indicate that

the challenges regarding substance abuse could not be addressed due to limited human and physical resources for the required treatment services. This became a risk to substance abuse treatment programmes. According to the National Institute on Drug Abuse (2009), relapse was a possibility, and failure to comply with treatment weakened the chances for successful recovery.

In addition to admission challenges encountered as discussed in the preceding paragraphs, relapse and aftercare problems were also acknowledged by some of the professionals in the following:

> *Due to proximity challenges to the centre, there is no aftercare support once a person is discharged from the centre* (Tshireletso, social worker)*; The problem is that after three weeks, there is no support provided to them. They are not able to attend aftercare support groups because that hospital is far* (Tumelo, mental health worker).

These findings point to a lack of aftercare and is in contravention of the Prevention of and Treatment for Substance Abuse Prevention Act (2008); which advocates for the provision of aftercare services in treatment centres. Furthermore, previous studies reported that if aftercare support was not provided, it meant that those recovering from substance abuse would not be equipped with additional skills to maintain their treatment gains, sobriety and avoid relapse (National Institute on Drug Abuse, 2009). Furthermore, aftercare support was recommended in substance abuse prevention strategies of other countries (International Centre for the Prevention of Crime, 2015).

The lack of aftercare support was attributed to the vastness of the Ramotshere Moiloa Local Municipality, which made it difficult for social workers to reach out to all the villages and provide aftercare support to discharged patients, as reported by one of the professionals in the following:

> *The vastness of the Ramotshere Municipality makes it difficult for social workers to provide aftercare support to discharged patients* (Tshireletso, social worker).

This extract points to the human resources barrier, implying that the number of allocated social workers was less than the aftercare support required by those recovering from substance use. This was a risk factor for those recovering from addiction.

The challenges relating to accessing substance abuse treatment highlighted above, points to a need for prevention rather than treatment as the best possible strategy for addressing the burden of substance abuse, as recommended by Beardslee, Chien, and Bell (2011). One of the professionals further reported in the following extract that families were unable to handle a person after being discharged from the centre:

> *Families are unable to handle a person after being discharged from the centre. Most of the time, family members find it difficult to forgive the person once the person is discharged. In addition, it takes long for a person to recover and maintain sobriety* (Tshireletso, social worker).

This shows that it is difficult for the recovering person to receive care and support from their own family. This then contradicts the provision of The Prevention of and Treatment for Substance Abuse Act (2008) and recommendations by the previous studies that substance abuse treatment worked with the support of the family (Rataemane, 2004 cited in Setlalentoa et al., 2015). In addition, previous studies (Ashley & Burke, 2010; Morozini, 2011; Patchin & Keveles, 2004; Umbreit et al., 2005) established that restorative justice sought to involve offenders or victims such as family members and community representatives in the reparation process. The reparation process include wrongdoers accounting to those they harmed and repairing the harm, as well as families and the community taking care of the wellbeing of others. The reparation process also addresses factors that lead to the person engaging in delinquent behaviour in the first place (Morozini, 2011; Patchin & Keveles, 2004).

The extract also indicates that the family members find it difficult to forgive the person when he/she is discharged from the rehabilitation centre. This is in contrast to the principle of restorative justice, which promotes positive feelings, rather than resentment and alienation. Restorative justice also requires that the offenders and victims make amends and repair harm (Pitsoe & Letseka, 2014; Winfield, 2015). The aforementioned barriers to substance abuse treatment indicate that the substance abuse rehabilitation programme was not sustainable because those discharged from treatment centres were at risk of not obtaining aftercare

support. This points to a waste of financial resources, as those admitted for rehabilitation are at risk of relapse. In addition, these findings are inconsistent with the provisions of the substance abuse treatment strategies of other countries (International Centre for the Prevention of Crime, 2015), the National Drug Master Plan (Department of Social Development, 2013), The Prevention of and Treatment for Substance Abuse and previous studies (Brody, 2013) about the need for aftercare support for those addicted to substances until they recover.

However, one of the professionals reported the following on the continued support provided to adolescents receiving therapy for substance abuse:

> *I also include default management and make them aware about it during the sessions. I also refer them to aspects mentioned in previous sessions. I review the previous sessions to check if the patient is following up. I always encourage them that if they need someone to talk to, they must go to the clinic; if they feel like crying, they must cry. By referring them to the clinic, that assist them to realise that there is help available. I also request them to contact me through SMS or WhatsApp. They like their phones and like to be talked to. I do not want patients to relapse. The sessions are open and dependent on the initial assessment with the client. There may be three and up to six sessions. If there are homework sessions in between, it may take 4 months, with 16 sessions. In some instances, they are not able to complete the scheduled sessions due to lack of finances, or lack of interest. Knowing that the areas where the clients are residing are not far apart, for those who cannot afford transport costs, alternatives are provided. They don't have to come to town where my consultation offices are located. I do provide alternatives; if I am visiting a clinic next to their village, they come to see me at that clinic. If they are not able to come see me during the scheduled date, I sometimes refer them to the clinic in their village or to the social worker who will be coming to their clinic on a specific date (Mphoentle, clinical psychologist).*

This shows that efforts are being made to provide continued support to adolescents receiving therapy. This is in keeping with the recommendations of the International Centre for the Prevention of Crime (2015), the provisions of the Prevention for and Treatment for Substance Abuse Act (2008) and a previous study that the length of time and intensity in treatment and aftercare were critical factors in helping those addicted to substances to stay clean (Brody, 2013).

Programme reflections were emphasised by previous studies as an essential aspect. It is important to determine the achievement of objectives related to improved health status and whether the programme implementation has improved. It is also essential to ensure accountability to funders and the community, to increase community support for initiatives, to contribute to the scientific base for community public health interventions, and to inform policy decisions (Department of Social Development, 2013; Minnesota Department of Health, 2014.; International Centre for the Prevention of Crime, 2015; Van Dyk, n.d.). The following reponses from some of the adolescents and professionals indicate that stakeholders who were involved in the development and implementation of substance abuse prevention programmes were afforded an opportunity to reflect about these programmes:

> *We are given an opportunity to evaluate substance abuse prevention programmes implemented in our school* (Modise, adolescent)*; We do evaluations as members of the TADA group* (Tsholofelo, adolescent). *After implementing programmes we have a discussion to check what was achieved, what the challenges were so that we can address them* (Gomolemo, adolescent)*; Compiled reports about activities implemented and presented them at the substance abuse prevention holiday camps* (Keabetswe)*; We compile reports for submission to the Department of Education and Department of Social Development* (Keitumetse, educator).

> *We are involved in evaluation of the programmes. We assess the impact of the programmes implemented, and make recommendations. We have reporting tools that are provided to us. This is done as and when we implement programmes. These reports are also discussed at the Local Drug Action Committee of Ramotshere Moiloa Municipality. These*

reports are also presented to both the Provincial Drug Action Committee and Central Drug Authority as and when required. We have quarterly meetings with the provincial office where we report achievements, challenges, and recommendations for consideration (Tshireletso, social worker)*; Yes, we do evaluate the programmes. In terms of awareness campaigns, we look at the target numbers that we planned to reach to check if we reached the target as was planned. With awareness campaigns, we do not have evaluation forms. We have evaluation forms that we use during workshops. In those evaluation forms, we cover the following aspects: expectations, presenters, and relevance of information provided. We do evaluate the workshops so that we can improve our training programme and ensure that it meets the expectations of those attending the workshops. We also evaluate services provided to those visiting the hospital* (Tumelo, mental health worker).

It was interesting to note that some adolescents targeted for substance abuse prevention programmes reported that they formed part of the planning, implementation, and reflection phases of the substance abuse prevention programme initiatives, as recommended by the International Centre for the Prevention of Crime (2015) and the provision of the National Drug Master Plan (Department of Social Development, 2013). This may have served as a protective factor for substance abuse among adolescents and promoted a buy-in of these programmes, as they were afforded an opportunity to give their reflections about the programmes implemented. Adolescents would also acquire reflection skills regarding the substance abuse prevention programmes implemented (Fetterman, 2007).

Nonetheless, according to the following abstract, other learners provided verbal feedback about the programmes implemented:

Evaluations of the programmes are done through meetings after each event where we discuss the programme with other learners who participated in our programmes. We normally ask them to tell us where to improve our programmes. Other students also come to us and provide feedback about the programme. Most of the times, they appreciate the programmes we implement and show interest to be part of the RADS

Programme. Some even thank us for implementing such a programme because it always addresses challenges they have as learners and that they value the information shared with them. We share feedback with our Life Orientation educators (Amantle, adolescent).

According to these extracts the adolescents were not provided with reflection forms for the substance abuse prevention programmes implemented. This signifies a lack of tangible evidence on reflections, which may have assisted in verifying the reports. Furthermore, the fact that there is no documented evidence as proof of the reflections, casts some doubt on whether the reports/reflections on the substance abuse prevention programmes were correct. .

In the following extract, one of the professionals pointed to the availability of the evaluation forms that were developed and implemented for substance abuse prevention programmes:

*Yes, we are involved in the evaluation of the programmes. We assess the impact of the programmes implemented and make recommendations. We have evaluation and reporting forms that are provided to us. This is done as and when we implement programmes. Members of the substance abuse forum also share evaluation reports with us. These reports are shared with the provincial office during our quarterly meetings where we report achievements, challenges, and recommendations for considerations (*Tshireletso, social worker*).*

In addition, one of the professionals in the following extract reported that they use reflection forms during workshops:

In terms of awareness campaigns, we look at the target numbers reached. No evaluation forms are used. We use evaluation forms during workshops and we cover the following aspects: expectations of the participants, their evaluation of presenters and whether the workshop was relevant and met their expectations so that we can improve when we conduct the workshop for other groups (Tumelo, mental health worker).

However, other professionals did not mention whether they use reflection forms or not. These extracts point to inconsistencies in how reflections on substance abuse prevention programmes were conducted among various stakeholders. This might be a risk factor for the effectiveness and efficiency of substance abuse prevention programmes implemented for adolescents (Department of Social Development, 2003).

In addition, these inconsistencies on programme reflections make it difficult to determine if the objectives of the substance abuse prevention programmes were achieved (Department of Social Development, 2013; Minnesota Department of Health, 2014; Van Dyk, n.d.). Despite the inconsistencies in programme reflections, these extracts indicate that reports are compiled and shared with other stakeholders involved in the substance abuse prevention programmes. Furthermore, extracts from adolescents and some of the professionals indicate that they were allowed to provide recommendations for substance abuse prevention programmes. This was consistent with the provisions of the International Centre for the Prevention of Crime (2015), National Drug Master Plan (Department of Social Development, 2013), and principles of empowerment evaluation (Fetterman, 2007) about stakeholder involvement in reflecting on programmes implemented.

Adolescents and some of the professionals reported that they reflect on substance abuse prevention programmes implemented to ensure that these are relevant to the needs of their target groups. This suggests that programmes were tailor-made to suit the needs of the communities served. This might have enhanced a sense of ownership of programmes implemented by those implementing the programme and the target group (Fetterman, 2007; Setlalentoa et al., 2015). The extracts also suggest that reflections were made for quality and programme improvement. This indicates that the appropriate programme might be implemented and may contribute to the effectiveness of substance abuse prevention programmes. Furthermore, these extracts are consistent with the recommendations provided by Brody (2013) that programmes should include rigorous reflections to measure success and improve treatment services.

Extracts about stakeholders reflecting on substance abuse prevention programmes are consistent with the principles of empowerment evaluation (Fetterman, 2007), the International Centre for the Prevention of Crime (2015), the provisions of the National Drug Master Plan (Department of Social Development, 2013), and the National Strategy for the

prevention and management of alcohol and drug use among learners in schools (Department of Basic Education, 2013). These afford both programme implementers and target groups an opportunity to reflect on programmes implemented. In addition, these extracts about the importance of programme reflections supported previous studies (Fetterman, 2001; International Centre for the Prevention of Crime, 2015; Minnesota Department of Health, 2014; Van Dyk, n.d.).

CONCLUSION

In this chapter, the findings of this study were presented. The focus was on substances abused by adolescents, individuals and family. The environmental risks and protective factors for substance abuse, effects of substance abuse, and curricular and extra-curricular substance abuse prevention programmes implemented by government and non-government stakeholders were also discussed. Further, recommendations on stakeholders and programmes required for substance abuse prevention were discussed. Furthermore, the discussions were focussed on referrals for treatment, Western and African traditional healing, religious substance abuse treatment, barriers to treatment, challenges relating to aftercare support, as well as reflections on programmes. In addition, gaps were identified regarding substance abuse prevention policies, programmes, treatment facilities, and programme reflections. The next chapter provides conclusions, limitations and recommendations for this study.

I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand? –James P. Spradley

CHAPTER 5
SUMMARY OF THE FINDINGS, LIMITATIONS AND RECOMMENDATIONS

INTRODUCTION

The previous chapter provided a discussion of the findings for this study. Therefore, this concluding chapter presents a summary of the findings to demonstrate that the study's aim and objectives expressed in Chapter 1 were addressed. In addition, the recommendations and contribution of this study are provided and limitations are acknowledged.

SUMMARY OF THE FINDINGS

The objectives of this study were stated in Chapter 1. First, it was to identify substances abused by adolescents in the Ramotshere Moiloa Local Municipality. Second, the reasons for the use and abuse of substances were to be explored. Third, another objective was to identify substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality. Fourth, the researcher wanted to address substance abuse problems by adolescents and identify the target group of the substance abuse prevention programmes. Fifth, another objective was to describe the levels of prevention approaches employed within the substance abuse prevention programmes. Sixth, the researcher wanted to identify methods employed to implement the programmes. Seventh, the researcher wanted to identify stakeholders required for the implementation of the substance prevention programmes. Eighth, this would be followed by identifying the strategies employed to evaluate substance abuse prevention programmes. Finally, the researcher wanted to provide recommendations for the development, implementation, and evaluation of substance abuse prevention programmes targeting adolescents.

As indicated in Chapter 1 under the significance of this study, it is expected that the findings from this study would also raise awareness of and support previous South African and international studies that adolescents are socially entrapped in the excessive use of substances such as alcohol, tobacco, cannabis, and nyaope (Dada et al., 2015; Department of Social Development, 2013; Mothibi, 2014; United Nations Office on Drugs and Crime, 2016).

The findings revealed a limited usage of cocaine, glue, methylated spirits, snuff (Dada et al., 2016; Mothibi, 2014) and *tlokwe-African Traditional beer* (Makindara et al., 2013). It also revealed a new substance abused by adolescents, *segonyamahlo,* and its contents. The ingredients of *segonyamahlo* include African sorghum beer, cake flour, and a car battery acid. The use of *segonyamahlo* was not reported in previous studies conducted in other South African provinces (Dada et al., 2016; Mothibi, 2014; Setlalentoa, et al., 2015) and in other countries (United Nations Office on Drugs and Crime, 2017).

I embarked on this study by considering Western theoretical perspectives such as developmental theories, biological theories, psychological theories, learning theories, progression theory, economic theories, symbolic interaction theory, social control theory, availability theory (Ciccheti, 2007; Griffin & Botvin, 2010; Mancini & Roberto, 2009; Morojele et al., 2012; United Nations Office on Drugs and Crime, 2015; Venter, 2014), and African perspectives to understand substance abuse problems among adolescents (Makhanya, 2012; Shirungu, 2016). When I analysed the data, I found a link to all the above theories as provided in this section, except for the symbolic interaction theory. This may be due to the legislation against the advertising of alcohol and tobacco. The findings of this study also corroborate with availability and economic theorists that adolescents abuse substances because they are readily available and affordable (Kawaguchi, 2004; Mokwena, 2015; Mothibi, 2014; Peltzer et al., 2010; Seggie, 2012; Venter, 2014).

Furthermore, the findings of this study showed sources and settings, such as family members from Gauteng, taverns, tuckshops, and schools, where adolescents acquired these substances. The findings also point to some of locals and foreigners selling substances in saloons and tuck shops. Furthermore, the findings link up with the learning theory, as it was revealed that adolescents abuse substances because they saw their parents and peers using substances (Burger, 2008; Carson et al., 2000; Davison et al., 2004; Department of Basic Education, 2013; Griffin & Botvin, 2010; Karen Lesly, 2008; Kumpfer, 2014; Rice & Dolgin, 2008; Lakhanpal & Agnihotri, 2007; Liddle & Rowe, 2006; Meyer & Salmon, 1988; Osman et al., 2016; Simmons-Morton & Farhat, 2010; Trobisch, 2016).

This study also revealed that adolescents learn to use substances from other people, such as uncles and cousins. The use of substances by cousins, parents, and uncles further confirm the findings of disease or biological theorists that substance abuse run in families (Berk, 2007;

Feldstein & Miller, 2006; Griffin & Botvin, 2010; International Centre for the Prevention of Crime, 2015; Manning et al., 2009; Trobisch, 2016). In line with developmental theorists and psychological theorists, findings of this study revealed that substance abuse is a high-risk behaviour among adolescents (Burger, 2008; Donald et al., 2007; Hernandez et al., 2015; Mudavhanhu & Schenck, 2014). Lending support to progression theorists, the findings indicate that adolescents progressed from gateway drugs such as alcohol, tobacco and cannabis, to the use of more dangerous drugs (Center for Behavioral Health Statistics and Quality, 2013; Griffin & Botvin, 2010; Lauren Brande, 2017; Nkansah-Amankra & Minelli, 2016) such as glue, methylated spirits, and *segonyamahlo*. Furthermore, the findings reveal that adolescents who endure hardships such as poverty, divorce, ill-treatment by family and others, adolescents in child-headed families, or adolescents who experience feelings of helplessness and a lack of progress with their studies turn to the abuse of substances to help them deal with these challenges (Karen Lesley, 2008; Rice & Dolgin, 2008).

Corroborating with social control theorists, the findings point at parental migration to urban areas such as Gauteng in search of greener pastures. Evidently, this make it impossible for parents to provide the required support to adolescents due to their demanding jobs (Griffin & Botvin, 2010; Pressley & McCormick, 2007; Rice & Dolgin, 2008; Saminsky, 2010). In addition, some of the adolescents in this study were orphans and had no one to take care of them (Rice & Dolgin, 2008). However, some of the findings reveal that some adolescents were taken care of by grandparents who were unable to control them. The findings further indicate a link with African traditional perspectives that offer a parallel belief system about the origins of substance abuse and its treatment with herbal medication (Ngobe, 2015).

These findings are consistent with previous studies that adolescents abuse substances because of personal, family, and environmental factors (Liddle & Rowe, 2006; Manning et al., 2009; Mudavanhu & Schenck, 2014; NHS Information Centre, 2011; Substance Abuse and Mental Health Services, 2008). Adolescents, parents and all professionals in this study expressed the devastating effects of substance abuse on adolescents. This included a negative impact on academic success as reported in previous studies (Mothibi, 2014). Furthermore, all participants indicated a need for intervention to address substance abuse challenges threatening adolescents.

Consistent with substance abuse prevention strategies of other countries and South Africa (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015), primary, secondary and tertiary prevention programmes were identified in this study. The stakeholders that were identified and recommended by the participants in this study to help with the prevention of substance abuse among adolescents included adolescents, parents, educators, health workers, law enforcers, traditional healers, traditional leaders, religious leaders, and political leaders. Even though the National Drug Master Plan (Department of Social Development, 2013) provide for the inclusion of all the stakeholders in substance abuse prevention programmes, the findings of this study revealed that traditional leaders and traditional healers were not involved in substance abuse prevention programmes. Furthermore, traditional leaders and traditional healers were not recommended as stakeholders in strategies of other countries (International Centre for the Prevention of Crime, 2015). The findings further revealed the involvement of stakeholders in the Bakwena N4 substance abuse project, Mmabana Recreational Centre, MAMORVICK and RADS. The mentioned stakeholders were not discussed in the literature reviewed in this study.

According to this study the methodology employed to implement substance abuse prevention programmes include education, mass media, and community programmes. This corroborated with substance abuse prevention strategies used in South Africa, in various countries, and in previous studies (Department of Basic Education, 2013; International Centre for the Prevention of Crime, 2015; Sussman, 2011). In addition, it was recommended by the participants of this study that the following should form part of substance abuse prevention programmes: challenges facing adolescents, sports activities, multipurpose centres, entrepreneurship opportunities, as well as information sessions, speeches, debates, and drama on substance abuse and its effects. The findings reveal that these programmes should be targeted at adolescents, educators, parents, and other community members. Parental involvement in substance abuse prevention programmes was emphasised in this study.

The findings point to non-compliance to the Liquor Act (2003), the Life Orientation Curriculum and Assessment Policy Statement (Department of Basic Education, 2012), Policy framework for the management of drug abuse by learners in public schools and in Further Education and Training Institutions (Department of Education, 2002), Prevention of and Treatment for Substance Abuse Act (2008), National Drug Master Plan (Department of Social Development, 2013), the National Strategy for the prevention and management of

alcohol and drug use among learners in schools (Department of Basic Education, 2013), and the Rural Safety Strategy (Institute for Security Studies, 2010).

It was revealed that there were limited financial resources for the implementation of substance abuse prevention programmes, as well as limited training and development on substance abuse prevention programmes, There was also a lack of recreational facilities and limited access to substance abuse treatment and aftercare support. Even though the findings revealed reflections on substance abuse prevention programmes, there were inconsistencies with regard to these reflections. Some professionals had reflection forms, whereas other stakeholders such as adolescents did not have. Also, other stakeholders such as parents, the traditional healer, and the traditional leader did not reflect on substance abuse prevention programmes. Notwithstanding the mentioned shortcomings, reflection reports served at Local and Provincial Drug Action Committees, as well as the Central Drug Authority in accordance with the provisions of the National Drug Master Plan (Department of Social Development, 2013),.

RECOMMENDATIONS

Policy Framework

Compliance to the Life Orientation Curriculum and Assessment Policy Statement (Department of Basic Education, 2012), as well as the policy framework for the management of drug abuse by learners in public schools and in Further Education and Training Institutions (Department of Basic Education, 2002) are critical in ensuring inclusion and participation of all learners in substance abuse prevention programmes. This may contribute to effective teaching and learning. To prevent easy access to taverns by adolescents, tavern owners must, prior to obtaining licences of approval for taverns, be trained on the Liquor Act (2003), Prevention of and Treatment for Substance Abuse Act (2008), National Drug Master Plan (Department of Social Development, 2013), and other substance abuse prevention programmes for adolescents.

Furthermore, to comply with the Liquor Act (2003), law enforcers in the rural area where the study was conducted must monitor the manufacturing and sale of alcoholic beverages as well as the supply of other illegal substances to minors. Moreover, community members should be

empowered in various ways to report manufacturers, producers and suppliers of illegal substances in their communities (Liquor Act 2003; South African Police Service, 2016). In addition, the illegal influx of foreign nationals and their businesses need to be monitored (Department of Home Affairs, 2016).

Training and development

Stakeholders implementing substance abuse prevention programmes among adolescents must undergo continuous training and development on the developmental stage of adolescence, as well as substance abuse prevention policies and programmes(Setlalentoa et al., 2015). These training and development interventions may equip them with information on how to address substance abuse problems among adolescents, within their own families, in schools, as well as community settings (Department of Social Development, 2013). This will give expression to the Setswana proverb *Ngwana sejo oa tlhakanelwa,* meaning that it takes a village to raise a child. In the context of this study, it means that all stakeholders are essential in preventing substance abuse challenges among adolescents in their communities. Peer education programmes such as the TADA group are also recommended for all adolescents and may form part of the Life Orientation certificate task that adolescents may do from Grade 7 to 12. There is also a need to mainstream aspects related to substance abuse in all learning areas in schools.

There is a need to include the topics (a) adolescence as a developmental stage, (b) self-esteem, (c) self-respect, (d) self-acceptance, (e) respect for others, (f) depression, (g) cyberbullying, (h) substances of abuse, (i) risk and protective factors for substance use, (j) use of substances by other family members, (k) child-headed families, (l) managing challenges confronting adolescents, (m) problem-solving, (n) peer influences, (o) social resistance skills against the use of substances, (p) impact of substance abuse on health, safety, and academic performance, (q) study skills, (r) substance abuse rehabilitation, (s) relapse, and (t) aftercare support in substance abuse prevention programmes for adolescents (The Prevention of and Treatment for Substance Abuse Act, 2008; Mothibi, 2014; Setlalentoa, 2009).

There is also a need for the differentiation of these programmes based on the specific needs and circumstances of adolescents in their families. Substance abuse prevention and treatment

programmes need to be gender-sensitive and consider special needs of the male and female adolescents.

For this training to be effective, there is a need for parental buy-in regarding their involvement in substance abuse prevention programmes (Department of Social Development, 2013; Pullen & Oser, 2014; Rural Health Information Hub, 2016; World Health Organisation, 2009).

Substance abuse prevention should start at home (Sussman, 2011). Parents and grandparents should therefore be empowered with the following skills:

- preparing their children for the adolescent stage (Nsamenang & Tchombe, 2011),

- monitoring, supporting, and managing adolescents (North, 2012; Robertson et al., 2010; Simmons-Morton & Farhat, 2010), establishing good relations with their children through communication, setting rules and boundaries on substance abuse, determining risk and protective factors for substance abuse (Griffin & Botvin, 2010; Spoth et al., 2012),

- being aware of the impact of substance use on academic performance, supporting their children to succeed in their studies, identifying an adolescent abusing substances, referring their children for rehabilitation, treatment for substance use, and aftercare support, identifying relapse, coping with the adolescent recovering from substance use, and assisting with reintegration into the family (Prevention of and Treatment for Substance Abuse Act, 2008),

- problem-solving, strengthening of the family structure, and collaborating with the school, churches and communities (Department of Basic Education, 2013; Department of Social Development, 2013).

Furthermore, there is a need for continued training and development of police members regarding adolescent development and how to interact with them. There is also a need to target risk and protective factors (Goliath & Pretorius, 2016; Harker et al., 2008; Poole, 2005; Substance Abuse and Mental Health Services Administration, 2015).

Recreational facilities

There is a need for the Department of Arts and Culture, the Department of Basic Education, the Department of Sports and Recreation, as well as the Ramotshere Moiloa Municipality to provide recreational facilities such as sports fields and gyms for adolescents. Recreational activities need to include anti-substance abuse messages through competitive sports activities (Department of Social Development, 2003; Department of Social Development, 2013; Department of Sports & Recreation, 2012). Other activities also need to include debates and speeches to raise awareness on substance abuse by adolescents. Furthermore, due to limited financial resources available, there is a need to improvise and use available resources for recreation. This may enable adolescents to participate in recreational activities and deviate from risky behaviours such as substance abuse. Other researchers and policymakers (Ames & Cunradie, n.d.; Department of Social Development, 2013; Ramlagan et al., 2010; Setlalentoa et al., 2015) also recommended that available resources should be used for recreation.

Rehabilitation centres and aftercare support

A rehabilitation centre in the Ramotshere Moiloa Local Municipality must be established to address challenges experienced in relation to substance abuse problems. The rehabilitation services must be easily accessible for the previously disadvantaged rural communities. The Department of Social Development and the Department of Health need to identify, acknowledge and support religious or spiritual rehabilitation centres and traditional healers within the municipality who may be offering rehabilitative services for substance abuse (Prevention of and Treatment for Substance Abuse Act, 2008; Traditional Healers Act, 2004). These departments should also provide information about processes to be followed to register a rehabilitation centre. This may lead to an increase in capacity with regard to substance abuse prevention and treatment centres in the Ramotshere Moiloa Municipality. Furthermore, this may ensure that organisations providing rehabilitation services understand the culture of people they serve. In addition, it may guarantee that they are within easy access for aftercare support and enable families to visit members admitted to rehabilitation centres.

Stakeholders

This study strongly recommends the multisectoral collaboration of stakeholders in substance abuse prevention programmes and participation in the Local Drug Action Committee of the Ramotshere Moiloa Local Municipality. These stakeholders include adolescents, parents, educators, mental health workers, social workers, police members or law enforcement officials, business people, traditional healers, traditional leaders, ward councillors, government and NGOs.

Reflections on substance abuse prevention programmes

There is a need for ongoing reflections on substance abuse prevention programmes implemented by all stakeholders. These reflections will assist in determining the need for substance abuse prevention, the achievement of objectives, and the improvement of programme implementation. Reflections will also assist in providing accountability, increase community support for initiatives, and inform policy decisions (Department of Social Development, 2013; Minnesota Department of Health, 2014; Van Dyk, n.d.). To make reflections more efficient, the progress and challenges of implemented programmes must be recorded in standard reflection forms (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015; Linnell, 2014; Substance Abuse and Mental Health Services Administration, 2015).

Future studies

There is a need for further studies on the perceptions of adolescents about substance abuse prevention programmes, with wider participation of adolescents and other stakeholders in all rural areas of the Ramotshere Moiloa Local Municipality. *Segonyamatlho* as a newly discovered substance of abuse among adolescents and a substance used to make nyaope must be further explored. I will further explore some of the findings of this study by writing academic journal articles on the integration of traditional and spiritual healing in the mental health framework with regard to the prevention of substance abuse by adolescents in the Ramotshere Moiloa Local Municipality. I will also explore the role of traditional leaders in substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality.

LIMITATIONS OF THE STUDY

Data collected in this study were limited to interviews and document reviews. Interviews were conducted with twenty four adolescents from two secondary schools, four educators, two parents, one mental health worker, a clinical psychologist, a social worker, a traditional healer, and a traditional leader. Unfortunately, I had to exclude other adolescents from other schools, their parents, NGOs and other government departments that could have offered additional relevant information on substance abuse prevention programmes for adolescents.

The documents analysed were also limited to substance abuse prevention policies, strategies, guidelines, programmes, and reports implemented in the United Nations Office on Drugs and Crime, the Medical Research Council, the departments of Economic Development, Basic Education, Health, Social Development, the South African Police Servicess as well as the substance abuse prevention strategies of seven countries. Other relevant substance abuse prevention policies, programmes and reports implemented in other departments or organisations and countries involved in substance abuse prevention initiatives were thus excluded.

The abovementioned aspects limited the data collected in this study. These limitations were not addressed in this study because qualitative studies usually consist of small samples (Creswell, 2014; De Vos et al., 2011; Mason, 2010) which are often useful in addressing the research questions.

The reason why I analysed a limited number of documents is because the research topic is evolving; there are other documents that may not have been available and accessible before I submitted the research report. However, even though the number of documents analysed were limited, they were useful in assisting me to address this study's research questions. The limited sample and documents analysed further assisted me to implement the study according to the research design outlined in Chapter 3, manage the study, and complete it with the available resources, and within the stipulated period. In addition, the development and contribution of knowledge occurred timeously (Johnston, 2014).

The themes identified in this study were based on the purpose of this study, research questions that were posed, and themes that emerged from the transcripts and summaries of

documents analysed. Therefore, despite the use of a co-coder to verify themes identified and enhance the credibility of the findings (Cho & Lee, 2014; Creswell, 2014; Wesley, 2010), there is a possibility that other themes, which may be relevant to this study, were not considered. This is because thematic analysis is an interpretive process, and there may therefore be a possibility for different researchers to develop different themes from the same data (Theron, 2015).

Despite the aforementioned limitations, this study was able to explore the perceptions of various stakeholders regarding substance abuse prevention programmes implemented for adolescents in the Ramotshere Moiloa Local Municipality. Future studies and research articles have also been recommended in the preceding section to address these limitations. Furthermore, even though the findings may not be generalised to other adolescents in other areas in the Ramotshere Moiloa Municipality and other provinces in South Africa, it may create an understanding of the substance abuse problem among adolescents and contribute to already existing information on substance abuse prevention initiatives for adolescents.

CONTRIBUTION OF THIS STUDY

The model below, as adapted from substance abuse prevention policies, strategies, and prevention programmes of various countries and previous studies reviewed in this study is proposed. See Figure 8 below. The first part of the model highlights the policy framework that needs to be considered when developing and implementing substance abuse prevention programmes in rural areas of the Ramotshere Moiloa Local Municipality where the study was conducted. The second part of the model raises awareness about substances of abuse, risk and protective factors, how to reduce risk factors, enhancing protective factors and determining the type of intervention to be applied. In accordance with substance abuse prevention strategies of other countries and South Africa, the third part of the model identifies substance abuse prevention programmes focussing on primary, secondary, and tertiary prevention (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015).

In addition, the third part of the model identifies programme development, implementation, reflections, and stakeholders required for substance abuse prevention programmes. The fourth part of the model highlights the importance of intersectoral collaborations and partnerships

(Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015). In agreement with recommendations provided by previous studies and substance abuse prevention strategies of various countries (Department of Social Development, 2013; International Centre for the Prevention of Crime, 2015; Linnell, 2014; Minnesota Department of Health, 2014; Substance Abuse and Mental Health Services Administration, 2015; Van Dyk, n.d.), the fifth part of the model emphasises a need for programme reflections, focussing on reflection forms, research, principles, enablers, and reporting.
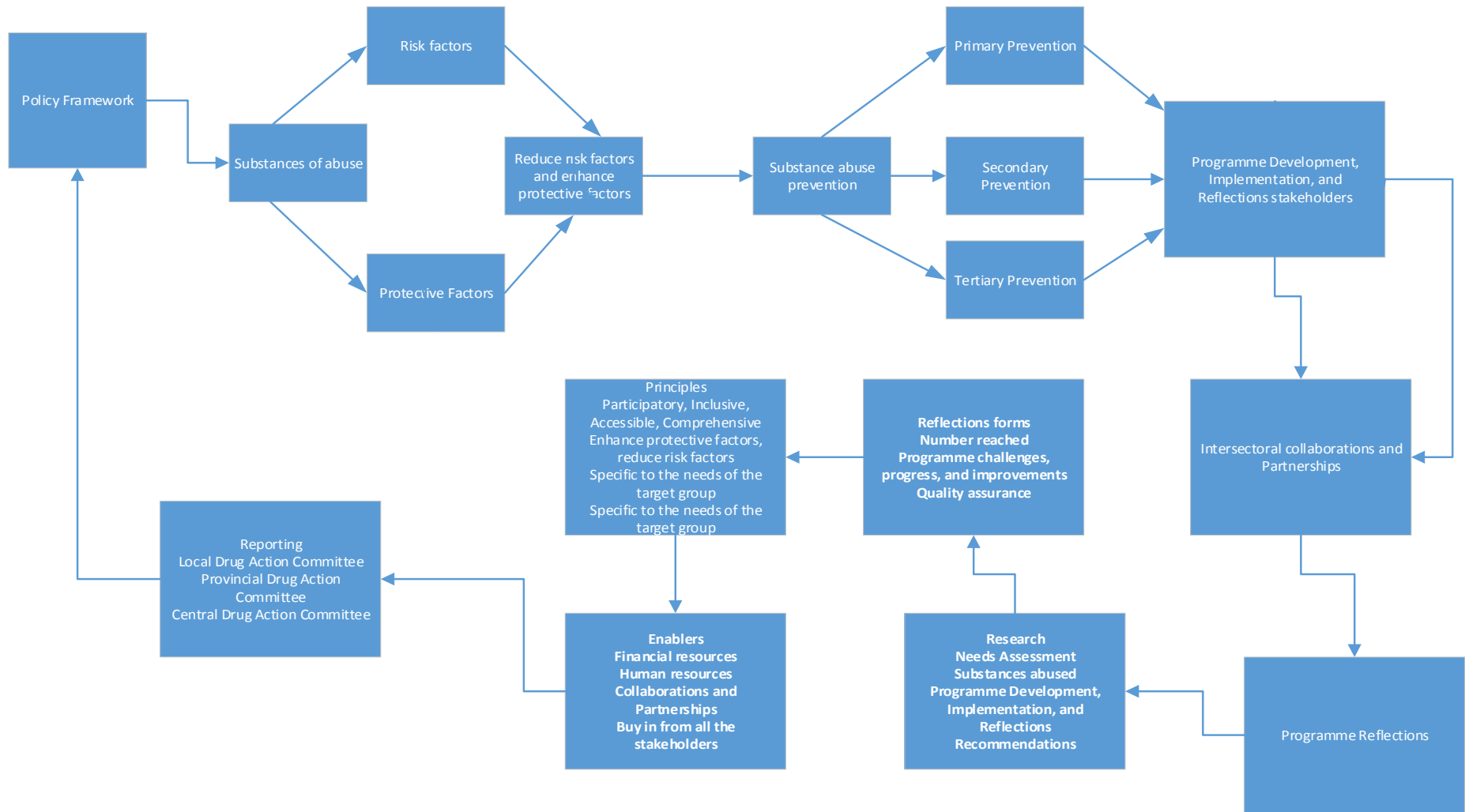
Figure 8: Proposed model for substance abuse prevention among adolescents

CONCLUSION

It is truly humbling to note that even though the Ramotshere Moiloa Local Municipality is a rural area and considered to be one of the previously disadvantaged communities (Ramotshere Moiloa Local Municipality Reviewed Integrated Development Plan, 2013), there exists substance abuse prevention programmes consisting of school-based strategies and extra-curricular strategies in this area in line with the provisions of the National Drug Master Plan (Department of Social Development, 2013) and strategies of other countries (International Centre for the Prevention of Crime, 2015; Substance Abuse and Mental Health Services Administration, 2014). Various stakeholders, including adolescents, are participants in the development, implementation, and reviewing of substance abuse prevention programmes in the Ramotshere Moiloa Municipality.

Despite the limitations mentioned before, the objectives of this study were achieved. The study also contributes new knowledge to already existing information about substance abuse prevention programmes. Gaps were also identified and recommendations made on how current substance abuse prevention programmes among adolescents in the Ramotshere Moiloa Municipality might be strengthened. Furthermore, this study acknowledges essential stakeholders to be considered for the development, implementation and review of substance abuse prevention programmes for adolescents. The importance of educating all the relevant stakeholders about substance abuse prevention policies is also acknowledged and recommended. This study further emphasises that substance abuse prevention should start in families. The role of the family is therefore acknowledged in the development of adolescents and, in particular, substance abuse prevention.

REFLECTIONS ON THE RESEARCH JOURNEY

The research journey was not easy. I had to strike a balance between my studies, family, and work responsibilities. Due to operational requirements I was unfortunately unable to take leave during my studies, even though there were opportunities for one to take leave and focus on their studies. Even though well thought out plans were in place to implement this study, there were barriers that I had to overcome, such as the recruitment of parents and police officials. I had to address these barriers through strategies such as continued persuasion of parents and the use of available documents of the South African Police Services. Analysing

the data was also a challenge, and I had to request the assistance of a co-coder and other doctoral supervisors to ensure that the data were analysed and presented in the required format for a doctoral study. At times, it was not easy to manage feedback obtained from the supervisor. I felt at times that the supervisor was delaying me from completing this study. I addressed this challenge by reading dissertations and articles by other authors and continuously reflecting on and revising this study. This enabled me to understand the concerns raised by my supervisor, which subsequently helped me to make the required changes to the thesis. What kept me committed to this study was the fact that I wanted to complete this qualification and always encouraged myself that if others could complete it, I shall make it as well. The support that I received from significant others such as my family, friends and other peer reviewers of my work encouraged me tremendously.

Despite all the efforts to apply for a research grant, my applications were not approved. I then opted to use my own financial resources. Notwithstanding all the challenges I encountered, I learned a lot from conducting a literature review, research methods, and discussions of the findings. I also acquired academic writing skills, which will assist me in writing journal articles. The analytical skills that I acquired will assist me in addressing other challenges I may encounter in life. This study assisted me in changing my perceptions towards African traditional perspectives. My interaction with the traditional healer in this study helped me to embrace diversity and to understand the role that traditional healers might play in addressing substance abuse problems. In addition, this study helped me to understand the hardships that pose a threat to adolescents and the importance of listening to their voices as and when substance abuse prevention programmes are developed and implemented.

Furthermore, I acquired knowledge about user-friendly programmes that may be considered when implementing substance abuse prevention programmes. The wealth of knowledge I acquired in this study inspired me to consider disseminating research findings through presentations at conferences, scholarly articles, and serving as a mentor for master's and doctoral students. I am also considering establishing a substance abuse prevention centre that will empower adolescents, parents and other caregivers in previously disadvantaged rural communities about substance abuse problems and how to address them.

It always seems impossible until it's done. -Nelson Mandela

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APPENDICES

APPENDIX 1: ETHICAL CLEARANCE

UNISA university of south africa
Department of Psychology

Ethical Clearance for M/D students: Research on human participants

The Ethics Committee of the Department of Psychology at Unisa has evaluated this research proposal for a Higher Degree in Psychology in light of appropriate ethical requirements, with special reference to the requirements of the Code of Conduct for Psychologists of the HPCSA and the Unisa Policy on Research Ethics.

Student Name: Ms. I P Mohasoa   **Student no.** 30115353

Supervisor: Prof E Fourie   **Affiliation:** Dept. of Psychology, Unisa

Title of project:

Substance Abuse Prevention Programmes Amongst Adolescents in Zeerust: A Systemic Review

The proposal was evaluated for adherence to appropriate ethical standards as required by the Psychology Department of Unisa. The application was approved by the Ethics Committee of the Department of Psychology on the understanding that —

- All ethical requirements regarding informed consent, the right to withdraw from the study, the protection of participants' privacy and confidentiality of the information should be made clear to the participants and adhered to, to the satisfaction of the supervisor;
- All permission that may be required by the community structures will be obtained before the study commences;
- If further counseling is required in some cases, the participants will be referred to appropriate counseling services.

Signed:

Prof. M Papaikonomou   Date: 2016-02-05
[For the Ethics Committee   ]
[Department of Psychology, Unisa]

APPENDIX 2: PERMISSION TO CONDUCT THE RESEARCH AT THE DEPARTMENT OF BASIC EDUCATION

41 Valkenier Street

Witpoortjie

1724

1 August 2014

The Area Project Manager

Department of Basic Education

Private Bag X6335

ZEERUST

2865

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT THE RESEARCH IN SECONDARY SCHOOLS IN THE ZEERUST AREA PROJECT OFFICE

This serves to request permission to conduct the research at the following secondary schools:

N.R. Mandela Secondary School

Ntebogang Secondary School

I am registered at the University of South Africa, for a Doctoral Degree in Psychology, under the Supervision of Prof Eduard Fourie (Department of Psychology). The title of the study is ***Perceptions of substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality, South Africa.***

The purpose of this study is to explore substance abuse prevention programmes targeting adolescents. Unstructured interviews will be employed to obtain data from the participants. Interview sessions are scheduled for two hours. There are no medical risks or other discomforts associated with the research. The findings of the research may help researchers and health practitioners to gain a better understanding of substance abuse prevention programmes targeting adolescents.

Looking forward to your assistance.

Yours Faithfully

....

I.P. MOHASOA (RESEARCHER)

APPENDIX 3: PERMISSION TO CONDUCT THE RESEARCH AT THE DEPARTMENT OF SOCIAL DEVELOPMENT

41 Valkenier Street

Witpoortjie

1724

1 August 2014

The Manager

Department of Social Development

Zeerust

2865

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT THE RESEARCH IN THE DEPARTMENT OF SOCIAL DEVELOPMENT

This serves to request permission to conduct the research in the Department of Social Development.

I am registered at the University of South Africa, for a Doctoral Degree in Psychology, under the Supervision of Prof Eduard Fourie (Department of Psychology). The title of the study is ***Perceptions of substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality, South Africa.***

The purpose of this study is to explore substance abuse prevention programmes targeting adolescents. Unstructured interviews will be employed to obtain data from the participants. Interview sessions are scheduled for two hours. There are no medical risks or other discomforts associated with the research. The findings of the research may help researchers and health practitioners to gain a better understanding of substance abuse prevention programmes targeting adolescents.

Looking forward to your assistance.

Yours Faithfully

....

I.P. MOHASOA (RESEARCHER)

APPENDIX 4: PERMISSION TO CONDUCT THE RESEARCH AT THE DEPARTMENT OF HEALTH

41 Valkenier Street

Witpoortjie

1724

1 February 2016

The Head of Department

Department of Health

North West Province

Mmabatho

2737

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE DEPARTMENT OF HEALTH

This serves to request permission to conduct research at the Department of Health, Ramotshere Moiloa District.

I am a registered at the University of South Africa, for a Doctoral Degree in Psychology, under the Supervision of Prof Eduard Fourie (Department of Psychology). **The title of the study is** *Perceptions of substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality, South Africa.*

The purpose of this study is to explore substance abuse prevention programmes targeting adolescents. Unstructured interviews will be employed to obtain data from the participants. Interview sessions are scheduled for two hours. There are no medical risks or other discomforts associated with the research. The findings of the research may help researchers and health practitioners to gain a better understanding of substance abuse prevention programmes targeting adolescents.

Looking forward to your assistance.

Yours Faithfully

....

I.P. MOHASOA (RESEARCHER)

APPENDIX 5: PERMISSION TO CONDUCT THE STUDY AT THE SOUTH AFRICAN POLICE SERVICES

41 Valkenier Street

Witpoortjie

1724

20 January 2017

The Station Commander South African Police Services

North West Province

Lehurutshe

2737

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN LEHURUTSHE POLICE STATION

This serves to request permission to conduct research at the Lehurutshe Police Station. I am registered at the University of South Africa, for a Doctoral Degree in Psychology, under the Supervision of Prof Eduard Fourie (Department of Psychology). **The title of the study is** *Perceptions of substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality, South Africa.*

The purpose of this study is to explore substance abuse prevention programmes targeting adolescents. Unstructured interviews will be employed. The interview sessions are scheduled for two hours. There are no medical risks or other discomforts associated with the research. The findings of the study may help researchers and health practitioners to gain a better understanding of substance abuse prevention programmes.

Looking forward to your assistance.

Yours Faithfully

....

I.P. MOHASOA (RESEARCHER)

APPENDIX 6: LETTER OF INFORMED CONSENT FOR ADOLESCENTS, PARENTS AND PROFESSIONALS

DEPARTMENT OF PSYCHOLOGY

COLLEGE OF HUMAN SCIENCES

UNIVERSITY OF SOUTH AFRICA

P.O. BOX 392

PRETORIA

0003

IRENE PATIENCE MOHASOA

41 VALKENIER STREET

WITPOORTJIE

1724

LETTER OF INFORMED CONSENT

I................................, the undersigned, consent to participate in the Doctoral study to be conducted by Ms I.P. Mohasoa, a student at the University of South Africa, under the supervision of Eduard Fourie (Department of Psychology). The title of the study is the *Perceptions of substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality, South Africa*

The purpose of the research is to explore the substance abuse programmes targeting adolescents. Unstructured individual face to face interviews and focus group discussions will be employed. Interview sessions are scheduled for two hours. Data obtained will be treated as confidential.

There are no known medical risks or other discomforts associated with the research. The findings of this study may help researchers and health practitioners to gain a better understanding of substance abuse prevention programmes for adolescents.

It was made clear to me that I may withdraw from participating in the study at any time. I agree to it that there is no financial compensation for participating in this study.

I understand my rights as a participant in this study and I voluntarily consent to participate in this study. I understand what the study is about, how and why it is being done.

I agree that the results of this study may be published in professional journals and conferences but the records will not be revealed and the participants will remain anonymous.

I will receive a copy of this consent form.

.... (Participant's Signature).................... (Date)

.... (Signature of Researcher)

Date.................................. (Place)..

APPENDIX 7: LETTER OF INFORMED CONSENT FOR PARENT

DEPARTMENT OF PSYCHOLOGY

COLLEGE OF HUMAN SCIENCES

UNIVERSITY OF SOUTH AFRICA

P.O. BOX 392

PRETORIA

0003

IRENE PATIENCE MOHASOA

41 VALKENIER STREET

WITPOORTJIE

1724

LETTER OF INFORMED CONSENT

I..............................., the Parent of.. grant permission for my child to participate in the Doctoral study to be conducted by Ms I.P. Mohasoa, Doctoral student at the University of South Africa, under the supervision of Eduard Fourie Department of Psychology. The title of the study is ***Perceptions of substance abuse prevention programmes implemented in the Ramotshere Moiloa Local Municipality, South Africa.***

The purpose of the research is to explore the substance abuse programmes targeting adolescents. Unstructured individual face to face interviews and focus group discussions will be employed to obtain data from the participants. Interview sessions are scheduled for two hours. Information will be treated as confidential. There are no known medical risks or other discomforts associated with the research. I agree that the findings of this study may be published in professional journals and conferences but the records will not be revealed and the participants will remain anonymous. I understand what the study is about, how and why it is being done.

I will receive a copy of this consent form.

.... (Signature of the Parent)................... (Date)

.... (Signature of Researcher)

Date................................ (Place)..

APPENDIX 8: A STATEMENT OF CONFIDENTIALITY

I...................................... hereby affirm that I will not disclose information obtained during interviews. I agree to discuss research related information with other members of the research team only. In any reports, papers, or published materials I write, I agree to remove any information revealing identity of participants in this study.

Name of research assistant:...

Signature:................................

Researcher's Signature :...

(Adapted from Berg, 2009)

APPENDIX 9: GROUP AGREEMENT FOR MAINTAINING CONFIDENTIALITY

I...................................... hereby affirm that I will not disclose information discussed during the focus group discussions. I agree not to disclose any information about the focus group to any person other than my fellow focus group members and the researcher.

Name:...

Signature:...

Researcher's Signature:..

(Adapted from Berg, 2009)

APPENDIX 10: INTERVIEW SCHEDULE

Demographic questions

- *Could you please tell me a little bit about yourself and what it is that you do?*
- *Not everybody is familiar with the town Zeerust, may you please tell me something about it?*
- *What is it like to live here?*
- *What is it like to grow up here?*

Essential questions concerning the focus of this study

- *Tell me more about teenagers living in Zeerust. How do their lives differ from teenagers growing up in Johannesburg?*
- *Is substance abuse in your opinion widely used and abused by them?*
- *Which substances are abused among adolescents?*
- *What do you think are reasons for them to use or abuse substances?*
- *Are there any substance abuse prevention programmes implemented in Zeerust? If yes, name the programmes.*
- *May you please tell me a little bit more about the programmes?*
- *Who are programmes aimed at?*
- *What are the main activities of those programmes?*
- *Do adolescents seem to respond well to programmes?*
- *Were you involved in the development of those programmes?*
- *If no, who developed those programmes?*
- *How were those prevention programmes implemented?*
- *Were you trained before implementing those programmes?*
- *After implementation of programmes, did you participate in their evaluation process?*
- *In your opinion, do you think these programmes are enough to prevent substance abuse? Or could more be done to prevent substance abuse among adolescents?*
- *In your opinion, who do you think can be the main stakeholders for the development and implementation of those substance abuse prevention programmes?*
- *If you were to develop a substance abuse prevention programme, what aspects or activities do think would be important to include?*
- *Why would you include such activities or aspects?*

- *How can adolescents be encouraged to get involved in the development of substance abuse prevention programmes?*

- *Should parents or guardians be involved in substance abuse prevention programmes? If yes, why should they be involved? If no, why must they not be involved?*

- *How can parents be involved in substance abuse prevention programmes?*

- *Who else in the community could get involved in substance abuse prevention programmes?*

- *Is there anything you think we have not discussed thus far which you think I need to know?*

APPENDIX 11: CO-CODERS' CERTIFICATE

Coding Certificate/2017

This serves to certify that

Mbongiseni Mdakane has co-coded the qualitative data for the study exploring:

**Adolescents' perceptions of substance abuse prevention programmes implemented in the
Ramotshere Moiloa Municipality, South Africa**

I declare that I have reached consensus with Irene Mohasoa on the themes of the data during a
consensus discussion. I have also provided him with a report.

Signed: *M. Mdakane*
Date: June 2017