PARTICIPANTS' PERCEPTIONS OF A HIGH SCHOOL SUBSTANCE USE PREVENTION PROGRAMME

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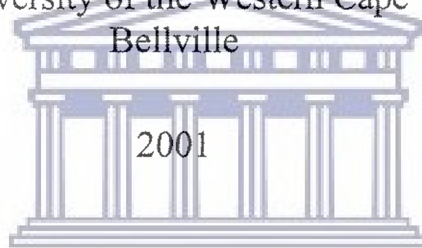

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ABSTRACT

There are many theories as to why adolescents engage in substance abuse. These theories have formed the basis of various substance abuse prevention programmes aimed at reducing this problem. Evaluation of these interventions is needed in order to assess their effectiveness and to improve on future prevention strategies. The literature highlights tensions and differences between the primary preventative approaches to substance abuse and the harm reduction model. It also suggests that psychosocial or life skills programmes and interventions employing a harm reduction approach tend to be viewed as more suitable for adolescents than other approaches. This study focuses on a high school intervention programme running since 1996, which has not yet been evaluated. It aimed to identify the programme's strengths and weaknesses, as well as participants' perception of the intervention. A qualitative research method was used, employing focus groups as the tool for data gathering. The sample for the study was made up of 30 volunteers from three grade 10 classes that completed the programme two years prior to this study. Data was transcribed verbatim and analyzed using thematic analysis. Links were made to the two approaches referred to above. Analysis of the data indicated that although stories used to warn and frighten people were shown to have a shocking impact on the participants, pupils found it difficult to make the connection between the speakers' horrific stories and their own experimentation with drugs and alcohol. It was found that participants appreciated the fact that they were being informed about the dangers of substance use, and that they were encouraged to take responsibility for their own decisions regarding this behaviour. The informal, non-judgemental stance of the speakers served to reinforce this message. In conclusion, the study indicated that the different methods used in the various prevention programmes are in fact not altogether different. It is suggested that the various models are potentially compatible, and can perhaps work together to establish an effective preventative strategy.

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DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own original work.

G. Washkansky

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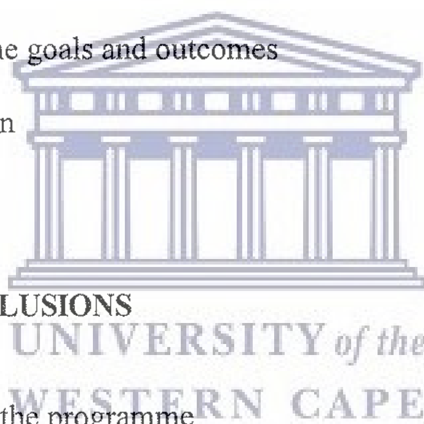
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CHAPTER 1

INTRODUCTION

Epidemiological research conducted both in South Africa and abroad has indicated that illicit psychoactive substance use is a widespread problem (Zetler, 1999). According to the United Nations Office for Drug Control and Crime Prevention (UNDCCP) (2000), cannabis is the most widely used drug in all parts of the world. Studies in North America and Western Europe indicate a decrease in the use of certain illicit substances and an increase in the use of other drugs, particularly ecstasy. In South Africa, research has indicated an increase in drug use as well as a significant rise in the number of individuals starting to take drugs before the age of thirteen (Lund, 2000).

Only five years ago, crack, cocaine and heroin were hardly a problem in South Africa. Now these hardcore drugs are flooding through our borders, leading to a noticeable increase in individuals with drug addiction. Most distressing is the fact that the dealers are targeting teenagers, and people seeking help for chemical dependency are getting younger. South Africa's recent emergence from an isolated and repressive authoritarian system to a democracy with freedom of choice has identified this country as an easy target. This, in addition to South Africa's geographical location, solid infrastructure and the opening of borders in order to join the global market, has made the country vulnerable to the influx of illegal drugs. Furthermore, the increase of drugs on the streets has led to substances being sold at prices affordable to disadvantaged communities, whereas in the past, certain drugs like cocaine were only available to the white elite (Williams & Friedman, 2001).

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Substance use patterns vary and take on many different forms. The dominant theories and models used to understand substance use tend to focus on chemical dependency and compulsive use. In most cases they exclude those who experiment and those who are occasional users (Zetler, 1999). These theories include the medical and moral models, as well as the more holistic understandings such as psychological and sociological theories.

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These dominant theories or models form the basis of many treatment programmes for the chemically dependent. They also play an important role in the formulation of substance prevention programmes targeting adolescents. Drug education has traditionally adopted the abstinence model, aiming to prevent teenagers from experimenting with substances. However, the 'just say no' approach utilizing scare tactics and other methods to frighten or to persuade youth not to take drugs, have to a large extent been ineffective in reducing adolescent substance use. Primary prevention strategies have come into conflict with the more recent harm reduction approach. Harm reduction employs a 'just say know' philosophy advocating a more realistic view of adolescent substance use, with its focus on educating in order to help teenagers to make informed decisions when using drugs and alcohol (Blackman, 1996).

A variety of methods have been used in South African schools to address the issue of adolescent substance use. Different strategies have included counselling, life skills; drug prevention interventions and other programmes run by the schools, as well as by various external organisations and individuals. However, it appears that these strategies have to a large extent failed in their attempts in changing attitudes and reducing the use of substances. The desperation to curb this increasing problem has led to the recent implementation of the controversial drug testing in schools, an indication that new methods of intervention are being sought.

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Many interventions continue to run in schools without being evaluated, and in many instances appear not to be effective. Some have even been known to have adverse effects (Lorion, 1983). Therefore it is important to evaluate these interventions and to provide feedback as to the utility of the adopted approach. This study aims to evaluate one such intervention, namely a school substance intervention programme utilizing the harm reduction model.

This thesis begins with an overview of the current trends related to substance use as indicated by epidemiological studies worldwide. Particular attention is focused on Europe, North America and South Africa. This is followed by an exploration of the many theoretical models used to explain psychoactive substance use, as well as to inform treatment and prevention programmes. Literature concerning drug education

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and intervention is then discussed, followed by a look at the various prevention programmes and how they differ.

The following chapter deals with research methodology. The chapter opens with a brief description of the programme to be evaluated, and outlines the aims of the current study. The subject of programme evaluation is then discussed. An explanation of the research methodology and a description of the sample, procedure and analysis of the data follow. Issues pertaining to reliability, validity, reflexivity and ethics are considered.

Chapter four involves a discussion of the dominant themes that emerged from the analysis of the data. Broadly, these categorise as a reflection of the impact made by the various aspects of the programme such as the programme providers, content, method and structure of the intervention.

The final chapter looks at the overall impact of the intervention as well as its strengths and weaknesses. The role of substance prevention programmes in schools is explored, and suggestions for further evaluative research are then made.

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CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

"Turbo", Diablito", "Greek Joint", "Wicky Stick" or "Donk", "Love Boat" or "Dust Blunt", "Fry amp" or "Water-Water" and "Candy Blunts" (National Institute on Drug Abuse (NIDA), 1998). These are just a few of the nicknames given to the multitude of drugs currently being consumed by young people around the world. Substance use patterns vary among different populations and takes on many different forms (Zetler, 1999). Theoretical models attempt to explain the etiology of adolescent substance use. These explanations form the basis of the many treatment and prevention programmes currently utilized to try and curb the problem. The chapter provides a brief overview of the relevant literature on substance using behaviour amongst youth, with particular focus on explanatory models and prevention programmes.

This section will begin with a definition of the different terms related to substance using behaviour, which will be followed by an overview of the prevalence of substance use amongst youth both globally and in South Africa. Thereafter an exploration of the current explanatory models and their different theoretical perspectives will ensue. Prevention programmes currently implemented in schools around the world, with particular focus on interventions that employ the harm reduction model, will then follow. The section will conclude with a brief look at some of the interventions used in the Western Cape, as found in a study conducted by the Education and Prevention Committee in 1999.

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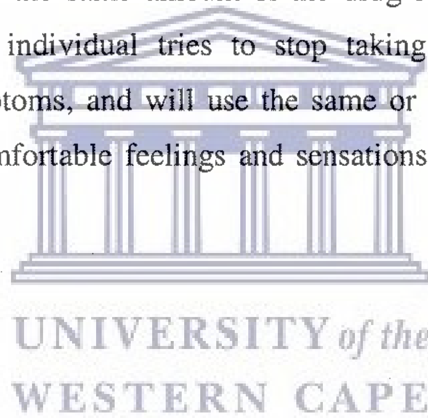
2.2 Defining substance use, abuse and dependence

Substance use according to Rathus and Nevid (1991) refers to the legal consumption of substances (such as alcohol) within limits, without having a negative impact on the user's life. The term substance abuse is a term used by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) to define 'a maladaptive pattern of severe substance use leading to clinically significant impairment or distress', resulting in impaired daily functioning and a reduced capacity to fulfil one's role obligations (American Psychiatric Association (APA),1994, p.182). Legal, social and interpersonal problems are indicated. Substance dependence according to the DSM-IV (APA, 1994, p.182) is characterized by 'a maladaptive pattern of substance use, leading to clinically significant impairment or distress.' The addicted or dependent individual develops a need for increased amounts of the substance in order to feel satisfied, as continued use of the same amount of the drug loses its effect. This is known as tolerance. If the individual tries to stop taking the drug he or she experiences withdrawal symptoms, and will use the same or a similar substance to avoid or to relieve the uncomfortable feelings and sensations associated with these symptoms.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2.3 Prevalence

Rates of drug and alcohol use tend to vary from country to country, with new drugs gaining popularity while use of other drugs decrease or level off. The 2000 World Drug Report estimated that approximately 141 million people worldwide consume cannabis, making it the most widely used drug in all parts of the world. Amphetamine-type stimulants follow second (approximately 30 million), followed by cocaine (17 million), heroin and other opiates (8 million) and, finally, injecting drugs (3.3 million) (Van der Burgh, 2000). Cannabis accounts for approximately 90% of the total drug use of teenagers aged fifteen and sixteen, in both Western Europe and North America (UNDCCP, 2000).

The National Household Survey on Drug Abuse conducted across the United States in 1999, found that 10.9% of youths aged twelve to seventeen reported use of illicit drugs. Marijuana was indicated as being the major illicit drug used by this particular

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population with 7.7% of youths being current marijuana users (Substance Abuse and Mental Health Services Administration, 2001)

In 2000, The MTF study or Monitoring the Future Study was conducted on 45,173 U.S high-school pupils in grades 8, 11 and 12 from a representative sample of 435 public and private schools nationwide. A survey was conducted in order to collect data on past month, past year and lifetime drug use. Results showed that for the fourth year running illicit drug use among 8th, 10th and 12th graders remained stable or decreased in some cases. All three grades showed a significant reduction in cigarette smoking. 12th graders showed a reduction in cocaine and crack, while 10th and 12th graders showed reductions in hallucinogens and LSD. Heroin, inhalants and methaqualone (a sedative) use had decreased among 8th graders (NIDA, 2000a).

A comparison to the 1999 MTF study revealed significant increases in the use of ecstasy among grades 8, 10 and 12 for the second year running. Anabolic steroids use increased among 10th graders, and heroin use among 12th graders. Since the 1999 study, marijuana use across all three grades has remained stable for all three categories (past month, past year, lifetime use). Decreases in use since the mid 1990s were indicated, especially among 8th graders. Alcohol use also remained stable across all three grades, although daily drinking in the past month showed a significant decrease (NIDA, 2000a).

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In Europe, a survey called the European School Survey Project on Alcohol and Other Drugs (ESPAD) was conducted in 1999 on fourteen to eighteen year-old teenagers in 30 countries across Eastern and Central Europe (Observatoire Francais des Drogues et des Toxicomanies (OFDT), 2000). Results indicate that alcohol, tobacco and cannabis are still the most frequently used psychoactive drugs in Europe. In comparison to a study done in 1993, rates of lifetime experimentation with tobacco in this population showed an increase of 20%. A less obvious increase was shown for lifetime experimentation with alcohol. However, alcohol use in 1999 proved to be more prevalent than it was in 1993. In the 1999 study, 59% of males and 43% of females aged eighteen were reported to have experimented with cannabis at some stage in their lives. This is a stark contrast to lifetime experimentation as shown by 34% of males and 17% of females in the 1993 study. Repeated use of psychoactive substances

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indicated that smoking increases dramatically with age, while repeated use of alcohol tends to plateau. Repeated drunken states showed a tendency to decrease. Cannabis showed a distinct increase in the repeated use category across both age and gender (OFDT, 2000).

Prevalence of lifetime experimentation and repeated use of other illicit substances was shown to be low. Ecstasy, although popular on the European rave and dance scenes for quite some time, has stabilized and is showing a decline in some European countries. However, cocaine hydrochloride may be used as a supplement to or replacement for ecstasy. There is also a growing concern, firstly that polydrug use has become more prevalent and secondly that a wider range of substances are now available in European countries, giving rise to more dangerous drug use patterns (NIDA, 2000b).

In summary, prevalence rates from the United States and Europe indicate that drug patterns and trends tend to vary according to different age groups, as well as the different substances used. In the United States, increased use of ecstasy, heroin and anabolic steroids is indicated, while use of marijuana, tobacco and alcohol appears to have stabilised. In Europe, cannabis, alcohol and cigarettes are still the most popular and frequently used substances. Use of ecstasy and other illicit drugs has stabilised and decreased, despite the growing concern that new and dangerous substances are appearing on the drug market.

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In contrast to North America and Europe, epidemiological research on adolescent substance abuse in South Africa appears to be less available. The largest substance related research currently conducted on a national level, is the South African Community Epidemiological Network on Drug use (SACENDU). Research monitoring cigarette, alcohol and dagga use was conducted among 1 360 grade 8 pupils attending a high school in Durban. Results of the study indicated that over 60% of pupils in each category had used that particular substance in the past 12 months (Bhana, 1999).

Fisher (2000) conducted a study on 3 474 high school pupils in the Western Cape. Results of the study indicated that 62% of all pupils reported having experimented

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with alcohol at some stage in their lives. Dagga was indicated to be the most common drug of experimentation, with 23% of pupils, grade 8 through 12, having tried it at least once. Ecstasy followed with 6% of all pupils reporting that they had experimented with this drug at some point. Mandrax and speed followed closely with 5% and 4% respectively. Only a small percentage reported having ever experimented with crack, LSD and cocaine (3%). Finally, 8% were reported to have experimented with glue and other inhalants (Fisher, 2001).

In addition, in 1998/9, research by Rave Safe, was conducted on 228 teenagers attending rave parties in Durban and Johannesburg. Results indicated that lifetime prevalence rates for ecstasy and LSD were as high as 70%, while poppers (amylnitrate) showed a lifetime prevalence of 60% (Parry, 2000). According to NIDA (2000b), there has been a rise in arrests and seizures of ecstasy, and concern is growing about the fact that some ecstasy tablets have found to be contaminated. There is also concern about the rise in polydrug use amongst the youth.

Statistics from the Cape Town Drug Counselling Centre (CTDCC) reveal that in 1999 half of the 583 clients seeking treatment for drug addiction had started using drugs before the age of thirteen (CTDCC, 2000). Furthermore, according to the Medical Research Council, statistics in 2000 found that 17% of all people fighting chemical dependency across 22 treatment centres in the Cape Peninsula were teenagers, in comparison to 6% in 1997. Cape Town was indicated to have the highest prevalence of drug use in comparison to other provinces in South Africa (Lund, 2000). Statistics have shown that dagga is the most popular first drug among users, with 60% of those addicted starting on dagga and 22% starting with alcohol. Statistics from the CTDCC reveal that in 1999, 33% of help seekers of all ages sought treatment for dagga combined with mandrax (white pipes). This figure has shown a marked decrease since 1993, when figures were as high as 63%. Other current and commonly used drugs by the general population are crack (15%) and opiates, usually heroin (7%) (CTDCC, 2000).

Furthermore, according to police statistics, more than 60% of school-going children in Gauteng are exposed to, experimenting with or addicted to psychoactive substances (Ferguson, 2000). The above research indicates that drug trends in South Africa tend

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to vary from study to study. However, the most common psychoactive substances experimented with and used by teenagers appear to be cigarettes, alcohol, dagga, ecstasy, speed, and mandrax. According to Williams and Friedman (2001, p.1) drugs are so easily available in Cape Town that finding the substance of your choice is 'as easy as ordering a pizza'. Drugs are rife in schools across South Africa, and children and adolescents have been found to be using drugs during school as well as after school hours (Ferguson, 2000).

As seen above, patterns of substance use among youth vary. Some use, some abuse, while others have developed a drug dependency. There are various theories or explanatory models to suggest why adolescents are addicted to psychoactive substances, or why they engage in substance using behaviour. Treatment programmes for addicted teenagers have been formulated based on the relevant theories. Many teenagers who use substances do not take heed of the many warnings they have been given regarding the dangers that lie ahead. Thus there is a need not only for treatment once the problem has been well established, but also for prevention in order to warn and educate teenagers about the perils of substance abuse. The following section will explore some of the main theories that help us to understand teenage substance use and addiction, and that are used to inform or guide treatment and prevention programmes.

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2.4 Theoretical Models

There are numerous theories that attempt to explain and understand substance use. The various theories have different perspectives, each defining the problem according to its own model (Zetler, 1999). As the various models are explored below, the definitions will shift in order to suit that particular theory. Each model has different, and in many instances, opposing beliefs and values that influence the way this behaviour is defined and understood. In many cases, those people responsible for dealing with the problem are inflexible, and will exclude other models or ideas in the belief that the different theories are mutually exclusive. This has resulted in much controversy in this field, and often does not allow for an appropriate intervention (Fisher & Harrison, 1997).

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The many theoretical understandings are divided into two over-arching categories, namely univariate and multivariate theories. The univariate category includes those theories that adhere to the belief in cause and effect, such as the medical or disease model, where dependence on a substance is seen as being caused by a single variable, such as a genetic predisposition to addiction. The moral model also falls into this category, with addiction or dependence being seen as the result of bad moral character. The multivariate category includes those theories that view the various forms of substance use as stemming from a variety of factors at play in the individual's life. Included in this category are psychological, sociological, cultural and multicausal theories (Zetler, 1999). The harm reduction model does not appear to fit into the above two categories and is therefore addressed separately. The following section will include a discussion of the above-mentioned explanatory models.

2.4.1 Univariate theories

Initially only applied to alcoholism but later generalized to other drugs, the **biological understanding** of chemical dependency is also known as the **medical, or the disease, model of addiction**. This model is accepted as a mainstream theory, and is believed and accepted by many (Berger, 1991). It also forms the basis of Alcoholics Anonymous programmes with their abstinence-oriented approach to treatment, and is very much at the forefront of guiding other treatment interventions. The disease model explains that addiction is not a secondary condition that evolves as a result of other psychological or social circumstances, but rather the 'primary disease that exists in and of itself' (Fisher & Harrison, 1997, p.40). As Peele (1985, p.6) states: 'the core of this concept is that an entire set of feelings and behaviours is the unique result of one biological process'. According to this model, there is a stage by stage progression, each with its own set of symptoms, that eventually leads one to a loss of control over one's drinking and ultimately culminates in an addiction. Once this has happened, the stages cannot be reversed and thereafter the addiction is incurable and can only be rehabilitated through voluntary participation in a treatment programme such as Alcoholics Anonymous and through voluntary abstinence (McNeece & DiNitto, 1994). The notion that the addiction is an illness and is incurable is the cornerstone of the Alcoholics Anonymous philosophy, and one is never 'cured or recovered'. The reason for this is the belief that one is always recovering regardless of how many

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years of sobriety one has achieved. The individual may decide to take a drink after years of being dry and will relapse into the addiction immediately (Fisher & Harrison, 1997).

The disease model has been supported by studies that suggest a genetic predisposition to alcohol. Research has found that alcohol abuse is more prevalent in some families as opposed to others. Twin studies have revealed that monozygotic twin pairs show higher concurrent alcoholism rates than dizygotic pairs. Lastly, children who have been adopted are more likely to resemble their biological parents as opposed to their adoptive parents when using alcohol (McNeece & Dinitto, 1994). However, despite this evidence, it is still not definitely known if genetic factors are in fact the cause of alcoholism (McNeece & DiNitto, 1994). In addition, genetic studies conducted in this area are viewed by some to be both questionable as a result of conflicting results of studies, and methodologically unsound (Berger, 1991).

Other evidence in support of this theory includes biochemical models. This approach suggests an abnormality in the metabolizing of sugar, or an allergic reaction to alcohol. A more popular biochemical finding is that alcohol produces a morphine-like substance called tetrahydroisoquinolines in the brains of certain users, which is responsible for the development of an addiction. The certainty of this theory is also unfounded, as it is difficult to establish cause and effect because this substance may have been produced after many years of alcoholic drinking. Brain dysfunction theories suggest that as a result of a neurochemical deficiency that manifested itself in childhood, minimal brain damage occurred causing a potential to inherit an alcohol addiction. Research has shown that the offspring of alcoholics are more likely to be born with minimal brain dysfunction (McNeece & DiNitto, 1994).

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It has been argued that the data supporting the disease model are weak, and that alcohol dependence is not necessarily hereditary but caused by an amalgam of factors and one cannot separate the biological from the environmental. What Berger (1991) sees as particularly problematic about this model is that it assumes that the person was psychologically healthy before he or she became addicted to alcohol or drugs, and that the addiction is purely biological. Berger also disagrees with the belief that everybody has the biological potential to become addicted to drugs if taken often enough and in

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sufficient quantity, whereas only certain people will become addicted to alcohol as a result of their unique biological makeup (Berger, 1991). Critics of the disease concept caution that individuals who believe that their addiction is as a result of an illness may not take responsibility for their addictive behaviour and subsequent actions, as they believe that they are sick and do not have control over what they do (Fisher & Harrison, 1997).

An advantage of the disease model is that if addiction is recognized as an illness, as opposed to a deficiency in one's character, it removes the stigma that society attaches to addictive behaviour. In many cases this will motivate the person to seek treatment for the illness, as opposed to feeling that one is simply an amoral, bad and worthless person (Fisher & Harrison, 1997). The following is a quotation from a pamphlet of a chemical dependency unit in Cape Town: 'The treatment aims to destigmatize the illness of addiction and integrate the chemically dependent individual back into society as early as possible.'

Both the legal system and religious groups view substance abuse and addiction as a poor personal choice, and believe that the individual has the ability to make better or less deviant personal choices. This is known as the **moral model,** and sees drinking, drunken behaviour and drug abuse as being indicative of a character or a spiritual deficiency within the individual. Some religious groups believe that the person requires religious or spiritual healing in order that he or she will stop using psychoactive substances (Fisher & Harrison, 1997). The legal system sees substance abuse and crimes committed as a result of alcohol or drugs as a violation of the law. This misconduct must be punished, as opposed to being treated as an illness or as a result of a psychological or social problem. Substance abusers are viewed by many in society as being bad, sinful and morally weak, and that imprisonment and other punishment is the best way to handle these individuals. Despite this popular belief, the approach has proven to be largely ineffective in rehabilitating these people and in preventing others from following suit (McNeece & Dinitto, 1994).

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2.4.2 Multivariate Theories

Multivariate theories include a number of different approaches: Psychological, social and multicausal theories are explored below.

There are numerous theories that fall under the **psychological approach** to substance use, abuse and addiction. Psychological theories are a lot more flexible than biological theories, and will include the social environment and the family, as well as other factors that may be impacting on the problem (McNeece & Dinitto, 1994). There are many psychological factors that contribute to adolescent substance use, some of which are of a general nature and cannot be categorized, while others form specific theories. Some of these theories include personality traits that correlate with substance using behaviour, classical analytic and more modern dynamic explanations, and social learning and behaviour theory.

Searll (1989) explains how young people are often curious at the prospect of experiencing a new sensation. Thus when offered the drug or alcoholic beverage, usually by their friends, they are quite willing to 'give it a try'. Often they mistakenly believe that they are in control of the drug intake and that they are invincible. In addition, adolescence is a difficult stage developmentally, and often gives rise to feelings of loneliness and isolation, not being able to 'fit in' and, most importantly, peer group pressure that contributes to their vulnerability. A 17 year-old heroin addict from Gauteng is quoted as saying:

> *'Everyone's using drugs, life's crap. People don't care and teachers really don't have a clue what's going on. Almost all my friends are doing something. I do heroin so I don't have to feel the pain of being alive'* (Ferguson, 2000, p.1).

Other factors to consider are boredom, excitement, rebellion and the need to be noticed, a cry for help, poor self-esteem related to feelings of inadequacy and a lack of confidence. Further contributing factors are a pressure to succeed, escapism, poor role models, family dynamics and certain personality traits (Searll, 1989).

As is the case with genetic theories of addiction, research in many cases indicates a high correlation between personality traits and addictive behaviour, but to date

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identifying the "addictive personality" has proven to be unsuccessful (Fisher & Harrison, 1997). What has been proven is that certain personality traits, as well as certain psychological disorders, are more prevalent among substance abusers than non-substance abusing populations (APA, 1994). Sensation seeking, impulsive behaviour, difficulties in delaying gratification, an antisocial personality, nonconformity and a lack of commitment to the goals of society, social alienation, a general tolerance for deviance and a sense of heightened stress are some of the personality traits associated with substance abuse (McNeece & DiNitto, 1994). Certain psychological disorders in childhood have been identified as possible indicators of substance abusing behaviour in later years. These are hyperactivity, learning disabilities, cognitive deficits, and conduct disorder (Kaplan, Sadock & Greb, 1994).

Classical psychoanalytic theory explains substance abuse as a defence against unacceptable sexual and aggressive drives, and views addiction to psychoactive substances as a substitute for the 'primal addiction', that being masturbation. Addiction has also been viewed as regression to the oral stage of development where one is fixated. Modern psychodynamic theory understands substance abuse as an attempt to deal with poor ego development and early narcissistic needs, or as an effort to overcome a deficiency in the sense of self. From this viewpoint, use of psychoactive substances is seen as an attempt at preventing the self from disintegrating, and thereby maintaining internal cohesion. It is also seen as an attempt at self soothing or self regulating in order to avoid psychic pain and other tensions and vulnerabilities that the person may be experiencing. As Kohut says, '. . . there is some missing aspect of their own psychological structure for which external supplies are needed, while other people do not need that external supply' (Berger, 1991, p.118).

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Regarding treatment, psychodynamic approaches have proven to be unpopular in that, in as much as one can explore one's past and gain insight into unmet early dependence needs and other failures, this does not help to stop the problem of substance abuse and addiction. In addition, childhood deprivation is not necessarily linked to psychoactive substance abuse, as many people who do not abuse psychoactive substances also experienced early childhood difficulties (McNeece & Dinitto, 1994).

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Social learning and behavioural theories have proven to be more popular than classical analytic and modern psychodynamic theories when formulating relapse prevention strategies. This is because addiction or substance abuse is viewed as being an adaptive or learned response that can be unlearned. The belief is that the positive reinforcement that one experiences when using the substance will invoke the person to use it again. Positive reinforcement may be experienced in terms of the approval gained from the person's peers and feeling less inhibited in social functioning (Fisher & Harrison, 1997). On the other hand the individual learns to avoid negative experiences by taking drugs or alcohol, and thus the behaviour may be negatively reinforced (Daley & Raskin, 1991). For example, a teenager might use a substance in order to avoid uncomfortable feelings such as stress, anxiety, tension, boredom and other psychological states. Use of the substance continues, and eventually a physical dependency develops. Once this happens the individual will begin to use the drug primarily to avoid experiencing the withdrawal symptoms, as the immediate reduction of these uncomfortable sensations is also highly reinforcing. In many instances dosages of the substance will increase as a result of the tolerance that develops with repeated use, and thereafter a serious addiction may follow (McNeece & DiNitto, 1994). In addition, young people are often significantly influenced by their peers, older siblings, parents and others with whom they come into contact. In many cases, the adolescent models behaviour observed in the significant other with minimal negative consequences. Parents also socially reinforce the use of alcohol by approving of its use (Fisher & Harrison, 1997).

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More broadly, there has been extensive experimental research that supports the learning perspective. However, it has been argued that the principles of conditioning, while effective in explaining certain fears and behaviours, may not be able to account for other more disturbed and complex human behaviour (Holmes, 1991).

Sociological perspectives hold society or humanity responsible for drug use and abuse (Schlaadt & Shannon, 1994). These theories view modern capitalism and the social and cultural influences as playing an important role in substance using behaviour. People who live in negative environmental circumstances, as well as those who ascribe to deviant subcultures, are at risk for abusing substances. Other factors

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that would put one at risk include the family and certain cultures that condone and encourage the use of substances.

Durkheim expresses the opinion that modern industrial capitalism has the effect of producing anomie and a 'state of crisis', which he sees as being quite normal within a capitalist society. Durkheim's insight into the 'thirst for novelties', 'unfamiliar pleasures' and 'nameless sensations' is rooted in what he feels is a society which has become subject to moral de-regulation, one of the deepest existential conditions of modernity. Furthermore, Durkheim's arguments about the deterioration of the social fabric brought about by unregulated capitalism is indicative of the fact that it forms an important cultural basis of modern deviance and other kinds of social activity (Sumner, 1994). Other sociocultural and environmental factors that influence adolescent substance use will now be considered.

Schlaadt and Shannon (1994) agree with Durkheim, and explain that the sociological perspective views society as being responsible for this problem. Social and cultural influences in a particular neighbourhood have a major impact on the use or abuse of drugs. Adverse economic conditions, neighbourhood disorganization as well as 'noxious' physical and social environments have been found to be related to increased drug use (Brook & Brook, 1996). Often adolescents will use drugs as a means of escaping the reality of limited opportunities (Jones, Shainberg & Byer, 1979). In many cases, this type of environment will reinforce a sense of hopelessness and anger that can often lead to violent and anti-social behaviour (Brook & Brook, 1996).

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However, substance abuse is pervasive across class, race and gender among both rich and poor, and no element of society is immune to the presence of substance abuse. Many people living in more stressful and toxic circumstances will cope without turning to drugs or alcohol than some privileged abusers who have been more fortunate (Jones, et al., 1979). Levinthal (1996) argues that, contrary to popular belief, studies have found that economic hardship and parental abuse do not in fact have a high correlation with substance abusing behaviour. He explains that adolescents who subscribe to a deviant subculture are far more likely to become users. These individuals have a tendency toward nonconformity with society, are more inclined to miss school regularly, have poor relationships with their parents and are often in

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trouble. Other risk factors in becoming part of this subculture include knowing a number of adults with a drug problem, an early history of experimentation with psychoactive substances starting at twelve or even younger and a lack of motivation to achieve at school. Having friends who approve of getting high and who use drugs themselves, is the most influential factor that would put a teenager at risk for substance abuse (Levinthal, 1996).

According to Fisher and Harrison (1997), the family plays an important role in predisposing children to alcoholism. Adolescents are more likely to use alcohol if they come from families who are rigid, disengaged, or moralistic, discourage the expression of feelings, experience much conflict and have family management problems. Research has shown that families with a history of alcoholism, criminality or antisocial behaviour, and families with parents who condone and abuse drugs or alcohol or who have friends who abuse substances, are putting their children at risk for substance abuse behaviour (Fisher & Harrison, 1997).

In addition, different subcultures tend to use different drugs. Individuals who ascribe to a specific subculture will in many cases use the drug associated with that particular subculture. For instance teenagers who enjoy going to raves tend to use acid or ecstasy, while children and adolescents living on the street sniff glue and thinners and smoke marijuana (McNeece & DiNitto, 1994). Certain situations or circumstances will dictate which drug is used, and when and how it is used. Thus, drinking socially amidst friends may be seen as acceptable, but drinking alone might be viewed as being deviant. Taking ecstasy at a rave or snorting cocaine with one's social group may be viewed as acceptable, while using harder drugs such as crack and heroin may lead to ostracism from the group (Fisher & Harrison, 1997).

Culture-specific theories explain that some cultures are far more relaxed about alcohol use than others. This would have a strong impact on drinking behaviour amongst the youth. Irish culture is known to have a very relaxed attitude toward drinking, and therefore it forms a big part of the social life outside of the home. Drunkenness is not necessarily viewed negatively unlike in other cultures, such as the Jewish and Italian cultures, where drunken behaviour is discouraged and condemned. In these latter cultures drinking is usually done with the family at mealtime, as with the Italians, or

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is used mainly during festivities, ceremonial occasions or with the family as seen in Jewish culture. The Irish have been known to have one of the highest alcohol prevalence rates in the world, whilst Italian and Jewish cultures are amongst the lowest (McNeece & DiNitto, 1994).

Multicausal theories include all of the above psychological (interpersonal), sociological (environmental) and biological explanations for psychoactive substance abuse (Schlaadt & Shannon, 1994). In contrast to univariate theories, such as the medical model which utilizes a cause and effect approach between a single variable and compulsive substance use, the multicausal perspective views addiction as stemming from numerous situations or factors in the person's life. These factors include biology and biochemistry, such as genetics, psychology and the personality, coping mechanisms, drug availability, and the sociocultural context such as the family, peers and the person's environment (Daley & Raskin, 1991). It follows that if the cause of an individual's addiction results from numerous and varied elements, then the treatment intervention must consider and include these different variables in order to aid recovery (Jones, et al., 1979).

According to the multicausal perspective, each theory is valuable within itself, but no one theory is better than the next as they complement one another to make an interdisciplinary multicausal model. This approach bares a similarity to the public health model which views addiction as being an interaction between the agent (the drug), the host (the individual with his or her own set of unique factors contributing to the problem), and the environment (cultural, political etc.). In addition, multiple patterns of substance use by a multivariate population will produce different consequences and prognoses, calling for different treatment interventions (Ashenberg Straussner, 1993).

The **harm reduction model** is different to the above theories in that it does not provide an explicit etiology or a causal understanding of adolescent substance use. It does, however, appear to have a humanist-existential stance in that it respects the choices made by the individual, and tries to understand substance use from the perspective of the user (Holmes, 1991). Proponents of the harm reduction model argue that it is very difficult to create a safe environment for users if substance use is

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criminilized. In contrast to conventional government policy which views substance use as a criminal offence, a more progressive policy toward psychoactive substance use is advocated. This entails a policy that does not marginalize or alienate, but rather seeks to integrate substance users into society (McDermott, 1991).

Harm reduction began as early as the 1960s in North America, with methadone maintenance programmes for injecting drug users. Methadone was used as a safe substitute for heroin and provided relief from uncomfortable withdrawal symptoms. It therefore prevented the individual from resorting to heroin and engaging in illegal behaviour. These programmes were seen as ways to reduce crime, and to restore people with chemical dependency to the work force (Riley, 1993). The harm reduction model takes a client-centred approach when working with drug users. It allows the user to work on his or her terms, taking a step by step approach toward eventual abstinence. This model, whilst adopting a pragmatic and non-judgmental attitude, allows the user to make more responsible and informed decisions about future drug use. Education is given about the ways in which the user is able to minimize the harm caused to herself, such as social, personal, legal and health-related harm. In addition, issues concerning community-related harm are also addressed. The substance user is made aware of the ways in which she may protect the family and the community from the consequences of her actions. This would include issues such as theft and robbery, violence between users or dealers, discarded injection needles in public places, prostitution and the spread of HIV (Macdonald & Patterson, 1991).

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In South Africa, Rave Safe, an organization started in 1993, provides drug education to people on the rave scene. Drawing on the harm minimization model, the intention is to provide non-judgmental assistance and advice to ravers through the use of staffed stalls and chill rooms set up at big rave clubs and parties (Rave Safe, undated).

2.5 Prevention Programmes

Thus far we have been talking about the various explanatory models in terms of how they inform treatment programmes for individuals who are already addicted, or who are currently abusing psychoactive substances. It is important to consider how these theories guide other forms of intervention when addressing the problem of substance

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abuse. Prevention programmes have become tantamount, if not more important than treatment programmes, in addressing the problem of youth and drugs. Teenagers are one of the main target audiences for these programmes, as the younger the person the more vulnerable to substance abusing behaviour. The chances of success are greater if one can delay the early onset of substance abuse, as the possibility that the person will turn to psychoactive substances at a later stage in their lives is less likely (UNDCCP, 2000).

According to Blackman (1996, p.135), a study conducted in Scotland in 1991 found that teenagers who had begun to experiment with substances, and who did not experience any negative consequences to their health, expressed that 'choosing to try drugs is both a rational and a positive choice'. In his article *Has Drug Culture Become an Inevitable Part of Youth Culture? A Critical Assessment of Drug Education,* Blackman (1996) traces the history connecting psychoactive substances to youth culture that began to be interwoven more seriously in the1960s. The relationship between drugs and youth culture has continued through the eighties, nineties and into the new millennium, with top pop groups and music icons serving as role models for drug use to young people. In addition, the advent of rave music has had its most recent impact on youth culture, providing 'a location and a context for drug use' (Blackman, 1996, p.138). Drugs and youth culture are closely interwoven, and Blackman (1996) stresses the importance of acknowledging this fact when providing drug education. What follows is an overview of the literature describing the different substance abuse prevention programmes currently utilized in schools internationally.

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Drug prevention literature is clearly divided into primary, secondary (treatment), and tertiary prevention, otherwise known as harm reduction. Primary preventative education currently appears to be dominated by social influence or life skills programmes. The notorious shock tactics and fear arousal techniques, although very popular in the past, are not all that common in current literature. However, these programmes are often mentioned as an example of what not to do. Research indicates a fair amount of literature about harm reduction. In particular it describes its rationale and its value in making a conceptual shift in policy towards helping youth to be safe on drugs and trusting them to make informed and responsible decisions. There is very little literature available regarding harm reduction programmes that have actually

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been evaluated. Currently, psychosocial and harm reduction programmes appear to be the most popular interventions. Recent literature tends to focus on the two models and strongly advocates one or the other approach.

Blackman (1996) explains that drug policy and debate that are used to inform drug education have become polarized, with harm reduction on the one hand and primary prevention on the other. The two models have opposing philosophical underpinnings, with harm reduction finding its roots in humanitarianism and libertarianism while taking into account the social context linked to drug use. Primary prevention, also known as the abstinence model, is rooted in the punitive law enforcement model together with religious and medical overtones. This results in an approach that is associated with individualism and victim blaming (Blackman, 1996). According to Paglia and Room (1999), primary prevention programmes send out messages of prevention and promote abstinence in order to prevent or to delay the onset of psychoactive substance use. Drug prevention programmes often include participants who may be at risk for drug use but are not yet involved. This intervention is therefore designed to reduce risk factors and to increase protective factors. In this way it is hoped that the onset of drug use is at least delayed if not prevented.

The harm reduction approach is seen as being important because of its concern with 'community damage limitation'. In some instances, even the police in the United Kingdom have begun to adopt this approach, by changing their threatening punitive methods, to cautioning participants instead. Unfortunately in many instances cautioning comes into conflict with government policy, which advocates primary prevention and a punitive approach. Prevention programmes are therefore in many cases very much informed by policy enforced by the government and reinforced by the media that serves to influence public opinion (Blackman, 1996).

2.5.1 Primary prevention programmes

Primary prevention programmes have taken various forms. These range from information dissemination, scare tactics, interventions that utilize peer support or teen counselling, to affective programmes and psychosocial or life skills interventions amongst many others. These interventions focus on the stages of substance use

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preceding addiction, and in different ways they aim to equip teenagers with the ability to abstain when confronted with the opportunity to take drugs or alcohol (Swart, 1995).

As mentioned above, primary prevention aims at preventing teenagers from experimenting with or taking drugs at all. Initially, and still used in some settings, primary prevention programmes took the form of **information dissemination**. It was hoped that by explaining the negative consequences of taking drugs, people would abstain from experimenting with illicit substances. This approach, while in some instances serving to educate and deter people from using drugs, in others provides the information that some individuals would use to take drugs (UNDCCP, 2000).

Primary prevention programmes in the twentieth century tended to promote the 'abstinence' model by taking a punitive and blaming approach to substance use (Blackman, 1996). In most cases these programmes are run by the police who believe that all one needs to do is simply to say 'no'. This type of intervention uses **scare tactics** in order to deter individuals from taking drugs. Participants are taught how to resist offers to take illicit substances. They are fed worst case scenarios of the stereotypical drug addict who uses drugs with disastrous consequences, as well as other shocking information, in order to raise their fears (Brown, D'Emidio-Caston & Pollard, 1997).

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Research has shown that participants view this approach as being unrealistic, and pupils feel that not only the message but also 'the messengers' lack credibility. In many instances these programmes have served to instil a negative view of the police or other educators adopting this approach (Dorsch, 1997). Studies have shown that this may create what is called the 'boomerang effect', where a negative view of the educator causes the individual deliberately to do the exact opposite of what they have been instructed not to do. In addition pupils often feel that have been lied to. This is known as Festinger's theory of cognitive dissonance. Pupils who witness others experimenting with or using substances in different social settings, will not perceive substance use as horrifying, but rather as fun and exciting. Thus they believe that these educators have lied to them and this creates a psychological tension (Brown et al., 1997). Studies have found that although these programmes do improve

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knowledge, they do little to change teenagers' attitudes toward psychoactive substance use (Blackman, 1996).

Programmes utilizing a **peer support or teen counselling** component as part of the programme have proven to be more effective in encouraging abstinence, as peers are seen as being a more reliable or credible source of information and may serve as more effective role models. Adolescents may also feel that they can trust and confide in their fellow peers rather than a teacher, parent or policeman (Dorsch, 1997).

Affective programmes have also tended to be widely used, yet have been shown to have minimal effect. This intervention, based on a humanistic psychology, focuses on the psychological factors that put one at risk, such as low self esteem. Individuals deal with self-awareness, explore their feelings and examine their values and belief systems as well as their decision-making patterns. The focus on intrapersonal change has been found to have little bearing on altering attitudes towards drugs and substance using behaviour. It is for this reason that affective-only programmes have tended not to be successful (Tobler, 1992).

Interventions that appear to have achieved better results are the more recent **'psychosocial' programmes.** This prevention strategy takes the etiology of drug use into account, and addresses social, cognitive, biological, attitudinal and developmental factors (Tobler, 1992). A multifaceted approach is adopted, which includes knowledge in order to educate about drugs, life in general and interpersonal skills, based on Albert Bandura's social learning theory. This approach focuses on teaching adolescents methods to cope with the daily pressures that they encounter. Resistance skills are taught, and information is given in order to help teenagers to create a barrier against factors that put them at risk for substance use. This includes techniques for resisting peer pressure, decision-making skills, techniques for reducing stress and mechanisms to enhance a person's self esteem. Peer support is encouraged in order to create a cohesive group among the participants. Teachers, parents, and the community also become involved (Rynal & Chen, 1996). Thus this type of intervention attempts to strengthen the individual's general personal and social competence, in the hope that it will lead to a reduction in the will to use substances (Meyer, 1994). It is argued by some that these interventions, more commonly known

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as 'life skills' programmes, tend to be promising and need to be developed further (Davies & Coggins, 1991). A shortcoming of this approach is that adolescents are often resistant, and are not motivated to apply the techniques that they have learnt when confronted with drugs.

2.5.2 Harm reduction programmes

As seen above, primary preventative methods aim to prevent or to delay the use of drugs. Secondary prevention involves persuading those already using psychoactive substances to abstain from doing so, and or to seek treatment. In contrast to the above, tertiary intervention strategies aim to reduce the risks related to drug use (UNDCCP, 2000). The **harm reduction or harm minimization model** takes into account the social context of drug and alcohol use and adopts a realistic approach. Being more realistic entails neither threatening nor focusing on getting teenagers to abstain completely. Rather, this model accepts that teenagers are going to experiment with or use substances, and prefers to caution teenagers about the various drugs, as opposed to threatening, shocking and persuading individuals not to use substances. The harm reduction model 'advocates a non-judgmental approach towards use and provides information on how to use specific drugs safely, that being with 'minimal personal risk' (Blackman, 1996, p.134).

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Since the 1980s, the harm reduction approach has become increasingly used as a prevention strategy. With the advent of the AIDS virus and HIV, as well as other dangers related to drugging behaviour, a need developed to educate individuals already engaged in drug abuse as to how they may minimize the harm that they are causing to themselves. Thus, programmes targeting youth are aimed at educating them about how to drug safely if they choose to engage with substances. This approach educates not only those individuals already using drugs, but also targets those teenagers who have not as yet experimented but who may be tempted to engage in psychoactive substance use. Individuals are helped to make an informed decision, so that before they engage in drugging behaviour, they are aware of the dangers involved and about how to use drugs in a safer fashion. According to one drug education policy: '. . . they should be encouraged to reject drugs because they believe

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that to be the right thing to do, not because they have been told to 'say no''(Blackman, 1996, p.136).

The harm reduction model is a person-centered approach and, as mentioned above, focuses on the teenager's experience with drugs. An example of this is a programme that acknowledges the fact that often teenagers will get substances from their friends, and not the drug dealers. In addition, while not denying the fun that is to be had on drugs, the programme focuses on educating and cautioning participants about the dangers of experimenting with the various substances. This would be accomplished by using techniques to which the participants can relate, and that are within their experience (Blackman, 1996). This model allows the user to make his or her own decisions about future drug use, but at the same time educates about the ways in which one is able to minimize the harm of a social, personal, legal or health related harm that may result. Community related harm is also addressed, and the substance user is made aware of the ways in which she may protect the family and the community from the consequences of her actions (Macdonald & Patterson, 1991).

This intervention has come into conflict with individuals who feel that this approach condones substance use. This is because this strategy does not focus on abstinence, but rather accepts this behaviour and attempts to provide the necessary information that allows for safer drug use. Proponents of this model argue that accepting the use of substances is not the same as condoning it. It is argued that teaching harm reduction is perhaps the middle road, or a compromise between the two extremes of prohibition and 'blanket legalization' (Riley, 1993). According to Davies and Coggins (1991), the harm reduction strategy cannot be ignored when one considers the fact that primary prevention programmes world wide have to a large degree been ineffective in curbing or preventing psychoactive substance use amongst teenagers.

Recently, **other substance prevention methods** have been sought. The internet has become instrumental as a drug prevention medium. Teenagers and parents may find support and information relating to drugs, as well as meet other people in 'chat rooms' that deal with drug related issues. On-the-spot testing for drugs in schools has been implemented in various countries in Europe such as Germany, France and the Netherlands (UNDCCP, 2000). More recently this has been discussed as a possible

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intervention strategy in South African schools, however legal and ethical implications may prevent implementation.

2.5.3 Prevention Programmes in the Western Cape

Locally, the different substance use prevention programmes running in schools in the Western Cape employ a range of philosophies and assumptions and have different insights into substance abuse problems and how they should be prevented. These programmes are run by a variety of organizations. Some are run by the police, some by the church, others by non governmental organizations (NGOs), private individuals who go into schools, drug rehabilitation centres who do outreach programmes, as well as The Western Cape Education Department (Morojele, Knott, Myburg & Finkelstein, 1999).

In 1999 the Education and Prevention Committee was formed by the Western Cape Alcohol and Drug Abuse Forum in order to assess substance intervention programmes implemented in schools based in the Western Cape. The focus was to assess firstly the appropriateness of the programmes being implemented, and secondly to assess whether there was sufficient coverage of prevention strategies within schools in the Western Cape. Eight programmes, including the intervention to be evaluated in the current study, contributed to the research by returning completed assessment questionnaires. The questionnaire was divided into eight sections, and focused on the background, structure, target audience, teaching methods, social competencies, goals and outcomes, evaluation, and additional features not previously covered in the questionnaire (Morojele, et al., 1999).

Results of the study indicate that the majority of the programmes focus on abstinence, and aim to prevent the use and misuse of drugs and alcohol amongst youth. A small number employ the harm minimization model, recognizing the reality of substance use and recommending referrals for those already affected by drugs. Some interventions are unifaceted, in that they focus on one approach, such as information dissemination or affective-only programmes. Other programmes supplement information or affective programmes with other strategies such as social skills training sessions (Morojele, et al., 1999).

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The different programmes employ a wide range of activities and age-appropriate methods. Puppets are used for children in grade one, while peers are used to facilitate some of the activities with the older groups. Other strategies include discussion groups, slide shows to display drugs, referrals and interventions, training courses for teachers and youth, role play, case studies and experiential learning. Both teachers' and pupils' involvement are an important part of all the programmes, and the different interventions vary in number and duration of sessions. The six to ten-year-old age group as well as the sixteen to seventeen-year-old age group were indicated to be neglected, as most of the programmes target their interventions at grades six through ten. The majority of the programmes aim to engender a sense of belonging in the community, positive peer influence and anti-drug social norms (Morojele et al., 1999).

Despite the fact that many of the programmes had pupils fill out evaluation forms, none of them showed any evidence of being effective in their intervention. Based on this study, a list of recommendations was made. Some of these recommendations are that programmes should avoid using unifaceted approaches, and should use information and affective methods, as well as more interactive teaching approaches such as social skills training. Shock tactics should also be avoided. Multiple years of intervention rather than a mere one, two or a few sessions are important, and all grades from grade one through twelve should be targeted. The community, teachers and parents, should be involved, and programmes should extend across disadvantaged and rural communities. It is also strongly recommended that drug prevention education use more intensive teaching methods, such as role-play and modelling, instead of only using discussions and regular teaching methods. Programme evaluation is a crucial part of these interventions, and facilitators should be open to the shortcomings of their approaches, and be ready and willing to make appropriate modifications (Morojele, et al., 1999).

Thus it appears that the trend in programme prevention is now for coordinators and policy makers to take more than just one theoretical understanding into account, and to design interventions that incorporate a multiplicity of factors. It is crucial to prevent and to respond to specific health problems in adolescents, but it is just as important to promote the healthy development of all young people, whether or not they have or are

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at risk for problems (Department of Health, 1997). A quotation from the Draft Policy Guidelines (Department of Health, 1997, p. 17) emphasizes this point:

> *'The challenge facing people developing policy guidelines and programmes for adolescent and youth health is to move beyond the impulse to respond to immediate health problems and to put in place interventions that promote adolescent development'*

In conclusion, the above has indeed demonstrated that psychoactive substance use is a pervasive problem in every corner of the world, and no country is impervious to its harmful effects. Unfortunately teenagers, and even younger children, are the most vulnerable. What may start out as innocuous fun, may lead to irreparable damage or even death (UNDCCP, 2000). There are many reasons why adolescents choose to engage with substances, and no one theory could be expected to explain the diversity of experiences and motives that lie behind this behaviour. Prevention programmes have tried many different approaches with very little success. Despite the belief that a multicausal model appears to have the most impact and to achieve the best results, there is still uncertainty as to how one can really curb this problem.

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CHAPTER 3

RESEARCH METHODOLOGY

In light of the fact that the current study is mainly concerned with eliciting attitudes, perceptions and opinions about the intervention programme, a qualitative methodology was chosen in order to allow for a more in-depth exploration of participants' experiences. Programme evaluation theory was used to identify the study as a formative one, given the nature and scope of the research. Information about the programme was obtained through asking open-ended questions in the focus group format. The following chapter will begin with a description of the programme. This will be followed by an explanation of the aims of the current study, as well as a description of how the study was conducted.

3.1 Description of the programme

The programme to be evaluated is part of a non-profit organization that was founded in 1996. The organization runs a high school substance intervention programme, as well as providing general aid and treatment to people struggling with chemical dependency. In addition, it currently runs training programmes for health professionals, offering information and advice in the treatment of alcoholism and drug addiction. The organization also involves itself in 'advocacy for the development of effective policy for the prevention and treatment of substance abuse and chemical dependency' (Draft Constitution, undated: p.1), as well as networking with other significant role players in the field of substance intervention such as government and NGOs. One of the main aims of the organization is to change public opinion and awareness of substance abuse and chemical dependency from a moral issue, to that of a primary health issue that impacts on the individual, family and the community.

The high school substance intervention programme is primarily aimed at educating and giving pupils information about various harmful substances that would enable participants to make an informed decision when confronted with the opportunity to take a substance. In this way it is hoped that the programme will 'reduce the demand for chemical substances through the provision of relevant, high impact education.'

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(Draft Constitution, undated: p.1). The programme roots itself in the harm minimization model and takes a realistic view of drug use amongst youth. The following quotation from the programme's Draft Constitution (undated: p.1) highlights the harm minimization approach: 'To reduce the harm caused to those already experimenting or experiencing problems through their own or someone else's drug/alcohol use.'

The programme consists of two sessions, lasting one period (50 minutes) each. The first session entails a discussion on alcoholism and drug addiction and their effects on the individual, the family and the community. The pupils have the opportunity to talk to recovering chemically dependent people, and are 'encouraged to take responsibility for seeking guidance in solving their own, their family's and the community's drug and alcohol related situations' (Draft Constitution, undated, p.1). The second session incorporates a discussion, as well as a question and answer session, with the same people who had come to see them the previous week. The people who address the pupils consist of the facilitator of the programme and two people who are in rehabilitation. These people would not necessarily be the same for each school.

The three schools participating in the study invited the organization to the school on an 'ad hoc' basis. In all three cases the programme slotted into the general life skills classes, and did not appear to form part of a specific substance intervention module. Life skills teachers provided follow up discussions in the session or two subsequent to the intervention.

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3.2 Aims of the study

The current study is a 'mini-programme evaluation' aimed at assessing participants' perceptions of the programme. Participants were asked questions in order to understand from their perspective whether or not the aims and objectives of the programme were achieved. As mentioned above, the programme takes the harm minimization approach as its underlying philosophy. Thus the current study aimed to explore, through the participants' responses, the extent to which harm reduction has been achieved and implemented. In addition, the study aimed to use the general feedback and information about programme strengths and weaknesses provided by the

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participants as recommendations to the schools involved in the study, as well as to the facilitator of the programme. It was hoped that this evaluation would form the basis for a more comprehensive evaluation in the near future.

3.3 Programme Evaluation

Since the 1960s there has been a rapid growth in the need for investment of funds in social welfare programmes (Cook, 1985). Large educational programmes began to be funded by governments in both the United States and Europe. The need arose to assess if these programmes ameliorated social problems, and if they indeed justified state funding (Scriven, 1991). The assumption that preventive strategies have only positive effects is naïve, and has led to the realization that these interventions are capable of having adverse effects on the very populations they are trying to help (Lorion, 1983). It has also been acknowledged that many of the interventions have little or no impact at all. In 1996, a three-year follow-up study on D.A.R.E (Drug Abuse Resistance Education), the most widely used school-based drug use prevention programme in the United States, revealed that in fact there was no significant difference between D.A.R.E participants and adolescents who had not experienced the programme (Dukes, Ullman & Stein, 1996).

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In order to assess a programme's effectiveness or failure, many aspects of the programme need to be considered. The researcher must look at 'the objectives of the programme, the underlying assumptions, specific programme activities designed to achieve these objectives, the rationale for believing that these activities are capable of attaining the objective, the separation of the "idea" of the programme from how it is being carried out, and the determination of criteria for observing the extent to which the objectives are being attained' (Suchman, 1977, p.48). Suchman (1977) explains the importance of determining how theory and its application are linked in the programme being evaluated. This entails looking at the activity being implemented, whether or not it achieves its objectives, how or why it was able to do this, and finally to look at the conditions which enable the activity to be effective.

It is therefore perhaps more useful in an evaluation to assess the programme at each stage of its development and implementation, in order to help strengthen its process,

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as opposed to an evaluation of the programme only at the end of its process. Louw (1999) describes a method of programme evaluation whereby 'feedback loops' are used at every level of the programme, in order to systematically make appropriate modifications to subsequent levels if need be. In many instances programme organizers are reluctant to have their interventions evaluated for fear that it will jeopardize their programme (Louw, 1999). One way of reducing this threat is to implement formative evaluation that looks at the process and how to improve or to better the programme, as it is being developed. This is in contrast to a summative evaluation that, at the end of the process, asks if the intervention really works (Sechrest & Figueredo, 1993).

In light of the above, since 1980, qualitative approaches to evaluation have become popular, in addition to the rigorous quantitative methods that were previously applied to assess the larger impact of programme interventions. Qualitative methods were introduced in order to complement quantitative evaluations, by commenting more on process, and therefore helping to improve ongoing programmes (Sechrest & Figueredo, 1993). Programme evaluations conducted with teenagers in the past (on substance use intervention) have tended to rely on quantitative methods, such as pre-test post-test comparisons and the use of various scales (Richards-Colocino, Mckenzie & Newton, 1996). Qualitative approaches appear to include tools such as interview schedules (Brown, et al., 1997) and focus groups employing open-ended questions and a participant observer (Gibb Harding, Safer, Kavanagh, Bania, Carty, Lisnov & Wysocky, 1996). Currently many evaluations employ both quantitative as well as qualitative methods.

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According to Raynal and Chen (1996), programme evaluations conducted in the past have not in many cases shown a significant decrease in substance use, but may show other positive outcomes such as a positive impact on increasing regular school attendance or more acceptable classroom behaviour. Thus the current study is more concerned with a range of outcomes and attitudes toward the present programme being evaluated, rather than merely finding out if participants have changed their substance intake behaviour since being part of the programme.

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This evaluation forms part of a formative rather than a summative programme evaluation. This is because the programme is still currently being developed and restructured as funding has been made available for more resources. The evaluation will focus on pupils' attitudes and perceptions of various aspects of the programme, in order to inform the facilitators about what activities or aspects worked or did not work. A summative evaluation of the overall effects of the programme is not within the scope of this study, and as described above, is not necessarily the most effective way of evaluating an intervention.

3.4 Reliability and Validity

It has been argued to date that qualitative methods have not been able to produce reliable and dependable data. Quantitative methods are said to be formulaic in nature, and are therefore standardized and valid (Sechrest & Figueredo, 1993). Recent literature highlights the debate regarding the relevance of standardized qualitative research methods. Guba and Lincoln (1989) argue that qualitative methods should replace quantitative methods completely. They believe that a quantitative analysis of a programme is not necessary, and that it is the values and construction of the researcher that counts. Many qualitative researchers tend to agree with Guba and Lincoln, and feel strongly that replicable, standardized research tools are not applicable when it comes to qualitative research (Marshall, 1986).

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In addition, some qualitative researchers argue that proving reliability of a study by trying to make social research replicable and generalisable, is counterproductive and limiting to one's process. This is because social phenomena are constantly changing, making it difficult, and perhaps unnecessary, to replicate the study and to measure the accuracy of the research instruments (Silverman, 1993). In this study it would therefore be unnecessary to prove reliability, as it is understood and accepted that individuals' opinions, attitudes and perceptions change over time. Thus one would not expect, nor in this case want to find, the same results should the study be repeated in the future.

In order to prove validity in a qualitative study, one needs to consider the 'personal', 'relational' and 'contextual' aspects of the research (Marshall, 1986, p.197). This is in

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contrast to quantitative research that makes use of objective scales in order to prove whether or not one has been truthful in giving an accurate representation of one's findings (Silverman, 1993). Marshall (1986) points to the increasing concern that qualitative research requires considerable rigour in order to demonstrate that a study is indeed valid. She provides a 'check list' outlining the ways in which rigour can be achieved. On a personal level, the researcher needs to be aware of his or her biases and their impact on the study. Reflection and awareness of one's process is also important. (This issue of reflexivity will be dealt with in more detail further on.) Management of confusion and anxiety during the study, and how this impacted on the research, also needs to be considered. The researcher's openness and transparency in his or her engagement with participants is important. This entails explaining to participants the nature and aims of the project and, in some cases, revealing one's own position in the research. Transparency may also entail being explicit about some of the uncertainties that the researcher is experiencing regarding the topic of interest. It allows for a more equal relationship between participant and interviewer. Being open also entails accepting and being sensitive to other peoples' opinions, even if they come into conflict with those of the researcher.

Relational validity is achieved through checking the appropriateness of the theory in relation to the data in the study. Theory is used primarily to make sense of the data and also to highlight the complexities of the research phenomena. Contextual validity refers to the awareness of how the study fits into the broader context. This includes relating one's research to other studies or work done in the field, and being aware of contexts pertaining to the study. The relevance and usefulness of the research to other people working in the same area should also be considered (Marshall, 1986).

Using this notion of rigour, validity in this study was enhanced through reading and rereading the transcripts several times, in order to identify the central themes. Subsequent to coding and categorizing the various themes, the audiotapes were then listened to again. The purpose of this was to check for data that I had perhaps excluded that would identify biases in my analysis. The analytical framework was also checked against the original text or transcript. Supervision sessions were valuable in guiding and 'overseeing' the entire process. This was done through my supervisor constantly challenging and questioning my interpretations of and possible biases

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related to both the literature and the data. This process has links to the concept of reflexivity, seen as central to the method of qualitative research.

3.5 Reflexivity

Banister, Burman, Parker, Taylor & Tindall (1994) explain the two main types of reflexivity that need to be considered in qualitative research. Personal reflexivity involves the researcher's awareness of his or her position regarding the definition of the problem to be studied. Banister et al. (1994) argue that subjectivity in qualitative research is viewed as a resource, and is not necessarily seen as negative. Thus, one cannot profess to be neutral when one's research always has a particular standpoint. Functional reflexivity refers to the process of the research including all the variables that impacted on or influenced the research in some way (Banister et al., 1994). As mentioned above, relational reflexivity refers to the appropriate interpretation and theorizing associated with one's data (Marshall, 1984). This also entails respecting the meanings brought to the research by both the volunteer and the researcher. Reflexive analysis also includes treating all material as important, rather than regarding certain data as something that is of no value and should therefore be discarded (Banister, et al., 1994).

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My personal investment in the subject matter of the current thesis was limited before I began my research. Thus, I started this study knowing very little and holding no particular viewpoint on the tensions between the various theoretical models or prevention programmes. As I began to read and learn, so I found myself leaning toward a particular theory. Supervision provided an opportunity to explore how my personal investment impacted on the way in which I was constructing and going about the process of presenting and interpreting the material.

There are several factors that played a significant role in the process of my research. On one occasion there were many interruptions during the focus group, such as other pupils walking in and out of the classroom and having to listen to messages delivered over the intercom. Pupils in this particular group had also been given incorrect information regarding how long their participation would be required. Thus some pupils had to leave early, leaving an incomplete group behind. In addition, this group

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spoke very softly, making transcription difficult. This may have contributed to the fact that the quality of the data was not as rich as was found with the other two groups.

The extended period of time between the current study and participants' experience of the programme is significant. Had the evaluation taken place shortly after the intervention, pupils' responses might have been very different. It is important to take into account the fact that after two years, the impact of the programme may have been significantly weakened. In addition, I did not transcribe the data personally, which may have influenced my engagement with the material and its analysis.

Below is an account of the research method used, as well as why it was chosen as the most suitable method for this particular study. A detailed explanation of how the study was conducted will also contribute to assessing its validity.

3.6 Focus Groups

The term 'attitude' has many meanings and facets linked to it. It may involve feelings and beliefs, or it may involve different manifestations of the topic being discussed. Attitude measurement for programme evaluation usually involves an assessment of the attitudes of a group of people, as opposed to the researcher making judgements on individual's attitudes and feelings (Henerson, Lyons Morris & Taylor Fitz-Gibbon, 1978).

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Focus groups have proven to be a useful method for exploring peoples' perceptions, attitudes, opinions and experiences (Kitzinger & Barbour, 1999), and thus this format was chosen as the most appropriate tool for gathering data in this study. In addition it would provide a safe environment where the teenagers could feel free to discuss topics of a sensitive nature, such as substance use, without feeling that teachers or other adults were watching them. The group discussion would also encourage and empower participants to express their views and opinions (Strebel, 1995).

Group interaction is the 'hallmark' of focus groups, as it is used to encourage participants to share. This in itself reveals insights that may not have been elicited had other research methods been used (Wilkinson, 1998). The skill of the researcher lies

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in the ability to refrain from trying to impose his or her own construction on accounts, and in being flexible enough to allow the discussion to flow naturally, whilst also ensuring that important issues are raised (Strebel, 1995). The use of focus groups is therefore a compromise between participant observation and informant interviewing. The approach manages to combine these two techniques effectively, in that it provides information that is directed by the researcher, and also allows for naturalistic observation (Morgan & Spanish, 1984).

In this study, the use of focus groups proved to be extremely useful in that the participants would remind one another about aspects of the programme that some had forgotten. Talking about the programme also provided a stimulus for interesting discussion around the topic of substance use. Furthermore, because the members of the group were familiar with one another, they felt comfortable enough to ask questions of one another, contradict, disagree and ask for clarity from one another. This added depth to the discussion.

As mentioned above, an important aspect of focus groups is to gain access to a range of opinions and experiences that people have to share (Morgan & Krueger, 1993). A disadvantage of the focus group format was that participants were often influenced by the responses of the rest of the group. It appeared as though some participants felt compelled to agree or to comply with what had already been said, rather than expressing his or her own opinion, as has been discussed by some writers (Albrecht, Johnson, & Walther, 1993). It is therefore important that there was an observer who took note of processes taking place within the group. These notes revealed elements that limited group members from expressing their opinions and were useful in the writing up of the analysis.

Feedback from the group after the discussion revealed that participants had appreciated the forum to discuss a topic such as substance use without the teachers being present. They also appreciated the ability to be open with one another and to hear and share opinions with others in the group.

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3.7 Sample

The three schools that participated in the programme were selected on the basis that all had a grade 8 class who had experienced the programme in the same year (1998). As a result of certain circumstances, the programme was inactive in 1999. Thus, when the focus groups were conducted in 2000, 1998 was the most recent year that three groups of the same age group had experienced the same programme. In 2000, when the programme once again became active, changes were made and it was not the same as the programme that had been run in 1998. The evaluation of the 1998 programme was seen as important in order to facilitate the changes that were being made in 2000 and beyond.

Guidance teachers were contacted and were requested to ask pupils to volunteer their participation in the focus group. The size of the groups ranged from eight to ten participants. The first group comprised of pupils from a public school. Four or five main speakers generally dominated the discussion with this group. These speakers were very talkative, enthusiastic and willing to share their opinions. The other half of the group tended to be quite reserved and content to allow the others to answer most of the questions. The main speakers appeared to be very open and upfront. The second group, being the only all girls and only all white group, was from a private school. Pupils in this group came from wealthier traditionally white areas. This is in contrast to the other two groups, who were far more culturally diverse. The final group was perhaps the most enthusiastic of the three groups. At times I felt that participants would say things to please me rather than say what was really on their minds. Everybody in this group made an effort to give their opinion and to partake in the discussion.

3.8 Procedure

Permission was obtained from the Department of Education to conduct the study. Letters explaining the rationale of the study, and requesting participation, were sent to the guidance teachers of the various schools. An arrangement was then made with the guidance teacher for a suitable time to conduct the focus group. On arrival at each school, volunteers had already been identified and were ready to begin. The group

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discussion was conducted in English, audiotaped and thereafter transcribed verbatim. There was also an Afrikaans speaker present who would be able to translate should the need have arisen.

The sessions consisted of a discussion about the programme. Participants were first asked to refresh their memories before we began reflecting on their thoughts, feelings and perceptions of their experience of the programme. They were then asked to discuss with some explanation, what they felt had worked and had not. They were asked for both positive and negative aspects of the programme, as well as what about the intervention made an impact on them. Participants were asked if any areas of their lives had been impacted significantly by the experience, or if it had brought about any changes in their lives. Recommendations on how to improve the programme were then requested (see Appendix A for interview guide). Once the discussion had been completed, the audiotape was switched off and a short debriefing session ensued. The facilitator then informed the group that should they have any pressing issues or feelings related to the topic, they should consult the school psychologist or guidance counsellor. Telephone numbers of various substance abuse centres were given to guidance teachers.

3.9 Analysis of data

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Specific research questions were used to guide the discussion in the focus group. These research questions provide the springboard from which certain themes emerge. The analysis of the data took the form of identifying these themes, by repeatedly reading through the transcripts in order to identify recurrent statements, behaviours or powerfully expressed feelings that were indicative of certain individual's most important experiences. A range of experience was identified by grouping and labelling divergent experiences or opposing views (Murray, 1998). The different themes were then coded or labelled, and categorized with similar themes from the other transcripts (Patton, 1990). The thematic analysis is therefore a coherent way of organizing or reading interview material. Not only does it allow for the answering of the researcher's questions, but also takes into account other relevant information that may have emerged during the discussion (Banister et al., 1994). Particular attention

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was also paid to group processes and dynamics that impacted on participants' ability to express their opinions.

It has been noted that qualitative evaluators often tend to isolate variables, and to link them together out of context in a linear way, as is done in a quantitative analysis. If data is not viewed constantly against the backdrop of the programme being evaluated, then interpretations about causes, consequences and relationships do not present a holistic picture of the programme, and the interpretation of the data might well be distorted (Patton, 1990). Another problem that evaluation researchers are confronted with is that the analysis of the data is very subjective. It is left up to the judgement, experience and intelligence of the researcher to decide which data is significant and meaningful. In many cases valuable data is overlooked as being unimportant, while irrelevant data is seen as being significant (Patton, 1990). This problem was addressed by going through the data repeatedly and by re-evaluating dominant categories and the linkages between the themes, as well as taking into account the issue of reflexivity, as discussed earlier in this chapter.

3.10 Ethical considerations

The significance and the aims of the study were explained to the participants, and informed consent was obtained. Care was taken to assure participants that all the information given in the focus group would be strictly confidential and anonymous. A short debriefing session was held after the focus group had finished and the audiotape switched off. This gave participants the opportunity to share any feelings that may have been evoked during the discussion, or thoughts that they wanted to share but did not want recorded. Feedback concerning the outcomes of the study will be sent both to the three schools concerned, and to the facilitators of the programme.

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CHAPTER 4

ANALYSIS

This section involves a discussion of the main themes that emerged from the data analysis. The five dominant themes that are presented are divided into the different aspects of the programme to be evaluated. The first theme deals with the impact of the speakers, the recovering chemically dependent people who spoke and shared their stories with the participants. The second theme deals with the impact of the content of the programme, while the third theme looks at the impact of the method used to convey the content. This is followed by an assessment of the structure of the programme. The final theme considers the overall impact of the intervention.

4.1 Impact of the speakers

The stories and personal experiences that were related by the speakers emerged as the most spoken about and dominant theme. Participants repeated and seemed to enjoy reminding one another about some of the details that they had heard. Pupils found the personal stories to be very intriguing, and were struck by the reality of the speakers' lives and the fact that they were not just telling mere stories, but real life accounts. The word 'shocked' was often used to describe their reactions to the speakers. Participants' language when talking about the impact of what they saw and heard tended to indicate a sense of distance regarding who a chemically dependent person is, how that person becomes chemically dependent and how it differed from their own understandings and experiences with substances. Pupils often spoke about the speakers' stories more like an illness or a terrible catastrophe that they now realize 'could happen to anyone'. An example of this was indicated by much talk around socio-economic status, and their surprise at the realization that the speakers in front of them came from 'good homes', and that people who abuse drugs are often wealthy. Participants tried to understand the realities of substance abuse as spoken about by the speakers, and this tended to generate much discussion about the character of the speakers and the stories that had captured their imaginations. The way in which they spoke about what they had heard suggested that they were trying to relate to these

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people, as most of them had not experienced this reality and it seemed very removed[1]:

> *And also it wasn't just a story, it was* ***her life*** *you know. It was what she'd been going through. It's not like. . . I mean. . . I don't know. . . like you read it in a book. . . it's her life. . .* [Group 2].

> *We were all just probably shocked. . . /ja. . . ja. . ./ . . . at some of the things that we heard. . . that people would stoop so low just to get hold of drugs. . .* [Group 3]

> *I think we were all so shocked at . . . how he actually looked.* [Group 3].

> *You very rarely get to see first hand how you look, how you change, mentally you are not as sharp as you were sometimes, well obviously because of the chemicals and whatever else you bring into your body but you very rarely get a first hand experience of what it can do. . .* [Group 1]

> *Yah, I mean I realize that most of the people that do hard core drugs come from rich communities, because they have money.* [Group 1].

> *Yes. . . I was going to say, it could happen to anyone. . ./ja/. . . /You can be rich. . . poor. . . you can be any way. . .* [Group 3]

It appears that the details of the speakers' stories as well as their appearances were imprinted on the pupils' memories to such an extent that they could remember many of these graphic details two years later. Blackman (1996) argues that these types of images, although shocking, do not succeed in making teenagers see the connection between what they are taught, and their own drug use or the potential danger to their health. Blackman explains that contemporary drug education tends to 'homogenize' or categorize young peoples' drug use in terms of a drug career. This approach, that he terms 'death-led' drug education, assumes a drug progression from soft drugs to hard drugs and ultimately to death. Prevention programmes often tend to focus on describing drug users as being people with great personal problems, and who represent a major social problem. Pupils are often educated about the medical understanding of substance dependence, describing 'the addict' as someone who is ill and who will do anything to get drugs. Thus lengthy and detailed explanations are given about evil drug pushers and dealers, as well as horror stories related to the person's eventual demise. This type of education is reinforced by the media, and by the major role players in society who use these very images to construct drug use and

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[1] [1]<u>Notatation</u>

/ This denotes an interruption of the conversation.
... This series of dots occurring anywhere in the sentence denotes a pause or an incomplete sentence.
Any words appearing in bold are words that are emphasised by the respondent.
(Brackets are used to indicate an emotional response from the group such as laughter, to clarify a word or to indicate who the speakers are talking about.

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abuse in a stereotypical way. Teenagers may not relate to these stereotypes, as their experiences of substances are very different. An example of this is someone who, for the first time in her life, has been offered an ecstasy tablet at a rave by a friend, and not by the demonic drug dealer. This individual is most likely to fail in making the connection between her own experimentation, and the devastating effects of drugs that she saw in a substance intervention programme (Blackman, 1996).

The speakers in the programme appeared to be representatives of a treatment programme that would adopt a medical model. The way in which the speakers illustrated their progression to addiction gives an indication of this theoretical understanding. The biological or medical model explains chemical dependency as a step by step process. Each step manifests symptoms that eventually lead to a loss of control over the substance, resulting in an irreversible and incurable addiction (McNeece & Dinitto, 1994). Thereafter, rehabilitation is possible only through the individual's willingness to co-operate with treatment. However, one is never 'cured', and is always vulnerable to a relapse (Fisher & Harrison, 1997). The speakers' stories seemed to depict this stage process indicating, as seen above, what Blackman calls a 'drug career' that ultimately results in devastating consequences.

Participants were struck by the speakers and their stories about the long term shocking realities of drug abuse. However, it is arguable as to whether or not they were given a sense of the dangers of experimenting that often does not lead to dependency, but may have other serious consequences. Blackman (1996) argues that drug prevention programmes need to make a shift from using stereotypes to scare participants, to focusing on understanding drug use as experimentalism. Recent literature on teenage drug prevention tends to advocate educating adolescents about the short-term impact of drugs and alcohol, as opposed to focusing extensively on the long-term negative effects of its use. There also appears to be a shift in the literature with educators being more honest about the advantages and benefits, as well as the dangers, of using substances (Paglia & Room, 1999).

A commonly held belief, as illustrated from the above quotations, is that people who abuse substances and who are chemically dependent come from poor communities. Sociological theorists view the social and cultural environment as playing an

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important role in teenage substance abuse (Schlaadt & Shannon, 1994). Poor economic conditions, as well as adverse circumstances in certain neighbourhoods and communities, are elements that put teenagers at risk for substance abuse. Adolescents often feel trapped and hopeless as a result of their limiting socio-economic environment, and turn to psychoactive substances as a means of escape (Brook & Brook, 1996).

On the other hand, studies have shown that individuals who come from wealthy circumstances are not less likely to experiment with, and become addicted to, psychoactive substances than those of a lower socio-economic status (Jones, et al., 1979). Research indicates that adolescents who often find themselves in trouble, and who engage in deviant behaviour not in keeping with the norms of society, are more likely to be attracted to substance abuse. In addition, associating with friends who use and approve of substances is the most influential factor in putting a teenager at risk (Levinthal, 1996). Other influential factors include people who come from dysfunctional families, and have parents who engage in or condone the use of substances (Fisher & Harrison, 1997). It appears that the speakers were effective in challenging some of the socially constructed stereotypes that are often held about drug users. On the other hand, as seen above, their 'shocking' stories and appearances may have served to reinforce other stereotypes.

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4.2 Impact of the content

Participants emphasized the importance of being taken slowly step by step through a chemically dependent person's process, and felt that the speakers did not adequately illustrate this. They stressed the importance of knowing at each stage exactly what the person was taking, what the substance looked like, how he or she felt immediately afterwards, in a few hours time, as well as the next day. Pupils also stressed the importance of knowing what could potentially go wrong, and what to do if something did go wrong. Pupils were essentially talking about harm reduction. Although the participants did not use the term harm reduction in our discussion, they alluded to it on numerous occasions. Participants felt that, instead of focusing on and giving more weight to the long-term effects of drugs and alcohol, they wanted to know more about the immediate effects of the various substances. In addition, pupils felt it to be

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important to know how to help somebody should something go terribly wrong while taking drugs. Participants felt that they were not educated enough about the various drugs, regarding how to identify them and how one may take a drug safely. They also felt it to be important that the focus be more on educating about the drugs commonly used by their age group. Thus they want to be updated about modification to some of the more popular and current drugs among teenagers, for example 'e' that is now being mixed with something else that could make it more dangerous. Some felt that it would be beneficial to have the facilitators of the programme bring some of the actual drugs to show the participants, as well as explain the immediate after-effects:

> *And like, like us nowadays, we are like older. I'm like saying that the people our age more towards our age are taking pills and 'A'* (acid) *okay but then they must say to us, they must say, they must tell us "when you are on it this is going to happen to you". Like when you are on it your heart is gonna go faster and you're going to. . . or if you don't drink water. They must tell us that, because that will scare us more than "heroin's going to hurt you after a year." I mean they must tell us more about what's happening there and then.* [Group 1]

> *And sometimes you will get it from your parents. "Put your hand over your drink when . . ."* (laughter from the group) *You laugh at them and just think Argh. . . Even when you're with your friends. . . and realize that your friend has been drugged. . . . ja and your friend is like on it. . . and starts like freaking out and like shaking. . . you know how to deal with that. . . right .. . it's a life skill that unfortunately we really need to have. . . It's things that get to you like ja everyday. . .* [Group 2]

> *. . . but then the people who come here, they must, I don't know, they should tell you more that you will feel good, you will. . . you are going to party for ages. . .* [Group 1]

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The above quotations indicate that participants wanted to be aware of the immediate risks involved when taking drugs. This appeared to be for various reasons. Some indicated that it would be important from a safety point of view, while others felt that it would be effective in reducing the demand for psychoactive substances. Resnicow, Smith, Harrison and Drucker (1999) conducted a study monitoring levels of substance use in relation to degree of perceived risk. It was found that adolescents who were heavy users of cigarettes or marijuana reported a significantly lower perceived risk in regular use of these substances, in comparison to occasional users. Both heavy and occasional users reported a low perceived risk in occasional use of illicit substances. The study indicated that some teenagers were moderating their cigarette or marijuana use in order to minimize the harmful effects associated with heavy use (Resnicow et al., 1999).

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On the other hand, in 1990, a national study conducted in Scotland on 1 197 pupils found that drug education had minimal impact on psychoactive substance use. Results of the study indicated that drug education did not reduce or increase usage (Davies & Coggins, 1991). According to Paglia and Room (1999), current users often do not respond to educational approaches that persuade them to stop using substances. Furthermore, given the normative nature of alcohol use in later adolescence and young adulthood, preventative measures are likely to be ineffective. It is for this reason that minimizing the harmful effects of substances has become a popular mode of drug intervention with older adolescents. Preventative education is seen to be more effective with young non-users and experimenters then frequent users and abusers.

Davies and Coggins (1991, p. 63) argue that the way forward in drug education is to move away from the popular notion of 'addiction' that relies on the individual's physiology and the pharmacology of the drugs. They argue that a new and more challenging philosophy would require 'a conception based on dynamic and purposive choices, which are volitional if not always wise'. Thus Davies and Coggins (1991) argue that drug prevention is about the ability to choose and about encouraging the individual to take responsibility for one's choices.

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Prevention programmes have to a large extent tended to focus on using strategies to indicate that the facilitators are against drug use, and therefore expect the same of the participants. As seen above, these approaches often use scare tactics and shocking drug related stories in order to deter participants from using drugs. The participants on the other hand do not witness these shocking stories when they go out to raves and other social places, and see their peers who look perfectly healthy having a lot of fun on one or another substance (Dorsch, 1997). According to Blackman, (1996, p. 138):

> *'The prevalence of the idea that drugs are good fun and that drugs are taken for enjoyment among young people cannot be ignored by drug prevention. Otherwise the assertion that drugs represent pleasure is then the prerogative of the immediate drug user/supplier, who provides positive explanations to the novice.'*

Thus despite the warnings about the dangers of taking drugs, teenagers often do not see or experience the adverse effects, and in many cases will only see the benefits and positive aspects of its use. Support, encouragement and admiration from peers, as well

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as the absence of social inhibition, when taking a substance, positively reinforce the experience. Social learning theory explains that this behaviour is a learned response, and is in many cases socially reinforced and modeled by significant others in the individual's life. The social acceptance, approval and positive reinforcement gained from peers will often motivate the teenager to use the substance again (McNeece & Dinitto, 1994). Psychosocial or 'life skills' programmes, based on Albert Bandura's social learning theory, take the above factors into consideration. The focus of this type of intervention is to equip teenagers with the tools to respond differently to these types of situations. Education about drugs is provided, and various techniques to resist peer pressure, reduce stress, enhance decision-making skills and build self-esteem are taught. Teachers, family and the community are also targeted (Raynal & Chen, 1996).

Blackman (1996) talks about 'pupil-centred' techniques that educate and caution pupils about drugs, as opposed to being given information against drugs. Research has shown that peer led-education and interventions, using teen counsellors as part of the programme, have tended to yield better results. This is because adolescents feel that they can trust and confide in their peers, who not only understand youth culture but in many cases also serve as more effective role models than the many adults who tell them not to take drugs (Dorsch, 1997).

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In addition, pupils seemed to prefer being informed and cautioned, to being threatened or told not to take drugs, and really appreciated the fact that they were not being judged for wanting to experiment. They also liked the fact that they were left to make the decision for themselves, rather than simply being told to 'say no'.

> *I think that... this woman (*name of person) *said that, she is not telling you not to do it. She's just informing you, giving you the choice... I mean, a person who after that said, " I want to experience that for myself" she didn't say... she didn't say, "Don't do it!" totally. If you want to, you can go ahead, but I mean..* [Group 3]

> *I think that you know these people are actually just warning you. In the future they are not going to stop you or anything. You are just going to have to remember it by heart, because I mean there's no way that you can remember (*name of programme in study) *when someone approaches you or (*another intervention programme), *you just have to know. It's the exact same like a packet of cigarettes, it has a warning label to it, so you just have to remember by heart that if you take this there are going to be consequences, you have to think before you do this.* [Group 1].

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Ja. . . it wasn't like a lecture. . . it was like talking to us. . . it wasn't like. . . "This is bad! Don't do it!" You know. . . you can do it but these are the consequences if you are thinking of doing all that kinds of stuff. [Group 2].

Once again without actually using the term, pupils were alluding to an important aspect of the harm reduction approach. As mentioned in the literature review, one of the main tenets of this model is the fact that it is person-centered and respects the decisions of the user (Mcdonald & Patterson, 1991). As seen in the above quotations, participants were informed about the consequences of using substances, but were never told not to take drugs. It appears that they were struck by the fact that, despite the warnings, it would still be acceptable if they chose to experiment.

Brown et al. (1997) argue that there needs to be a conceptual shift when considering school-based substance intervention programmes. Facilitators need to make a conceptual shift firstly regarding how they view the participants, and secondly in terms of how the programme is delivered. They argue that pupils need to be made to take responsibility for their own behaviour, thoughts and feelings when in social situations, especially those situations where psychoactive substances are present. Programmes need to shift, to encouraging the decision-making capabilities of the youth, by providing credible information about substances in order to reduce the potential harmful consequences of taking drugs, as well as offering help to those who need it. According to Brown et al. (1997, p. 80), 'Drug education needs to be re-conceptualised to address the capabilities, not the inabilities, of our youth'. They argue that the limited effectiveness of many of the substance interventions lies in poor conceptualisation, as opposed to problems with programme implementation.

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Blackman (1996) agrees with this argument by pointing out that drug education programmes work on the assumption that young people are irresponsible, and cannot be trusted to make the right decisions with regard to psychoactive substance use. This assumption leaves parents, teachers, police, programme facilitators and other adults in a state of anxiety, as Blackman puts it, which reinforces the belief that as a result of teenage naivety and irresponsibility, programme prevention must resort to the 'dogmatic approaches' of the past which have proven to be ineffective.

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4.3 Impact of the method

Participants spoke often about the fact that they really appreciated the informal approach to the programme. They found that the small groups and the intimacy of their contact with the speakers made it more personal, and different from the standard lecture that they have been exposed to in the past. The facilitator of the programme, as well as the speakers, would sometimes use humour, and came across as friendly and open. This did much to make the programme stimulating and 'not boring'. They also appreciated being treated as adults and as equals to the speakers, rather than being spoken down to. In addition, participants spoke much about other substance intervention programmes, and the different methods that they had experienced throughout the years:

> *And also the groups we were in were much smaller, so she's not speaking to the entire school. . . you know.*[Group 2]
>
> *And she was also like fun. Ja. . . she would say something that would let us laugh. Ja. . . down-to-earth*[Group 2]
>
> *Yes. . . she was just very informal and casual. Whereas all the other drug speakers are like very strict and straight forward. . . ja. . . .and they like planned and stuff like that ja. . . .and she was like open as if having. . . ja. . . a normal conversation.*[Group 3]

In keeping with these findings, a study conducted on an elementary and high school substance abuse intervention programme, using live theatre combined with role-playing and discussion, indicated that the use of small personal groups to generate discussion was seen to be successful. It was found that the small groups encouraged participants to request individual counselling for drug related problems, gave them a safe space to talk about substance related issues, and also served as an important means of education (Gibb Harding, et al., 1996). Size and composition of the group, as well as the self-image of the participants, were observed to have a strong impact on pupil participation. Groups that comprised both high-risk and low-risk participants, as well as participants who have a positive self-image and those with poor self-esteem, may cause an imbalance in group participation. It was noted that in most instances the low-risk participants and those with a healthy self-image dominated the discussion, while the others who needed to talk kept quiet (Gibb Harding et al., 1996).

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Participants from all three groups spoke about another programme intervention that they had experienced, which they all agreed had made a strong impact. The intervention consisted of a theatre piece by a recovering chemically dependent person who illustrated step by step his journey toward chemical dependency. Pupils felt that this programme was very effective, in that it gave a lot of detail as each new substance was introduced. The actor would show and explain in a story form exactly what it was that he was taking at that moment, what the immediate after-effect was and the longer-term consequences of experimenting with that particular substance. Participants also reminisced about other methods they had experienced which they felt had a negative impact, or no impact at all, such as an intervention run by the police, and videos that they were shown in their Religious Instruction class:

> *It* (the one-man-play) *had the same basic idea as the (*name of intervention) *programme but it showed us more instead of just telling us.* [Group 1]

> *I figure. . . they* (the police) *try to like scare us out of using drugs. . . ja especially with the picture of the man who had his face cut off.*[Group 3]

> *. . . but when the other people came. . . like the police came, and told us, "this drug, don't use it. . . this is what it does. . . it didn't help. . . any of us.* [Group 3]

> *its just, it feels more accessible if you see, if you get to know the people. You know, if you just sort of, if you watch like a video, okay, lets say its, we watched one in R.I.* (religious instruction) *and you know like about how gangs and drugs like ruin this town and then they built a church.*
> *That was a waste of time, space and energy* (laughter) *That didn't even strike me.* [Group 1]

According to Gibb Harding et al. (1996), a 'communication centred-approach' based on the combination of live theatre, role-play and discussion served to break down the barriers of communication between the participants and the facilitators of the programme. It was found that live theatre and role-play provided a stimulus for discussion, encouraging adolescents to talk about some of their own personal experiences related to substance use, as well as those of their peers and families. Research has shown that over the past fifteen years drug educators have increasingly used theatre and media. The more successful programmes tend to be those that incorporate an interactive discussion with the participants following the media event (Gibb Harding et al., 1996). According to the UNDCCP (2000), when targeting adolescents, interactive methods such as role-play and discussions are more effective than didactic teaching methods.

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The way in which the participants spoke about the play, in comparison to the current programme being evaluated, did not show any indication that one was better or worse than the other. What they were saying rather suggested that the two programmes could complement one another. On the one hand, pupils preferred the 'one-on-ones' of the programme, but felt that the play had taught them more by showing them a lot of detail. As seen above, impersonal videos shown to participants had little effect, and pupils complained bitterly that they were boring and that they could not relate to them. It appears that media can be very effective, provided the stimulus is interesting, holds the participants' attention and is followed by a discussion. Programmes run by the police using scare tactics evoked a noticeable negative response. Pupils tended to joke and laugh incredulously when talking about and reminding each other of their experiences with the police.

Scare tactics in many cases rely on authoritarian figures using punitive measures and moralistic paternalism in order to prevent adolescents from using drugs. This school of thought believes that educating teenagers about the dangers of drugs will only encourage them to experiment, thereby causing them to become addicted (Beck, 1998). The police have in many cases run programmes that rely on scare tactics and punitive methods. The approach involves telling participants, and in some cases showing them graphic details, of people caught up in the worst possible drug scenarios. Participants are then told to say 'no' to drugs and are threatened with punishment if caught (Brown et al., 1997). Pupils in the current study related that the police had even encouraged them to come forward with information about their drug using peers. They felt the overall method used by the police to be unrealistic and ineffective. These programmes have been known to improve knowledge, but do little to change attitudes toward the use of substances (Blackman, 1996). According to Beck (1998, p.28): 'reliance on external control and authoritative pronouncement weakens the development of internal controls and learning to make informed decisions '.

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4.4 Programme structure

Several issues raised related to the structure of the programme, and generated much discussion as pupils agreed and disagreed with one another. Many pupils felt that they

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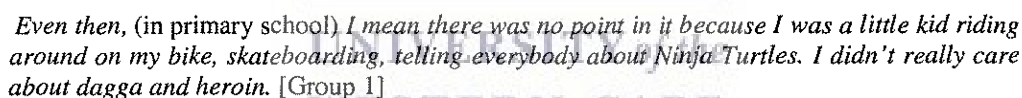
were too young to have experienced the programme when they were in grade 8 (std. 6), and felt that they were not ready for that particular type of intervention or for the number and variety of substances that were dealt with. The majority of the participants also felt that both the duration as well as the number of sessions were not long enough, thereby limiting the impact of the programme. Pupils complained that the presence of teachers had a negative and limiting effect on the intervention. Participants also discussed the value of having or not having parents incorporated into the programme.

4.4.1 Target audience

As mentioned above, there was much debate amongst pupils in all three groups about whether they were too young to have experienced the programme when they were in grade 8. In addition, some pupils indicated that in junior school they had experienced intervention programmes to which they could not relate, because drugs were not yet within their experience. There was a mixed response as pupils considered the question of at what age it would be appropriate to introduce substance intervention programmes into schools.

> *Even then,* (in primary school) *I mean there was no point in it because I was a little kid riding around on my bike, skateboarding, telling everybody about Ninja Turtles. I didn't really care about dagga and heroin.* [Group 1]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> *They're very immature* (talking about the current grade 8 class)*. . . ja, so that. . . uhm. . . you might see a person who's there on drugs and ja. . . he's shaking and people will laugh at him. It's not. . . I don't think that's right. I don't think it's funny.* [Group 3]

> *I just think that it is wise for children to be educated about drugs at an early age. . . ja. . . not when it's too late. . . when you're about sixteen and you already know about. . . ja. . . I just think that they should be. . . even if they don't understand it.* [Group 2]

The above quotations suggest that participants perceive drug prevention programmes in the early years as being something that children do not understand. The quotations illustrate pupils' scepticism about being introduced to drug education at an early age. Participants generally were of the opinion that drug prevention programmes should only be introduced in the senior years of high school. This is perhaps indicative of the fact that the programmes that they experienced when they were younger were not age appropriate, and therefore the participants could not relate to them. Some participants

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however did feel positively toward being educated at a young age, and indicated that starting drug education in the early years is important, 'even if they don't understand it:'

4.4.2 Age appropriate interventions

Participants emphasized and often spoke about the difficulty that they had in relating to where the speakers 'were at'. Pupils felt that although in grade 8 (when they participated in the programme) they had heard of heroin, cocaine and other more 'hard core' drugs, many of them were just beginning to experiment with dagga, 'e' and some of the 'softer drugs' as they termed them. This was in addition to smoking tobacco and drinking alcohol, which most of them had already tried before grade 8. They acknowledged that some people in their grade 8 class were also experimenting with more dangerous drugs. Participants, however, felt that on the whole they were at the beginning phase of drug and alcohol experimentation, whereas the speakers where already at a stage or a phase where the drug progression was out of control and their lives had been turned upside down by the consequences. It was felt that the speakers needed to talk more about that beginning phase, and to spend more time explaining in greater detail the first substances that were taken, their effects that led the person to want more, and how one substance led to another which resulted in eventual dependency. Participants felt that there was a 'gap' when listening to the stories, in that they began with the dependent person saying that he or she had started with this or that drug, and then prematurely proceeded to talk about life as a chemically dependent person. By speaking about and emphasizing hard drugs like heroin, crack and cocaine, pupils felt that the softer drugs like dagga and ecstasy were ignored and seen as not being worthy of more attention, which could potentially give the message that the soft drugs are safe:

> *You're very naïve then, you don't want to hear that okay I started smoking, then I did heroin.. It doesn't really click, you know.* [Group 1]

> *Basically when you younger, then it's just like dagga, and maybe e's* (ecstacy). . *.ja. . . and stuff like that. But when you become older. . .*[Group 3]

> *they like go heroin and all the heavy drugs and things like that, they can ruin your whole life. But pills and stuff they don't tell you about it, so you like think. . .* [Group 1]

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And I mean we are past the smoking and drinking stage. . . I mean they should come now when its all starting to happen. In standard six I wasn't even at that point, then it was like 'I smoke cigarettes'. . . [Group 1]

It appears that the participants really appreciated the personal and intimate contact with the speakers. However, many of them felt that the grade 8 class may not be ready or emotionally mature enough for the level of intimacy, open sharing and communication on the part of the speakers that characterized the programme. In addition pupils felt that they were not ready to cover the broad range of psychoactive substances that were spoken about, and needed the programme to focus on only one, two or three substances at most, depending on the age of the participants. As seen in the literature review, statistics in South Africa have indicated that nicotine, alcohol and dagga, also known as gateway drugs, are the most popular first substances with which minors begin to experiment (Lund 2000). Therefore when targeting programmes at a junior school level, these are the substances that should get the most attention, introducing the more serious drugs progressively as pupils get older.

According to Hostetler and Fisher (1997), drug prevention education with children and pre-adolescents is crucial, as early use of substances is often associated with heavy use and abuse in later years. This point is reiterated by the UNDCCP (2000) which explains that it is both cost effective and better to prevent drug abuse, rather than having to deal with the problematic consequences at a later stage. The report stresses that drug intervention focusing on delaying or reducing substance use, must start at an early age because the majority of individuals who discover psychoactive substances do so in the school going years, when one is more vulnerable to substance abuse.

In order for a prevention programme to be successful, it needs to be appropriate to the particular developmental stage of the participants. It appears that most of the participants felt that in grade 8 they were not ready for the intervention being evaluated, and that an age specific intervention would have been more effective. The general consensus was that the programme would have been a lot more beneficial had they received it at their current age (grade 10). Thus the shortcoming of many of the prevention programmes, specifically the ones introduced to pupils in junior school, is

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that the intervention does not in many cases introduce age appropriate activities to which the pupils can relate.

Tobler (1992) explains that substance intervention programmes introduced at a younger age, such as grades 6 through 8, should generally be more structured. These programmes would incorporate structured activities used to introduce the content and teach the acquisition of skills such as refusal, and what she calls broad-spectrum skills, such as communication skills and assertiveness training. These 'social influence' programmes often tend to use smoking only, and do not focus on other drugs. According to Tobler (1992), programmes run with small groups that are unstructured, more informal and which allow for more personal interaction between the participants, where feelings, ideas and experiences are shared, tend to be more appropriate for the senior grades. Here the role of the facilitator is to encourage open communication and a trusting relationship between participants, without taking an authoritarian position. Participants are encouraged to talk about the way that they are coping with and handling life, with a particular focus on drugs.

The World Drug Report on substance intervention programmes in North America (UNDCCP, 2000) states that prevention education should be age-specific and developmentally appropriate. The report describes an example of a typical programme that could run in North America. An intervention programme for the early school years would normally include a discussion of substances and other products that are dangerous to one's health. Prevention throughout the middle years of schooling is aimed at delaying experimentation with psychoactive substances and encouraging abstinence. Finally, programmes in the senior or final years of school focus on harm reduction and cautioning pupils about the dangers of substance use (UNDCCP, 2000).

4.4.3 Number and length of sessions

A consistent theme emphasized across all three groups was the time factor. Firstly, pupils felt that the sessions were not long enough and, secondly, that there were not enough of them. As a result of each session lasting a period of only 50 minutes, pupils did not have much time to ask questions at the end. Participants felt that the programme lost its impact simply because there was no follow up and no consistency

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after the one or two sessions that they experienced. Pupils seemed to be surprised and very disappointed by the lack of continued contact with the people whom they had met and got to know personally:

> *And I mean everyone had a question. I mean everyone wanted to ask questions of her. . . and by the next week. . ., you've forgotten what you wanted to ask.* [Group 2]

> *But then automatically. . . the. . . the teachers like ushered them off uhm. . . and then you just see them in their cars and off they go. . . uh*
> *They didn't stay around for conversation, or if you could relate to them personally, like some of us. . . someone wants to come up to them personally uhm. . . and speak to them. We didn't have that opportunity uhm. . .'*[Group 3]

> *I thought it was very. . . it was, it freaked me out at first but now that they haven't been back for so long its lost its touch.*
> *Its like after about a week or so you just forget about it.* [Group 1]

On the other hand, a few participants did feel that the duration of the sessions was sufficient.

> *Uhm. . . because. . uhm. . when someone speaks about something. . . uhm. . . and they like drag it along, then it spoils the whole thing uhm . . and you forget everything in the beginning.* [Group 3]

Colocino, Mckenzie and Newton (1996) explain that substance intervention programmes need to be instituted over a period of at least two years, as changing of attitudes and behaviour of high-risk youth is extremely difficult. They go further to remind us that change is slow, and therefore these programmes need to be continued over a lengthy period of time. According to the UNDCCP (2000), research has proven that drug prevention should last throughout the individual's school career, involving both the pupils and the parents. It also suggests that substance prevention education programmes that function as part of a broader health or social skills model, incorporated within the school curriculum, would be more effective than an intervention that stands on its own. The above suggestion made by the UNDCCP is well suited to the current context. It is probably not financially viable or practical in many instances to have the programme return to the school on a continuous basis. Had the teachers incorporated the programme into a suitable life skills or drug education model, pupils might not have felt so strongly about the lack of follow up and continuity.

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4.4.4 Teacher/parent involvement

In the instances where the teachers were present during the programme (groups one and three), pupils felt that they were limited as to which questions that they could ask, and also found that they could not share some of their own personal experiences with the speakers. This was a common theme, and pupils felt that their time with the speakers would have been more beneficial in the absence of the teachers:

> *Another thing is, now they have the teachers sitting with you. Ja. . . so the teachers make you feel uncomfortable. . . uncomfortable ja. . . so if you've got any experience that you want to relate. . . mmm. . . and you can't. . . you don't wanna. . . you don't wanna let the teachers know that you are. . . smoking or drinking, or doing dagga.*[Group 3]

> *And he was very honest and open, it was a pity we couldn't ask questions.*
> *Because the teacher was in the room.*
> *They were willing to tell you things but you know it still didn't. . .*
> *You couldn't ask the right questions* [Group 1]

> *Did you have the teachers with you?*
> (In unison) *No!*
> *In fact I would have been scared if they had asked a teacher to come. . .*
> [Group 2]

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Some of the participants felt it to be important that parents also receive education about substances. However, they were outnumbered by the majority who felt strongly about the fact that they did not want the parents to be involved at all. There was much laughter as individuals spoke about parents and some of their idiosyncrasies, as well as their ignorance about what youth are getting up to these days. Most individuals appeared to want it to stay that way, and felt that they did not want their parents to be educated and to therefore start interfering in their lives. Several people felt it to be important that parents be incorporated into the programme, and that they are educated about what their children are exposed to. These pupils stressed the importance of parents' involvement in order to be able to identify the warning signs, and to know early on if there is a drug problem. Apart from these few people, all the others seemed to be strongly against parents being exposed to the intervention, and felt that parents should rather be 'updated' by means of pamphlets, as one pupil suggested. Some felt that even if their parents were educated, it would not change the fact that they could never understand what their children are experiencing now, because of the generation gap:

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They should be, they should know what's going on with their children you know What their children are exposed to. [Group 1]

Parents should just stay away. . . because they become extremely over protective. Ja. . . any false move, then it's . . .[Group 3]

I mean times have changed. I mean. . . they (parents) *turn grey at things that are just. .* [Group 2]

Many individuals were concerned that if their parents were educated, they would not trust them when going out at night with their friends, and would become intrusive and ask a lot of questions that they felt they would not like to answer. It appears that most pupils were not willing to share information with their parents and would prefer to keep their private lives to themselves. The assumption that lies behind many of the substance use prevention programmes is that the individual's decision to use substances is related to many factors. This includes peers, family, school, the neighbourhood/community and society, all of which contribute in one way or another to put the individual at risk. These programmes aim to reduce these risk factors by working with the community, the family, the school and the individual, thereby increasing resiliency and protective factors. In many cases, these programmes do bring about positive changes in the individual's life, such as increased school attendance, better grades and increased participation in school and community activities. Hostetler and Fisher (1997), in their longitudinal evaluation of project C.A.R.E (Children At Risk Education), carried out on fourth graders, found that including family skills training into a prevention programme was effective in improving family communication, decreasing behavioural problems and increasing intent to reject psychoactive substances. However, results of the study were disappointing in that, at three-year follow up, reduction in later substance use did not show a significant decrease (Hostetler & Fisher, 1997).

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Gibb Harding et al. (1996), in their substance intervention programme using live theatre, role-play and discussion, found that adolescents in many cases reported and emphasized the fact that their families were their main source of support and information. Participants were also noted to have said that they would turn to their families for support, before their friends, if they were being pressured into taking drugs. In addition, teenagers described the difficulties and the pain that they experienced living with parents who were substance abusers. In many cases

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adolescents lack the necessary support needed to help them cope with substance abuse within the family. The findings of the study indicate that adolescents turn to both adults and to their friends for help and support. However, when parents are abusing substances, adolescents no longer see them as role models or as a reliable support system (Gibb Harding et al., 1996). These authors conclude that, based on discussions held with the participants, it is just as important to provide drug prevention programmes to parents and the community. This would facilitate an integration of the community that would help teenagers to both combat and cope with drug and alcohol related problems.

Hostetler and Fisher (1997) explain that a positive relationship between parent and child will often deter an adolescent from taking drugs. High-risk youth have in many cases been identified as having poor relationships with their parents, characterized by a break down in communication between the parents as well as between parent and child, lack of parental discipline and rules, and parents who condone substance use or use drugs themselves.

4.5 Programme goals and outcomes

Participants were asked whether they felt that the programme had made any significant changes in their lives or influenced them in any way. On the whole pupils felt that there had been very little long-term impact on their lives since experiencing the programme two years previously. One or two said it had made them more aware and careful when choosing friends. Others responded by saying that they were more knowledgeable and informed about psychoactive substances after the programme, and they could therefore impart this information to others. One person said the programme had made her 'more curious'. Most of the participants expressed the sentiment that when one is in a situation confronted with the decision of whether or not to take drugs, a substance prevention programme is furthest from one's mind. This alludes to the fact that, on the whole, the programme had not shifted or changed participants' attitudes towards experimenting with substances. Some reiterated the point that the lack of follow-up also contributed to the limited long-term impact:

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Yah, it changed my mind, but I was like anti-drugs for about two days (laughter from the group). *After that it's like you are back to the same routine, back with old friends, back to the old thing.* [Group 1]

And if it gets to the point where you have to choose between taking a drug or not, you are not going to think about the programme, that's not going to change the choice you make.[Group 1]

Ja. . . I don't think that any talk about it (drugs) *will like put you off it or keep you on it. . . really. . . uhm. . . ja. . . it's actually how you feel at that time. . .* [Group 3]

Everyone's curious, they don't know what to do about it. [Group 2]

The above quotations seem to encompass Blackman's argument that, despite the warnings, adolescents are still curious about experimenting with drugs, and these substances are very much part of their experience as teenagers. As mentioned above, Blackman (1996) discusses the normalization of drug use, which views substances, especially soft drugs, as an integral part of youth culture, seen by youth to be a fun and positive experience. This is the reason for Blackman's opinion that drug education needs to focus on experimentalism, and when educating about drugs one cannot ignore the fact that drugs are fun, and that teenagers will opt to experiment despite knowing about the potential hazards. Blackman argues that one needs to tailor intervention strategies to suit the needs of adolescents, through cautioning and education about harm reduction, which empowers the adolescent to make wiser choices when it comes to substance use (Blackman, 1996).

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In addition, as mentioned above, multifaceted psychosocial programmes have tended to be very effective. Adolescents are taught skills in order to help them cope when confronted with compromising situations. They are able to use these skills in resisting peer pressure and in making wise and responsible decisions (Raynal & Chen, 1996).

4.6 Conclusion

The analysis of the data has provided an indication of participants' perceptions of the overall impact of the programme, as well as some of the perceived strengths and weaknesses. Dominant themes related to the different aspects of the intervention were explored and discussed. Analysis of the data highlighted the impact that the speakers and their stories had on the participants. However, pupils generally agreed that they would prefer to learn more about the immediate effects of psychoactive substances,

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rather than focusing on the long-term consequences of drug addiction. Participants responded positively to the fact that they were being encouraged to make their own decisions regarding drug use. They identified the warnings issued, and acknowledged that programme providers were teaching them to take responsibility for their actions. The 'non-lecture' style, informal conversation and the absence of an authoritarian figure contributed to pupils feeling as though they were being treated as equals, as individuals capable of making their own choices.

It therefore appears that the programme did have a strong harm reduction component. This was evident in the method or style that was used to address the pupils in order to reinforce a sense of maturity and responsibility. Pupils were made aware of the consequences of their actions, and the message of personal choice appeared to be successfully conveyed. On the other hand, one of the main aims of the programme was to 'reduce the demand for chemical substances through the provision of relevant, high impact education.' (Draft Constitution, undated: p.1). It seems as though the education provided was less 'high impact and relevant', and more suited to a treatment programme for chemically dependent individuals. Thus the informative side of the programme appears to require educational input more suited to the needs of the target population, and more in keeping with the harm reduction philosophy. This entails updating and providing input on current drug trends and on the more immediate effects of the various substances. Implications of the above findings are discussed in the final chapter.

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CHAPTER 5

CONCLUSIONS

This section starts with providing a context as to how the programme fitted into the curriculum of the three schools that took part in the research. This is followed by a summary of the overall impact of the programme. Several issues concerning policy, opposing theoretical models, and incorporating interventions into the school curriculum are considered. More specifically, issues related to method, content, and suitability are briefly addressed. Suggestions for further research are then given.

In all three schools, the intervention formed part of the broader life skills component of the school curriculum. None of the schools reported having a particular module on substance abuse, and the programme tended to happen on an 'ad hoc' basis'. There was, however, follow up in life-skills classes by the teacher, subsequent to the intervention. This would entail a discussion based on pupils' experiences, and tended not to include structured education around the specific substances. One school reported that each year different organizations are called in to provide one or two sessions to the pupils in order to provide a different angle, and to prevent boredom. Another school reported inviting the programme to return to the school three years in a row. Thereafter, different drug intervention programmes were sought in order to provide the pupils with a different experience. In the three schools, the selected intervention would be presented to all pupils in the high school, from grade eight through grade twelve.

5.1 Impact of the programme

It appears that overall the participants were shocked by what the speakers looked like, their 'weird' behaviour and the stories that they had to tell. Pupils felt that the speakers really made them aware of the implications and consequences of substance abuse. They also appreciated the fact that despite the warnings, the speakers were not telling them not to experiment with substances. Rather, the speakers made it clear that they needed to take responsibility for their decisions. The stories illustrated effectively the impact of this behaviour on the individual's mental and physical health, and also

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highlighted the destruction and pain that it caused to their families. Graphic details were also given about harming others physically, and stealing to get drugs, as well as other horror stories that involve the law and legal implications. The speakers, having experienced the realities of chemical dependency were found to be credible by the participants. The personal interaction, together with their emotional openness and honesty, gave the stories a context, thereby giving them more weight and meaning. The participants also appreciated the informal 'non-lecture' style. They found both the speakers and the facilitator to be accessible, friendly, easy going and honest.

Participants' responses reflect a need for more education around the various substances. They found that the attention was too focused on the longer-term, more general consequences of substance abuse. Pupils found that there was a gap between their own experiences with softer drugs and the stories about hard core drugs that were told. They appeared to want the speakers to spend more time talking about the drugs that are popular and current amongst their age group, and to which they can relate. Responses indicate that a lot more detail is required about identifying the substance, being safe while on it and knowing what the immediate consequences are to one's health. There was an indication from the pupils that the programme would perhaps be more suited to the senior grades, when a lot of the pupils have begun to experiment with harder drugs such as heroin and cocaine. What follows is a more in-depth look at the various aspects of the intervention.

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5.2 Primary prevention verses harm reduction

Proponents of the two models may argue for abstinence or risk reduction. It appears from the literature that the two models are polarized and cannot be reconciled. Perhaps this is not necessarily the case, and the models could in fact complement one another. Literature on substance intervention programmes indicates that psychosocial skills interventions, characteristic of the abstinence model, have in many cases yielded positive outcomes. Participants are taught the necessary skills in order to cope with compromising and difficult life situations. Education that incorporates these two models provides the learner with both life skills, as well as information on risk reduction (Raynal & Chen, 1996). In this way the adolescent is given the tools to choose and to take responsibility for his or her own decisions.

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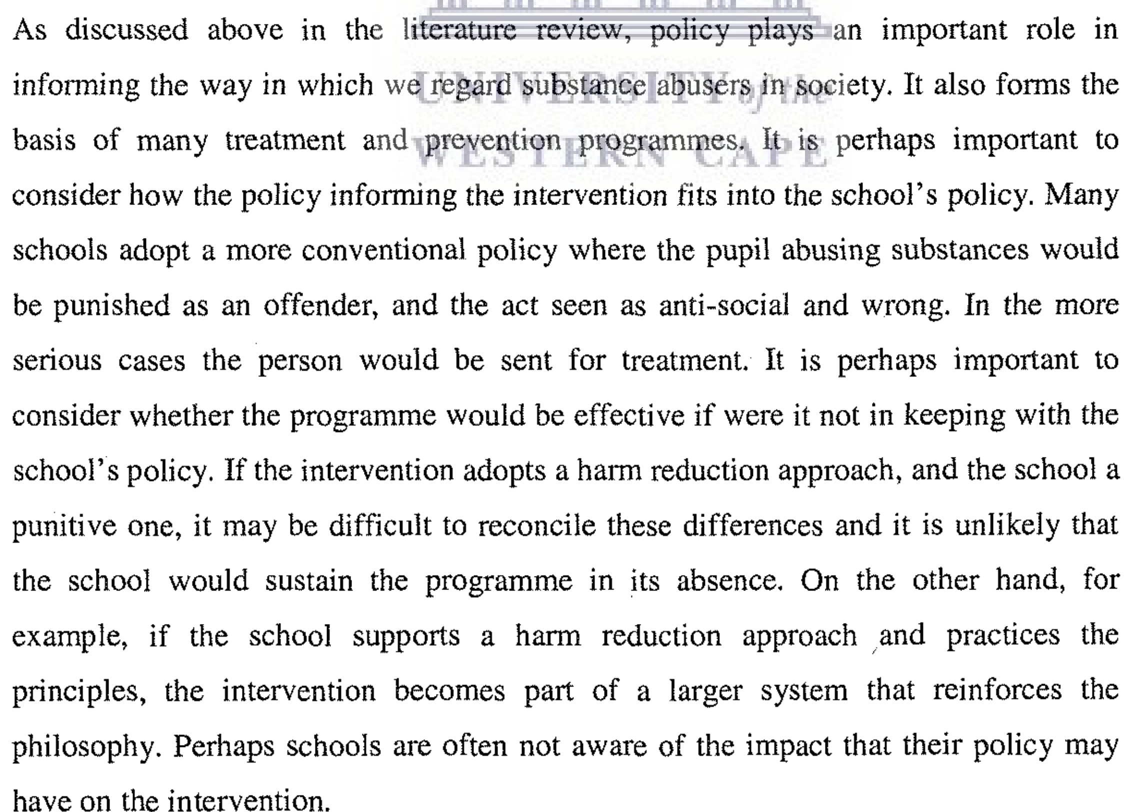
In addition, the literature highlights the differences between the various prevention programmes. On closer inspection, these approaches are in fact not as different as they might seem. For example, programmes that use information dissemination are perhaps not all that different from the harm reduction approach, in that the latter aims to provide information and education about substances. The only apparent difference between the two approaches are the goals or objectives of the programme. Information dissemination interventions aim to provide information about the negative aspects of substances that will encourage adolescents to abstain from experimenting. The harm reduction approach provides information that will hopefully reduce the demand for substances, and/or the harm caused while using drugs and alcohol. There are many similarities and commonalties between the various approaches, the essential difference being the expected goals and outcomes of the programme. The particular philosophy or policy underlying the programme guides these outcomes. Thus some of the approaches are more compatible than they initially appear to be.



5.3 Policy

As discussed above in the literature review, policy plays an important role in informing the way in which we regard substance abusers in society. It also forms the basis of many treatment and prevention programmes. It is perhaps important to consider how the policy informing the intervention fits into the school's policy. Many schools adopt a more conventional policy where the pupil abusing substances would be punished as an offender, and the act seen as anti-social and wrong. In the more serious cases the person would be sent for treatment. It is perhaps important to consider whether the programme would be effective if were it not in keeping with the school's policy. If the intervention adopts a harm reduction approach, and the school a punitive one, it may be difficult to reconcile these differences and it is unlikely that the school would sustain the programme in its absence. On the other hand, for example, if the school supports a harm reduction approach and practices the principles, the intervention becomes part of a larger system that reinforces the philosophy. Perhaps schools are often not aware of the impact that their policy may have on the intervention.

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5.4 Substance intervention programmes and the school curriculum

It is perhaps important that the school decide how it is going to incorporate external substance prevention programmes into a broader 'health or social skills model' (UNDCCP, 2000) within the school curriculum. Continuing drug prevention education within the school curriculum would perhaps prevent the problem of pupils feeling that the prevention loses its impact because it is not sustained. Judging from the three schools that participated in the study, schools generally rely on the impact of one or two prevention programmes, with a few follow up sessions run by the teachers, to constitute the only drug prevention education for the year. The intervention tends to fit in to a more general life skills programme.

The focus of 'outcomes based education', currently being implemented into the South African school system, is to concentrate on capacity building through life skills within the curriculum, and to be creative and goal focused. Perhaps there are ways in which the various teachers can incorporate education about drugs into their lessons. In this way they would be able to sustain drug education. An example of this would be teaching the effects of drugs on the brain in a biology class, or giving statistics related to drug prevalence rates in a maths class. Thus there would be ongoing education about drugs that would support the life skills programme. In addition, perhaps the life skills classes could be more structured, with modules that focus on specific outcomes. In this way, a drug prevention programme would fit into a module comprising of life skills that surround the issue of substance abuse. This would perhaps give the intervention a context, rather than simply being presented to the school on an 'ad hoc' basis. The various organizations could also help in guiding school policy with regard to substance use, as well as providing booster sessions if the school so wishes.

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5.5 Method

As the literature suggests, shock tactics generally do not work with adolescents. Teenagers' experiences with substances are more experimental, as opposed to individuals being in the midst of a serious drug addiction. Interventions such as the one in the study, that rely on the shocking appearances and stories of the speakers, are perhaps more suited to a treatment centre for people trying to overcome chemical

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dependency and who can relate to the stories being told. In addition, it is very important that the method reflect the philosophy or theoretical understanding that underlies the programme. The intervention in this study appears to be better suited to the disease or medical model, as the focus is on dependency rather than risk reduction.

On the other hand, participants' responses suggest that the shocking stories had a strong impact on them. These stories are perhaps like 'sensationalized' newspaper articles. More than teach the audience, they provoke a sense of curiosity in dramatic and gruesome details. It appears that pupils remembered the details of the stories as a result of the strong visual imagery that captured their imaginations, in the same way that a horror movie would. Pupils seemed to almost enjoy the stories, and found them to be intriguing and perhaps even entertaining. The stories were far removed from their own experiences, not just regarding drugs but life as well. The way in which the participants spoke suggested that they were transported into a different reality, perhaps even a temporary escape from their own lives. Thus it is perhaps important to question the apparent impact of this method. The fact that pupils were fascinated or shocked by the stories, does not give enough of an indication of what they actually learned.

5.6 Involvement of parents

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It is interesting to note that the literature is very positive about parental involvement in prevention programmes and goes as far as recommending this in one way or another. According to the literature, programmes that include family skills training and which facilitate a positive relationship between parent and child, are seen to be important in that it will in many cases deter a child from taking drugs (Hostetler & Fisher, 1997). This is quite different to the responses of the participants, who tended to be very opposed to their parents' involvement. It appears that pupils are afraid that their parents will become over protective of them should they be educated and informed about the things to which teenagers are exposed. Participants seemed to prefer keeping their parents 'in the dark', and did not appear to be in favour of open communication with them. The conflict existing between what literature thinks is best, and what participants want, appears to need further attention. Perhaps it would be valuable to address this issue with participants who are against the idea. This could

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be very helpful in allowing pupils to talk about their relationship with their parents, and some of their fears regarding parent participation.

5.7 Further research

Finally, substance intervention programmes employing the harm reduction approach need to be evaluated in order to assess their effectiveness. This study has looked at participants' perceptions of such a programme. A more full-scale evaluation would be the next step in evaluating whether or not the harm reduction approach is indeed being used, and if it is effective in altering participants' attitudes and behaviours regarding substance use. It is perhaps important to take into account the long period of time that lapsed between the participants' experience of the programme and their participation in the focus groups. As mentioned above, in order to improve a programme it is better to evaluate the various stages, and to make changes as the programme progresses. The current evaluation is perhaps weakened by the fact that, being formative in nature, it was conducted so long after the programme took place, more characteristic of a summative evaluation. It is difficult to assess whether participants actually learned and applied things from the sessions with the speakers, making it difficult to know if harm reduction had indeed been achieved. Had the research been carried out sooner, pupils might have responded differently regarding the impact that the programme was having on their lives and experiences with substances.

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It is therefore recommended that the process of evaluation begin from the moment the seeds of the intervention are sown. Firstly, it is perhaps a good idea to conduct a needs assessment, thereby integrating and incorporating teenagers into the process from the beginning. Adults often make the mistake of thinking that they know what teenagers need, thereby alienating them. It would be useful to evaluate each stage of the intervention, using qualitative methods, in order to get feedback from the participants regarding what is and what is not working. Thereafter, facilitators are able to make the appropriate changes based on the feedback. A summative evaluation, using a statistical analysis, would constitute the final stages, and would perhaps be very useful in giving an indication of the longitudinal effects of the programme.

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5.8 Conclusion

'Say No! to tobacco, that poisonous weed.
Say No! to all evils, they only can lead
To shame and to sorrow; Oh, shun them, my boy,
For wisdom's fair pathway of peace and of joy.'
(Freese, as cited by Beck, 1998, p. 21)

The above quotation written in 1901 encapsulates the current strongly held view that psychoactive substance use is evil or bad and shameful. It is interesting to note that attitudes since this quotation was written have to a great extent not changed, and that the major role players in society continue to construct substance use in this way. This dissertation has explored the different perspectives explaining psychoactive substance use, and how the various theories have informed methods of treatment and prevention education. More specifically, it has highlighted the tensions that exist between the two dominant theories or philosophies that inform programme prevention, namely primary prevention and harm reduction and suggested that bridging of the two is necessary. Analysis of the data has given an indication of the impact of the programme from the participants' perspective, pointing out its strengths and weaknesses. The different aspects of the programme were then discussed, drawing on support of literature in the field. Finally, conclusions were drawn and suggestions were made for future interventions and research.

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APPENDIX A

Interview Schedule

What was in the programme? Explain it to me.

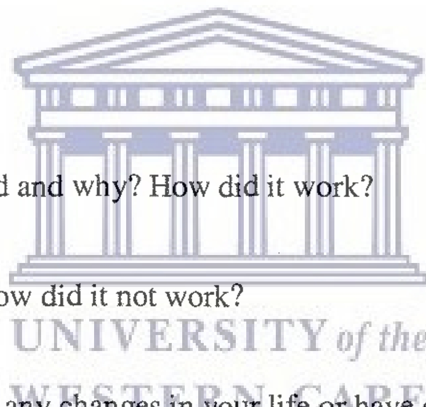
What were your experiences of the programme?

-What were some of your reactions

What were some of the positive aspects of the programme?

What did you find to be negative about the intervention?

What had an impact on you?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What did you find really worked and why? How did it work?

What did not work and why? How did it not work?

Did the programme bring about any changes in your life or have other things contributed to that change?

Do you feel that other areas of your life may have been impacted significantly through this experience?

Do you have any recommendations that you would like to make that you feel may improve the programme?

Is there anything that you would like to say that has not been brought up here today?

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