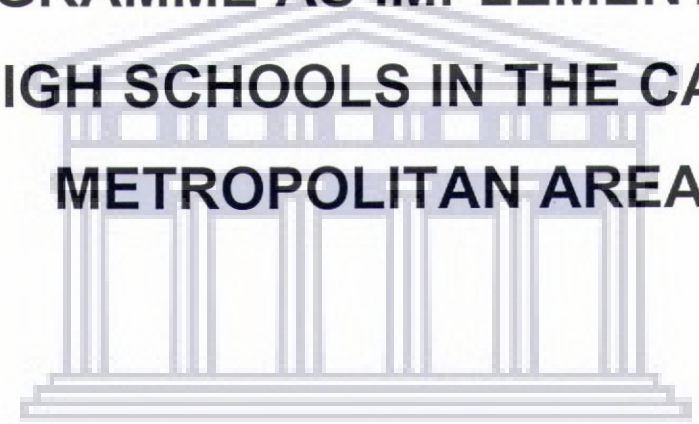
A DESCRIPTIVE STUDY OF THE TEENAGERS AGAINST DRUG ABUSE PROGRAMME AS IMPLEMENTED AT HIGH SCHOOLS IN THE CAPE METROPOLITAN AREA



ERROL BANDA

A DESCRIPTIVE STUDY OF THE TEENAGERS AGAINST DRUG ABUSE PROGRAMME AS IMPLEMENTED AT HIGH SCHOOLS IN THE CAPE METROPOLITAN AREA

By

ERROL BANDA

Submitted in partial fulfilment of the requirements for the degree of **MAGISTER ARTIUM** in the Department of Social Work, University of the Western Cape.

Supervisor : Professor F G Kotze

November 2001

DECLARATION

"I declare that the research: ***A Descriptive Study of the TEENAGES AGAINST DRUG ABUSE Programme as Implemented at High Schools in the Cape Metropolitan Area***, is my own work and that all the sources that I have used or quoted have been acknowledged by means of complete references".

ERROL BANDA

SIGNED: .....

DATE: NOVEMBER 2001

ABSTRACT

In the Cape Metropolitan Area the drug industry has exploded, and the reality is that teenagers are the main target group of drug lords. TADA [Teenagers Against Drug Abuse] is a prevention programme operating in high schools with the aim to prevent drug use amongst students.

Since its implementation, the programme has not been evaluated to determine its effectiveness. Furthermore, the TADA programme is not widely known within the educational sector. Consequently, the TADA groups find it difficult to expand it.

There are currently 13 schools in the Cape Metropolitan Area where the TADA programme is presented. A random sample of 6 schools were selected. A total of 120 questionnaires were distributed to the 6 schools. At each of the 6 schools, 10 students who were involved in the TADA programme, as well as 10 non-members, received a questionnaire.

The aim of this research was to give a full description of the TADA programme and determine views of students on how TADA programmes are implemented and whether these programmes are reaching the youth. Recommendations are made in an attempt to make it more accessible to high school youth and other teenagers.

The research revealed that a different approach is needed to make this programme more successful within high schools in the Cape Metropolitan Area, as well as in other areas outside the Western Cape Province.

ACKNOWLEDGEMENTS

I hereby wish to extend my sincere appreciation to the many individuals, organisations, high schools and institutions who co-operated, supported and assisted me in this research.

I am extremely grateful to Professor F Kotze who supported and guided me through this research; Dr Charles Parry of the Medical Research Council for his help and friendship, and to my colleagues in the social service field.

A special word of thanks to all the students who participated in this study and their willingness to share their views.

My special thanks and gratitude go to my wife and children for their understanding, love and patience.

Finally, all thanks to God for giving me the strength to complete this study.

CONTENTS

		PAGE NO.
Declaration		(i)
Abstract		(ii)
Acknowledgements		(iii)
List of Tables		(vii)
CHAPTER 1 : BACKGROUND TO SUBSTANCE ABUSE, AND RELATED ISSUES		**1**
1.1	INTRODUCTION	1
1.2	A SOUTH AFRICAN OVERVIEW OF SUBSTANCE ABUSE	2
1.3	THE EXTENT, PATTERNS AND TRENDS OF SUBSTANCE ABUSE IN SOUTH AFRICA	6
1.3.1	Treatment Issues In South Africa	8
1.3.2	Treatment Issues In The Western Cape	10
1.3.3	Prevention Programmes for the Youth in South Africa	13
1.3.3.1	The Lions-Quest Skills for Adolescence Programmes	13
1.3.3.2	POPPETS (Programme of Primary Prevention: Education Through Stories)	14
1.3.3.3	Peer counsellors	14
1.3.3.4	The school programme	15
1.3.3.5	TADA (Teenagers Against Drug Abuse)	15
1.3.3.6	"I'm Addicted to Life" Anti-Drug Campaign	16
1.4	PROBLEM STATEMENT	16
1.5	Objectives of the Research Study	18
1.6	Research Methodology	19
1.7	Significance of the Study	19
1.8	Demarcation of the Study	20
1.9	Key Concepts	20
1.9.1	TADA	20
1.9.2	High school	20
1.9.3	Cape Metropolitan Area	21
1.10	CHAPTER LAYOUT	22
1.11	SUMMARY	22
CHAPTER 2 : DRUG ABUSE AMONGST YOUTH		**24**
2.1	THE DRUG PHENOMENON	24
2.2	THEORIES EXPLAINING THE DRUG PHENOMENON	27
2.2.1	Physiological Theories	27

2.2.1.1 Physical Dependence theory 27
2.2.1.2 The Genetic theory 29

2.3 SOCIAL THEORIES 30
2.3.1 Social Learning Theory 30
2.3.2 Sociological Theory 31
2.3.3 Social-Behavioural Theory 32

2.4 PSYCHOLOGICAL THEORIES 33
2.4.1 Psychoanalytic Theories 34
2.4.2 Gestalt Theory 35
2.4.3 Humanistic - Phenomenological Theory 35
2.4.4 Cognitive Theory 36

2.5 SUMMARY 37

CHAPTER 3 : THE TADA PROGRAMME AS A PREVENTATIVE MODEL 39

3.1 ORIGIN 39

3.2 TADA AS A PREVENTATIVE MODEL OF INTERVENTION 40
3.2.1 The Goals of TADA 40
3.2.2 Target Group 42
3.2.3 Implementation of The TADA Model 42
3.2.4 An Analysis of TADA Programme Activities 44
3.2.5 A Situational Analysis of TADA Groups In The Cape Metropolitan Area 46

3.3 THE TADA PROGRAMME 49
3.3.1 High Expectations of Students 49
3.3.2 The Dependence on a Mover 50
3.3.3 Ridicule by Teachers and Fellow Students 50
3.3.4 The Use of Shock Tactics or Strategies 52
3.3.5 The Lack of Training 52
3.3.6 Lack of Exciting Programme Activities 52
3.3.7 Funding Problems 53
3.3.8 Victimisation of Students 53
3.3.9 Stigmatisation of the Name 54
3.3.10 Marketing and Promotion 54

3.4 SUMMARY 54

CHAPTER 4 : A GENERAL OVERVIEW OF TREATMENT PROGRAMMES FOR DRUG ABUSERS 56

4.1 BRIEF HISTORICAL OVERVIEW OF TREATMENT 56

4.2 AIMS AND GOALS OF TREATMENT PROGRAMMES 57

4.3 TREATMENT PROGRAMMES FOR ADULTS 60
4.3.1 In-Patient Treatment for Adults 61
4.3.2 Out-Patient Treatment for Adults 67

4.4 TREATMENT PROGRAMMES FOR YOUTH WITH DRUG DEPENDENCY PROBLEMS 71
4.4.1 Out-Patient Treatment for Youth with Drug Dependency Problems 73
4.4.2 In-Patient Treatment Programmes for Youth With Dependency Problems 76

4.5 MOTIVATION FOR OPENING A JUVENILE TREATMENT CENTRE 77
4.5.1 Target Groups 77
4.5.2 Procedure and Treatment Period 78
4.5.3 Goals of the Treatment Programme 78
4.5.4 Treatment Components of the Juvenile Treatment Programme 79

CHAPTER 5 : FIELD RESEARCH AND DISCUSSION 82

5.1 RESEARCH METHODOLOGY 82

5.2 RESEARCH FINDINGS 83
5.2.1 Reasons for Establishing the TADA Programme 95
5.2.2 Views on the TADA Programme 95
5.2.3 Types of Activities That TADA Groups Engaged in 95
5.2.4 Suggestions to Gain More Support 96
5.2.5 Attitudes of Fellow Students Towards TADA 102
5.2.6 Need for TADA in School 103
5.2.7 Suggestions to Improve the TADA Programme 103

5.3 DATA INTERPRETATION AND ANALYSIS 104

CHAPTER 6 : CONCLUSIONS AND RECOMMENDATIONS 109

6.1 CONCLUSIONS 109

6.2 RECOMMENDATIONS 110
6.2.1 Developing a Drug Policy 111
6.2.2 The Need for a Registration Form 112

6.3 PROPOSED FRAMEWORK FOR THE EFFECTIVE IMPLEMENTATION OF THE TADA PROGRAMME 113
6.3.1 A Policy Statement 113
6.3.2 Guidelines: Enabling Effective Programme Planning and Implementation 114
6.3.2.1 Programme Planning 114
6.3.2.2 Strategies 115
6.3.2.3 Programme Comprehensiveness 116

BIBLIOGRAPHY 118
APPENDICES

LIST OF TABLES

PAGE NO.

TABLE 1.1 : NATIONAL SEIZURES BY SANAB FOR DRUG DEALING AND POSSESSION OR DESTROYED IN MASS CULTIVATION AREAS (CANNABIS): 1993-1998 3

TABLE 1.2 : STATE TREATMENT CENTRES 9

TABLE 1.3 : REGISTERED TREATMENT CENTRES/HOSTELS/ COUNSELLING SERVICES 9

TABLE 4.1 : RESPONSES FROM TADA MEMBERS ON HOW THEY BECAME AWARE OF TADA 83

TABLE 4.2 : RESPONSES TO THE YEAR IN WHICH TADA WAS STARTED IN SCHOOLS 84

TABLE 4.3 : RESPONSES FROM TADA MEMBERS REGARDING WHO STARTED THE PROGRAMME IN THEIR SCHOOL 85

TABLE 4.4 : REASONS FOR JOINING TADA 86

TABLE 4.5 : NUMBER OF TADA STUDENTS IN SCHOOL 86

TABLE 4.6 : RESPONSES TO THE DECREASE/INCREASE IN TADA MEMBERS 87

TABLE 4.7 : REASONS FOR TADA MEMBERS LEAVING 88

TABLE 4.8 : EXTENSION OF TADA PROGRAMMES TO SCHOOLS 89

TABLE 4.9 : TADA MEMBERS' RESPONSES TO THE PROBLEMS THAT TADA EXPERIENCE 89

TABLE 4.10: TADA MEMBERS' RESPONSES TO MEETING TIMES 90

TABLE 4.11: INVOLVEMENT OF TEACHERS 91

TABLE 4.12: TADA STUDENTS' KNOWLEDGE OF DRUGS 91

TABLE 4.13: BIOGRAPHICAL DETAILS OF TADA MEMBERS 92

TABLE 4.14: RESPONSES FROM NON-TADA STUDENTS OF HOW THEY BECAME AWARE OF TADA 97

TABLE 4.15: NUMBER OF NON-TADA STUDENTS IN SCHOOL 98

TABLE 4.16: NON-TADA STUDENTS' VIEWS OF THE TADA PROGRAMME 99

TABLE 4.17: NON-TADA MEMBERS' RESPONSES TO ENCOURAGE STUDENTS TO JOIN TADA 99

TABLE 4.18: EXTENSION OF TADA PROGRAMMES TO SCHOOLS 100

TABLE 4.19: TADA STUDENTS' KNOWLEDGE ABOUT DRUGS 100

TABLE 4.20: NON-TADA MEMBERS' THOUGHTS OF THE TADA PROGRAMME 101

TABLE 4.21: BIOGRAPHICAL DETAILS OF NON-TADA MEMBERS 102

CHAPTER 1

BACKGROUND TO SUBSTANCE ABUSE, AND RELATED ISSUES

1.1 INTRODUCTION

Throughout the world drug abuse is recognised as one of the major factors contributing to the ill health and social problems of communities. In South Africa there is an increasing tendency amongst teenagers and adults to experiment with drugs despite the fact that the country has certain policies and prevention programmes in place aiming at combating drug abuse. Teenagers are one of the high-risk groups and there are several programmes in place specifically informing and educating this age group on the dangers of drugs.

It is also a fact that recent events and wide spread media coverage have made sure that all South Africans have become aware of the serious alcohol and drug problem in the country. Many of the people are concerned about how it may affect their families, their children's health, education and future.

South Africa is in a process of transition and, therefore, the need to look at the effectiveness of some of these preventative programmes. There is also the need to determine if these programmes do help to prevent drug abuse amongst teenagers. The latter motivated the researcher to evaluate the Teenagers Against Drug Abuse (TADA) programme in this respect.

The Western Cape branch of the South African National Council on Alcoholism and Drug Dependency (SANCA) have confirmed that no research has been done on the TADA programme in the Cape Metropolitan Area. During 1996 there were 25 TADA groups in the Cape Metropolitan Area. This number has decreased and according to the SANCA co-ordinator responsible for this programme, there were 13 TADA groups in 1998. The reality is that drug abuse among school children has increased. The researcher, therefore, decided to do a full description of the programme and

determine the views of students on how TADA programmes are implemented and how these programmes are reaching the youth.

This chapter describes the background to the South African situation concerning substance abuse, the trends and patterns and current treatment issues. Attention will be drawn to preventative programmes for the youth. The research methodology and the objectives of the study will also be explained.

1.2 AN OVERVIEW OF SUBSTANCE ABUSE IN SOUTH AFRICA

Edmonds and Wilcocks (1994:1) mention that for many decades South Africa, due to its political policies, was isolated by the international community. This meant that South Africa was relatively safe from large-scale drug invasions. When South Africa joined the international community, the drug market opened up and the country witnessed an increase in the use of hard drugs such as heroin, cocaine and mandrax.

According to Parry and Bhana (1999:76), statistics supplied by the South African Narcotics Bureau has shown that there has been an increase in the confiscation of illegal drugs (see Table 1.1 below).

TABLE 1.1 : NATIONAL SEIZURES BY SANAB FOR DRUG DEALING AND POSSESSION OR DESTROYED IN MASS CULTIVATION AREAS (CANNABIS): 1993-1998

	1993	1994	1995	1996	1997	1998
Cannabis (kgs)*	1 707 807	7 182 906	1 426 831	272 805	415 695	981 317
Cannabis (kgs)**	847 336	268 652	238 813	203 354	172 129	197 116
Methaqualone (tabs)	3 527 228	2 668 221	886 846	432 808	1 629 531	1 307 109
Cocaine (gms)	78 388	69 561	187 615	106 629	150 932	635 908
Ecstasy (tabs)	0	1 262	2 121	3 139	118 784	111 733
Heroin (gms)	1 846	24 745	5 942	811	1 548	5 383
LSD (units)	10 969	16 701	3 107	11 804	2 730	6 426
Speed (tabs)	0	0	0	128	303	507
Hashish (kg)	0	27 086	7 858	1 065	2 150	20 689

* - including amount destroyed in mass cultivation areas
** - only from amount seized during arrests involving dealing in or possession of drugs

Table 1.1 indicates the amounts of various substances seized by SANAB between 1993 and 1998 for dealing and possession combined. Seizures of cannabis have generally shown a decline over the past six years. Mandrax seizures have also shown a decline since 1997. The data, however, shows an increase in seizures of other illegal substances, such as cocaine, ecstasy, heroin, LSD, speed, and hashish. Cocaine seizures, in particular, have shown a steady increase since 1993.

According to Edmonds and Wilcocks (1994:1) South Africa has for many decades been relatively safe from large drug invasions, whilst drug syndicates set up comprehensive networks throughout the United States, Europe and the United Kingdom. When drug stocks and demand reached saturation point in these areas, the focus turned to Southern Africa. This

meant especially in South Africa, that economically deprived citizens were eager to make a quick profit by being couriers or crop producers.

In South Africa there has been a paradigm shift concerning the drug problem. The abuse of drugs was traditionally perceived as a personal problem, but now it is being seen as a community issue. Currently communities are challenging drug lords and gang leaders and put pressure on the government to act against gangsterism and drugs. The Reconstruction and Development Programme (1994) document emphasises principles like people driven processes, nation building, peace and security, which seem to spur some communities and give them the courage to confront the drug lords and drug dealers.

The illegal flow of drugs into the country is a great concern for the government. This has led to the fact that millions of South Africans (especially young people) are experimenting with drugs. According to Rocha-Silva (1995:19) the findings of national and regional surveys done amongst certain sectors of the young population, indicated that the majority of young people in South Africa take alcoholic beverages at some time or the other. The surveys also reveal that more males use drugs than females. The government has been aware of the drug increase, and has since 1990 introduced several measures to control drug abuse. Some of these measures include warnings on packages and prescription requirements for narcotic drugs.

The government has also focused on preventative programmes in order to combat the drug abuse culture. The "I'm Addicted to Life" is a national anti-drug programme aimed at breaking the hold of the drug culture in South Africa. There are various other projects with the same purpose, such as the Poppets and the Lions Quest programmes. A multidimensional approach is now advocated where the emphasis is placed on prevention rather than curative care.

Edmonds and Wilcocks (1994:1) state that South Africa finds itself in the grip of a major drug boom and that it lacks the official infrastructure to deal with a burgeoning drug trade and all its concomitant implications. This is true because so often it is said that the South African government does not have the human resources to enforce regulations and that there are insufficient treatment facilities. The government on the other hand acknowledges this, and encourages awareness of the problem so that solutions can be found at a grassroot level.

Business has also entered the fight against crime and drugs and is actively involved by contributing financial support to organisations and building facilities in communities. Business Against Crime is but one of the many organisations providing financial support to crime fighting agencies such as anti-crime forums and the South African Police Services (SAPS).

Recently people have become dependent on quick fix solutions. Children are also taught that headaches, emotional problems and pain can all be alleviated by taking drugs, pills, alcohol and dagga. Many children see how their parents use drugs as a means to dull their pain and suffering and later on in life follow their parent's example.

In 1997, the Minister of Welfare requested the Drug Advisory Board to develop a drug master plan for South Africa. Apart from the fact that the country needed such a plan, this step was also in accordance with international practice. In March 1999 the South African Government accepted this plan.

The South African National Drug Master Plan will be used as the blueprint for South Africa's response to drug abuse (Department of Welfare 1999:3).

In this plan the government sets out national policies and broad priorities in the campaign against substance abuse.

However, it is a fact that substance abuse is increasing and that drug lords are behind this. In the researcher's deliberations with schools, members of the public and youth organisations, it transpired that the drug situation is exploding.

1.3 THE EXTENT, PATTERNS AND TRENDS OF SUBSTANCE ABUSE IN SOUTH AFRICA

The Finance Week (August 15 - 21, 1996), reported that drug sales in the Western Cape in 1995 were estimated at between R1 billion and R2 billion. According to this newspaper the national drug business in 1996 is estimated at R3 - R4 billion. The Weekend Argus (September 13, 1997) reported that there were at least 124 South Africans in prisons around the world, most of them convicted or awaiting trial on charges related to smuggling or possession of drugs. These people were responsible for bringing in drugs to South Africa. Amongst them was a former Miss South Africa finalist. Incidents like these show how serious the drug problem in South Africa is.

According to Parry (1994:21) alcohol misuse has been associated with a range of medical problems including cirrhosis of the liver, sexually transmitted diseases and other trauma, like accidents and interpersonal violence. It is also probably an important contributing factor behind the high crime rate. The cost of drug related problems to the South African economy in terms of job and traffic accidents, loss of productivity, health, crime and family breakdown is in excess of billions of rands annually. The financial cost to the government is R5 billion per year (Department of Welfare 1995:1). It is also true that no co-ordinated and integrated way of operation exists between welfare organisations. There is a lot of duplication of services and a low level of cost-effectiveness.

General population surveys and public opinions indicate that alcohol, tobacco, over the counter medicine (pain relievers) and dagga are the most frequently abused substances. Research done by the Medical Research Council in Cape Town has shown that almost two-thirds of non-fatal injuries, resulting from interpersonal violence, that were admitted to trauma units in Greater Cape Town, were clinically assessed as alcohol-related. Of all the adult deaths from interpersonal violence only 24,3 % had zero BAC (Blood Alcohol Count) levels at autopsies (Van der Spuy 1994:1).

Drug related crimes in South Africa have increased according to The South African Institute of Race Relations (1998:41). A report published by SAPS showed that the number of drug related crimes reported during 1997 increased by 99 % over the incidents reported in 1996. However, credit should also be given to the government for the fact that it made various efforts to reduce the harmful consequences of drug-related crime.

Research done in South Africa indicates that the main problem group as to especially alcohol abuse are males between the ages of 18 to 35 years (Rocha-Silva 1992:56). From this research it is also clear that alcohol and tobacco are the most popular abused drugs in South Africa.

Drug abuse amongst women, youth and street children is increasing substantially, and the same applies to the prison population. Substance abuse was prevalent in metropolitan centres, but now it has also spread to rural areas. This has led to a significant increase of problems experienced by rural communities. In addition to poverty, rural communities now also have to deal with substance abuse problems and ruthless drug dealers.

1.3.1 Treatment Issues In South Africa

The general policy of the Drug Advisory Board (now known as the Central Drug Authority) and the government, is reflected in the National Strategy Against the Abuse of Alcohol and other Drugs. For the sake of the comprehensiveness and rationality, the strategy contains four main aims which are prevention, treatment, research and control, and law-enforcement (Department of Welfare 1994:3).

In South Africa treatment services are based on this strategy which advocates a holistic approach. The basic aim of most treatment programmes is to provide therapy, inform, prevent and reunite the dependent with his/her family and the community. Detoxification, drug-free counselling, self-help groups, outreach programmes and support to families of drug abusers are all services, which are offered. Staff at these treatment centres consists of social workers, doctors, psychologists, occupational therapists, nurses and social auxiliary workers. The majority of such staff has undergone drug related training to enable them to deal effectively with the problems that drug dependents are experiencing.

Tables 1.2 and 1.3 indicate that there are 5 state treatment centres and 23 registered treatment centres in South Africa dealing with drug-related problems.

TABLE 1.2: STATE TREATMENT CENTRES

PROVINCE	TYPE OF SERVICES			
	No. of centres	In Patient	No. of Beds	Detox.
Gauteng	1	✓	450	✓
Western Cape	1	✓	260	✓
Kwa-Zulu Natal	2	✓	220	✓
Free State	-	-		
Eastern TVL	1	✓	96	✓
N.W. TVL	-	-		
Northern TVL	-	-		
Northern Cape	-	-		
Eastern Cape	-	-		
TOTAL	5		1,026	

TABLE 1.3 : REGISTERED TREATMENT CENTRES/HOSTELS/ COUNSELLING SERVICES

	SERVICES OFFERED									
									Hostels After-care	
Province	In-Patient	No. of Beds	Out Patient: Coun-selling Services	After-care Programs	Prevention Programs	Com-munity Deve-lopment	EAP	Training	No.	Beds
Gauteng	10	507	15	18	13	7	7	10	1	23
Western Cape	3	162	8	8	6	4	4	2		
Kwa Zulu Natal	2	42	4	5	4	3	2	2		
Free State	2	70	4	5	4	2	1	1		
Eastern TVL	1	40	2	3	3	3	2	2		
North. W. TVL	1	31	1	1	1	1	1	1		
Northern TVL	1	15	2	2	2	2	1	1		
Northern Cape	1	30	1	1	1	1	-	-		
Eastern Cape	2	35	3	4	3	2	2	2	2	21
TOTAL	23	932	35	47	37	25	20	21	3	44

(Source: Second Draft: National Substance Abuse Strategy on the White Paper, Department of Welfare, 1995.)

All the various provincial welfare departments have provincial co-ordinators whose tasks it is to drive this campaign on a provincial level. Of all the anti-drug programmes, this programme is well-known, especially amongst the young people. However, there are several prevention programmes like

TADA, The Horizon Project, Peer Counselling, Life Skills and Youth Outreach, all providing either life skills training or information on alcohol and other drugs.

1.3.2 Treatment Issues In The Western Cape

Van der Burgh (1981:207) states that the first vines were planted three years after the arrival of Jan van Riebeeck at the Cape in 1652. South Africa, especially the Western Cape, is acknowledged as the world's leading wine and brandy producers. It is therefore no surprise that the bulk of drug abusers in this province use alcohol.

Van der Burgh further states that it is indeed the practice of farmers in this area (the Western Cape) to provide wine to labourers as part of payment for services rendered. This is called the "tot" system, commonly known as the "dop" system. In addition to this, international drug dealers are active in this region and in the process young people (especially those who are unemployed) are attracted to drug related activities.

Dagga (cannabis), taken in combination with methuqualone (mandrax) is particularly popular in the Western Cape. These drugs are used by children and adults, especially in the disadvantaged areas on the Cape Flats. Not only is the abuse of these drugs concentrated in large cities in the Peninsula region, but it has also spread to rural areas and prisons. During 1999 local and community newspapers reported clashes between drug lords in rural communities. Some of these clashes occurred in rural areas such as Clanwilliam and Bredasdorp. The rapid spreading of drugs to rural areas has created an extra burden on poor and disadvantaged communities.

For people who need help with their drug abuse problems there are several possibilities in the Western Cape Province. There are registered treatment

centres i.e. Ramot, Toevlug and Hesketh King and the Tygerberg Hospital where an in-patient unit is in operation. Other centres are De Novo State Treatment Centre, Cape Town Drug Counselling Centre and various other out-patient facilities.

Treatment philosophies and programmes are up to date, well constructed and do meet the needs of drug dependents. The province has a comprehensive approach in their strategies for the prevention and treatment of substance abuse which are based upon the following principles:

(i) Integrated and sustainable programmes;
(ii) A people-driven process;
(iii) Peace and security for all;
(iv) Nation-building;
(v) Reconstruction and Development, and
(vi) Democratisation of South Africa.

(Department of Welfare 1995.)

Most of the resources in the Western Cape Province are situated in the Cape Metropolitan Area. The traditional disadvantaged rural communities where there is a scarcity of resources, due to the vast distances, cannot utilise resources which are situated in the inner cities of the Cape Metropolitan Area.

The Weekend Argus (August 24/25, 1996) reported that drug sales in the Western Cape were between R1 billion and R2 billion in 1995. This figure has increased during the past years due to the sharp rise in drug smuggling. People living in disadvantaged communities such as townships and informal settlements seem to be particularly at risk with respect to alcohol and drug

abuse. In these communities drugs are more available and accepted as part of everyday life.

Drug abuse causes injuries, deaths, crime, prostitution, breakdown in family life and moral standards. These are the issues some communities want the government or local authorities to address. For some communities in the Cape Metropolitan Area the situation has become unbearable, hence the launch of anti-drug movements.

The most popular anti-crime and drug movement is People Against Gangsterism and Drugs (PAGAD) who through their clashes with drug dealers has focused international attention on the drug problem in the Cape Metropolitan Area. Local newspapers, especially the Argus, carried extensive reports on clashes between the above-mentioned organisation and the drug lords. The Weekend Argus (August 10/11, 1996) described how tension hanged heavy in the air on the Cape Flats and in suburbs closer to the city centre as PAGAD's deadline to the drug lords drew closer. Due to this organisation and other stakeholders, a lot of pressure has been placed on the government to deal with drugs and crime. However, there are also communities who feel powerless against the threat that drugs pose for their children and the community. Rather than face drug dealers they connive with them and become part of the drug culture. The clash between PAGAD and CORE (Community Outreach Forum) continues and there seems to be no immediate solution.

In the Western Cape Province community based services are limited and should be promoted, especially in the rural areas. A factor that compounds the situation is the lack of resources especially finance.

1.3.3 Prevention Programmes for the Youth in South Africa

South Africa, like many other countries such as Canada, America, Israel and Nigeria are looking towards preventative programmes as a solution to the problem of drug abuse. Elainy and Rush (1993:10) state that the ultimate aim of prevention programmes is to change the drug-taking behaviour of the individual.

As mentioned earlier, welfare services are unco-ordinated and not integrated. This is where the human factor (knowledge and attitudes of recipients) comes in, which makes it quite complicated to determine the impact of prevention programmes. The researcher is of the opinion that all prevention programmes should be evaluated to determine the outcome of recipients' drug-taking behaviour. This will help managers of programmes to target prevention strategies which do have an effect on behaviour.

Some of the major prevention programmes in South Africa will be highlighted next to indicate the extent to which they reach youth.

1.3.3.1 The Lions-Quest Skills for Adolescence Programmes

The main objective of this programme is the prevention of problems like drug use, teen suicide and other harmful behaviour during the period of adolescence (12 to 16 years). The target group is Grade 8 and 9 pupils and this is an educational programme. Teachers are trained and the cost of training per teacher is approximately R350 for four training sessions per year. There are between 25 and 60 pupils in a class and each student has to pay R17 for a workbook. This programme is presented mostly in private schools where students can afford it. It does not benefit youth from poor communities. This programme is run by Lions-Quest.

1.3.3.2 **POPPETS** (Programme of Primary Prevention: Education Through Stories)

This programme presented by SANCA consists of a training course for teachers on how to present the programme and an educational programme for pre-school children on the prevention of dependence producing substances, e.g. drugs, alcohol, cigarettes and medicines. The objectives of this programme are to educate young children and help them make an informed choice about drugs and secondly help them develop healthy emotional and social skills through the acquisition of sufficient information. The Poppets programme does not reach young children who do not attend pre-school or crèches. Children, especially in the rural areas who do not have these facilities, are left out.

1.3.3.3 Peer **counsellors**

This programme is also managed by SANCA.

Youth between the ages of 15 and 20 years are targeted to become peer counsellors. To become a peer counsellor a young person must have the following qualities i.e. self-discipline, interest in the issues of alcohol and drug abuse, good verbal and interpersonal skills, and must also be interested in volunteerism and community involvement.

The aim of the programme is to create a youth to youth relationship where young people are trained to help other young people with alcohol and drug problems in their lives. This programme is informative and educational and it also reaches the non-school going youth.

1.3.3.4 The school programme

This is a fairly new programme, which was started in 1995 by SANCA in several schools in Gauteng.

This programme started after it became known that several pupils in Gauteng schools were abusing drugs and some were arrested for selling drugs at school. The aim of this programme is to assist schools in writing a drug policy and to establish a pupil support programme.

Schools approach SANCA for help and the latter assists the schools in drawing up a drug policy. This also helps schools to identify early signs of alcohol or drug abuse. The ultimate ideal of this programme is that schools establish their own TADA groups. From there on the pupils can mobilise support and initiate further activities around drugs and other important issues.

1.3.3.5 TADA (Teenagers Against Drug Abuse)

The programme started in 1986 when a group of Grade 10 pupils in Durban decided to do something about the drug problem. They had been addressed by Ms Adele Searle, a well-known campaigner against drug abuse. Subsequently, they started the first TADA group (Keshwar & Louw 1993: 12).

The programme is mainly a self-help support group for teenagers, run by teenagers. The group invites experts to address and teach them on subjects they need more information on. Usually a teacher is chosen as guardian of the group, but only to facilitate and not to dictate (For full details about this programme see Chapter 3).

1.3.3.6 "I'm Addicted to Life" Anti-drug Campaign

According to Foster et al (1997:306) the Department of Welfare launched the programme in May 1995. The focus of the campaign was the youth as well as older individuals abusing drugs. A 13-part TV programme was produced and screened on national television. Thereafter a manual based on the video cassettes of the TV programme was developed by the Western Cape Education Department, and subsequently provided to schools and concerned organisations.

The Department also appointed provincial co-ordinators in the various provinces to drive this programme. In 1996 Provincial Drug Demand Reduction and Retrain The Trainer workshops were held where especially young people were involved. The purpose of all these activities was to make young people drugwise, and to concentrate on the positive utilisation and recreation of leisure activities in order to avoid drug use.

Prominent people such as premiers, film stars and community achievers were used to promote anti-drug awareness. This is one of the government's most successful anti-drug campaigns. However, in the poor provinces this campaign is fading due to the fact that these provinces have poverty as their focus. In the Western Cape this campaign has been successful and many schools used the theme "Addicted To Life" in various school projects.

1.4 PROBLEM STATEMENT

The drug industry has exploded in the Cape Metropolitan Area. The reality is that young people are the main target group of drug lords and other drug related organisations. Most drug abusers are introduced to drugs at a school-going age.

TADA is a drug prevention programme operating in high schools. The main aim of this preventative programme is, to prevent drug use among young people and provide life skills. According to Keshwar and Louw (1993:12) this programme was introduced in 1986 in a school in Durban and later expanded to schools in other provinces. However, it is currently clear that the programme is not widely implemented and that it has a limited affect on students.

The number of TADA groups in the Cape Metropolitan Area has decreased and there are currently only 13 groups. This is an indication that support for this programme is minimal and the factors affecting this programme has to be addressed.

Moreover, there is also criticism from organisations and communities regarding the success of this programme. SANCA as controlling body admits that the programme needs to be restructured to attract more young people. It is important that TADA as a school-based prevention programme should be effective if it wants to make in-roads in fighting drug abuse among young people.

Besides financial constraints there are also other factors which affect this programme. Some of these factors are, for example, no innovative projects, a lack of support and poor promotion of the programme. There are also problems regarding the context/settings within schools that make it also difficult for this programme to expand. Apart from the above, young people who are not equipped with knowledge, are risk-prone in terms of handling drug-related problems. A few bad mistakes usually deter other students from joining.

There is reason to believe that the low number of students involved in TADA at schools is due to the fact that it is not considered as an integral part of the

school programme. Once this has been done, a sense of commitment and enthusiasm for the programme will develop.

Young people become members of TADA without receiving any training. If TADA members are better equipped this may help drug-free lifestyles.

1.5 OBJECTIVES OF THE RESEARCH STUDY

Most stakeholders (Government and Private Sector) in the substance abuse field rely heavily on prevention programmes and spend huge sums of money on these programmes. However, some of these programmes are ineffective due to the fact that they make no or little impact on the attitudes and behaviour of the target population they are supposed to reach.

The objectives of this research are:

(i) To give a full description of the TADA programme and its objectives.

(ii) To analyse the content (programme activities) of this programme.

(iii) To determine views of students on how TADA programmes are implemented and whether these programmes reach the youth.

(iv) To make suggestions based on the findings on how to improve the programme and expand it.

There is the potential for this research and its results to be utilised as a guide by professionals i.e. social, youth- or community workers interested in doing preventative work amongst youth with drug problems.

1.6 RESEARCH METHODOLOGY

A descriptive research methodology was used in this study. There are 13 schools where the TADA programme is implemented. Six schools were selected and teachers were requested to give the questionnaires to TADA groups and non-TADA members. At each school the TADA group consisted of 10 - 20 students. From the 6 schools 60 TADA members were given questionnaires as well as 60 non-TADA members. In total 120 questionnaires were distributed to the 6 schools. The co-operation of the schools was excellent and all 120 questionnaires were completed. For the researcher this was a positive start and it indicated the commitment of students who were involved in the research study. A letter accompanied the questionnaires briefly explaining the aim of the research, and also stating that the information will be kept confidential. (See Annexure A.)

1.7 SIGNIFICANCE OF THE STUDY

The increase in substance abuse especially amongst teenagers has led to an outcry amongst parents and communities. This has led to the question "What prevention programmes for teenagers exist in the Cape Metropolitan Area and what is their nature?". The researcher will give a full description of the TADA programme and its objectives and determine if this programme does indeed reach out to teenagers.

Literature and media reports reflect the problems and difficulties school children experience in making decisions as to whether or not to take drugs. No research has thus far been done on TADA in the Cape Metropolitan Area and this justifies the decision to research and explore the difficulties TADA members have to face in promoting a healthy life style without drugs.

Furthermore, most stakeholders in the service field of substance abuse agree that prevention should be prioritised. The researcher as a role-player from a State Department involved with prevention programmes, found it imperative to undertake this research in the interest of making this programme expand more in schools.

1.8 DEMARCATION OF THE STUDY

There are TADA programmes throughout South Africa. The aim of this research was to focus only on those TADA programmes implemented in the Cape Metropolitan Area. In 1997 there were approximately 20 TADA groups in this area. Currently (1998) there are only 13 TADA groups. The main reasons for focusing on only TADA programmes in the Cape Metropolitan Area is because all the TADA groups in the Western Cape Province are situated in this area. Secondly, due to logistical constraints it is impossible for this study to be inclusive of all TADA groups nationally. However, results from this study are likely to have relevance for all TADA programmes.

1.9 KEY CONCEPTS

1.9.1 TADA

This concept was formed by a group of high school students in 1986. They were teenagers fighting against drug abuse. The abbreviation stands for Teenagers Against Drug Abuse and clearly indicates that it is initiated and controlled by teenagers. (See Chapter 3 for more detail about TADA.)

1.9.2 High school

An educational institution where students from Grade 8-12 are accommodated and taught.

1.9.3 Cape Metropolitan Area

In the Tygertalk (10 July 1997:1) the Cape Metropolitan Area is described as the area stretching from Cape Town to the outer boundaries of the Strand and Stellenbosch. The Cape Metropolitan Area has six municipalities and these are:

(1) The Cape Town Municipality – the areas included are the City Centre, Camps Bay, Clifton, Mitchells Plain, Gugulethu and some of the Southern Suburbs.

(2) The South Peninsula Municipality – includes areas in some of the suburbs of Grassy Park, Constantia, Plumstead, Diep River, Noordhoek, Kommetjie, Simon's Town, Fish Hoek and Muizenberg.

(3) The Blaauwberg Municipality – areas are Ysterplaat, Brooklyn, Milnerton, Blouberg, Melkbos, Atlantis and Mamre.

(4) Tygerberg Municipality – areas here are Khayelitsha, Mfuleni, Durbanville, Goodwood, Parow, Bellville and Bellville-South, Elsies River and Belhar.

(5) The Oostenberg Municipality, which include Kraaifontein, Wallacedene, Bloekombos, Scottsdene, Brackenfell, Kuilsrivier, Eerste River, Blue Downs and Blackheath.

(6) The Helderberg Municipality, which represents the Strand, Macassar, Sir Lowry's Pass, Somerset West, Nomzamo, Lwandle and Gordon's Bay.

1.10 CHAPTER LAYOUT

Chapter 1 describes the background to the South African situation with regards to the analysis of substance abuse, the trends and extent of substance abuse as well as treatment issues in South Africa and specifically in the Western Cape Province. This chapter also describes the research objectives and methodology.

Chapter 2 deals with drug abuse as a phenomenon and theories explaining this phenomenon amongst young people.

In Chapter 3 there is a discussion of the TADA programme as a preventative model of intervention and a description of problems experienced in the implementation of the programme.

Chapter 4 gives a general overview of treatment programmes for drug abusers.

Chapter 5 describes the field research and findings.

Chapter 6 comprises of the conclusions and recommendations.

1.11 SUMMARY

Substance abuse is on the increase in South Africa and the effects are felt at all levels of South African society. A question exists regarding the ability of the TADA programme to effectively prevent substance abuse among school-going youth.

The overall aim of this study therefore is to give a full description of the TADA programme, determine the views of students on how TADA programmes are implemented and how these programmes are reaching the youth.

CHAPTER 2

DRUG ABUSE AMONGST YOUTH

This chapter describes drug abuse as a phenomenon and also draws attention to theories explaining it. The emphasis will also be placed on how these theories can relate to the use or abuse of drugs among young people.

2.1 THE DRUG PHENOMENON

Substance abuse problems are often perceived from a moral point of view. Although drug abuse is labelled today as an illness, many still believe that it stems from a moral failing or a "lack of character", that the person is inherently bad and should get rid of it. This perception makes it difficult for drug abusers to come out in the open and acknowledge their addiction.

It is, therefore, clear that drug abuse is a complex subject, involving various factors such as psychological, medical and social factors. Researchers or community leaders who ignore the pivotal role some of these factors play, will not be able to develop a proper understanding of the drug problem or the drug phenomenon.

The drugs, or chemical substances which people tend to abuse are also known as psycho-active chemical substances. The reason for this is that these drugs have the ability to change people's moods, feelings and perception. The drugs that effect people's moods are also sometimes called "mood changing" drugs.

In our society, young and old, strive to escape from the harsh realities of life, and this is where drugs provide this escapism. This drug phenomenon has

become part of our society. A positive drug message is given to young people by the mass media. They are made to believe that drugs are harmless and that it can help you feel relaxed if you are tense, sleepy if your cannot sleep, happy if you are sad and strong if you feel week. So if the world of reality becomes too painful, drugs are there to help us achieve our own Utopia.

The researcher is of the opinion that the South African mass media still faces mainly on sensation and does little in terms of promoting anti-drug messages. Instead, young people are bombarded with messages about how good certain brands of beer or cigarettes are. Companies use major newspapers in order to sell their product and the newspapers are heavily dependent on the lucrative advertising fees they charge.

The drug abuse phenomenon in South Africa cannot be isolated from global influences. According to De Miranda (1987:1), the trends and patterns for drug abuse in any country are closely linked to customs, values, mores and cultural differences of the people in that country. The researcher agrees with the above statement because in cultures practising abstinence, limited drug abuse or no drug phenomenon exist.

The drug phenomenon has led to the establishing of various cultures. For example the "hippie" culture was associated with drug abuse, long hair, beards, dirty jeans and communal living. During the 1960's this culture emerged in the United States of America and later, through the mass media, spread to South Africa.

In the 1970's, for example, a "Rastafarian" culture emerged in South Africa spurred on by the reggae music of Bob Marley (a legendary singer promoting the Rastafarian culture). Dagga was seen as a traditional and sacred herb and used by Rastafarians. Till this day there are Rastafarians in South Africa

who are actively lobbying for the legalisation of dagga (also called ganja by Rastafarians). In the Cape Metropolitan Area most Rastafarians live in areas such as Somerset West and Macassar.

To explain the drug abuse phenomenon more clearly, a brief discussion on drug use among the various South African groups will follow. In the African cultural group the brewing and use of alcoholic beverages has become an integral part of their lives. According to Gumede (1992:53) beer brewing is one of the oldest customs in Africa. Beer drinking was only for adults and it took place under controlled supervision, i.e. celebrating a good harvest, a marriage or a victory. Later the African cultural group came in contact with other cultures. Women and young adults who were originally protected by their cultural norms were influenced by habits of people from other cultures and this, in turn, led to usage of alcohol and other drugs.

Alcohol abuse, especially in the wine producing regions of the Western Cape, is an integral part of life. There is also the tot system (commonly known as the "dop" system) that further exacerbates the regions drug problem. This system promotes the provision of alcohol to farm labourers as part of their payment. The Coloured group is the main victim of this "dop" system. Currently this group, with the effects of urbanisation and modernisation, is also abusing drugs such as dagga, mandrax and cocaine.

The Indian cultural group seems to have less drug problems due to the fact that they maintain an abstinent culture regarding alcohol use. The Islamic cultural group also maintains abstinence. However, there are a considerable number of people from the last-mentioned groups who do use drugs. It is thus clear that firm religious and moral beliefs are sometimes not enough to deter people from using drugs. (Burger 4th Feb. 2006)

From the researcher's point of view, it is clear that social and cultural factors play a major role in the increase in drug abuse.

2.2 THEORIES EXPLAINING THE DRUG PHENOMENON

According to Turner (1986:645), the various theories differ from one another, but there are also similarities. For example, each attempts to address some aspects of the person-in-a-situation, which is essential in social work.

These theories are explained in an attempt to create a better understanding of the drug phenomenon and how it can lead to an increase in drug use or abuse among young people.

2.2.1 Physiological Theories

These theories emphasise the individual's physical dependence on drugs. Willis (1969:15) states that in 1964 The World Health Organisation Expert Committee on Addiction - producing Drugs decided to drop the term "addiction" and accepted the word dependence. One of the reasons was that addiction means different things to different people.

In their definition of drug dependence the World Health Organisation (W.H.O.) described it as a state of psychic or physical dependence or both on a drug, arising in a person following the administration of that drug over a period or on a continuous basis.

2.2.1.1 Physical dependence theory

According to the physical dependency theory there is an intimate biochemical relationship between the drug and the individual's metabolism.

The rate at which physical dependence is developed varies from one type of drug to another (Willis, 1969:17). For instance, young people sniffing glue, physical dependence is a relatively late phenomenon. According to this theory, young people using drugs like alcohol, dagga and mandrax in large quantities will show early signs of physical dependence. Well-known symptoms include delirium tremens, dizziness and nausea.

This theory also states that the young drug abuser will have a conspicuous tendency to increase the dose of the substance. It is then that young abusers will steal, connive or do anything to get money to buy drugs. What is particularly disturbing is that schools often expel these young people without making any attempt to refer them to appropriate welfare agencies. In the Western Cape this happens on a regular basis and these individuals, who are perhaps in the first stage of physical dependence, join gangs in an attempt to attain money to buy drugs.

Willis (1969:18) acknowledges that tolerance is also an important factor in the physical dependence theory. The young drug abusers will acknowledge how their bodies could deal with large quantities of drugs. Having lost their tolerance they are now unable to deal with small amounts of drugs. It often happens that young drug users are found dead of an overdose which is due to the fact that they have lost their tolerance.

The physical effects young drug abusers endure are weight loss that can lead to anorexia, drowsiness, sweating, abdominal cramps, vomiting, skin effects - picking of the skin around nail beds and physical self-neglect. According to this theory young drug abusers are also nervous, restless and display anti-social behaviour like violence.

Finally, some children born from young mothers who are physically dependent on alcohol, present foetal alcohol syndrome (FAS). During

pregnancy the growth of the baby is deterred due to the mother's excessive alcohol abuse. In the Western Cape, the Foundation for Alcohol Related Research (FARR) is currently (2001) involved in research studies on FAS children. Some of the findings have indicated that the FAS rate is the highest in the Western Cape.

2.2.1.2 The genetic theory

This theory explains alcoholism as a hereditary factor. In fact it goes as far as stating that alcoholism runs in families and, therefore, some societies have major drug abuse problems. Bloom and Kupfer (1995:1795-1797) mention that there are classical genetic studies that consist of work done on family studies, twin studies and adoption work. In brief the findings of some studies are:

(i) Family studies - The studies of families of drug abusers strongly suggest familial influences. Male relatives were almost twice as likely as female relatives to display substance abuse.

(ii) Twin studies - These studies found a significantly greater concordance for substance abuse in monozygotic males than in dizygotic males.

(iii) Adoption studies - The findings of the adoption studies indicate that there was a significant correlation between drug abuse in the adoptee and alcohol problems in the biological parent. (Bloom, and Kupfer, 1995:1795-1797).

According to the genetic theory, the drug abuse phenomenon (addiction) runs in families and it is hereditary. The question here is; does drug use in adolescence predict future drug abuse? Common sense should indicate that

it might in fact be true. However, it is true that not all young drug users become addicts.

2.3 SOCIAL THEORIES

These theories emphasise the role that values and norms play in encouraging or discouraging the use of drugs among society's members. Here are some of the important social theories:

2.3.1 Social Learning Theory

According to Craig (1976:30), all learning occurs within the framework of a person's biological development. For example a child of 2 years old is biologically unable to write his/her name and cannot take responsibility for an infant while the mother goes out. As the child develops he/she is able to learn and generalise certain situations. Social learning theories have been remarkably productive in generating insights into the reasons why young people use drugs.

Social learning theory investigates the way young people use models to learn social traits such as aggression, dependency and generosity. Young people learn these traits from their role models. In the Western Cape, especially in areas like Manenberg, Bonteheuwel and Mitchells Plain, young people emulate the actions of gangsters.

Kauffman (1981:275) also emphasises that adolescents who misuse alcohol are characterised by a low self-esteem, high anxiety, depression and have parents and associates who are heavy drinkers. Adolescents thus emulate the drinking patterns of family members and peer groups.

Attitudes and religion also play a pivotal part in encouraging or discouraging drug use among young people. For example certain groups in South Africa advocate abstinence and it is supported by their religion. Some groups on the other hand associate alcohol use with special occasions and ceremonies such as marriages, births and graduations. Drinking on these occasions usually receive the support of peers, while outside these boundaries it is disapproved.

2.3.2 Sociological Theory

Every part of society is seen as having a specific function which contributes to the smooth running of society as a whole (George & Wilding 1976:2). This statement is true because it is a fact that society with its norms and values, impacts on the individuals behaviour and choices. Talcot Parsons has contributed a lot towards this theory and is generally accepted as the founder. In the sociological theory, culture is a major factor. If the goals of a culture are to achieve abstinence then the emerging of a drug abuse phenomena is impossible.

Foster et al (1997:301) states that many crimes can be directly or indirectly related to alcohol or drug abuse and to the trade in these substances. In the Western Cape Province alone the number of persons appearing in court on alcohol or drug-related offences were 4193. Many of these crimes were committed by young people who came from poor sociological environments where shebeens and gangs are plentiful.

Craig (1976:13) points out that socialisation does not stop when an individual leaves childhood, but continues on in adulthood and old age. This is true because children who are accustomed to throwing tantrums learn new behaviours when they enter school. It is often in the school environment that children learn about drug use when they are amongst their peers.

The sociological environment in which a young person finds himself/herself may also play a role in the decision to take or avoid the use of drugs. Nowadays advertisements portray drug use (especially wine, beer and tobacco) as socially acceptable and gives the impression that the use of these drugs makes one successful and brings status. Many young people are attracted to the use of tobacco and beer by these enticing advertisements. Besides advertising, peer pressure plays an important part in luring young people to use drugs. They want to be part of the group and be accepted.

In March 1999 the South African government accepted the National Drug Master Plan as a policy document aimed at addressing substance abuse issues in a holistic manner. This plan is also to ensure that young people, at risk of drug misuse or who experiment with or become dependent on drugs, have access to a range of advice, counselling, treatment, rehabilitation and after-care services. (Department of Welfare 1998:11).

The sociological environment of teenagers in the Cape Flats seem to enhance the engagement of teenagers in drugs and crime. However, according to Kauffman (1981:276) a child growing up in a high delinquency area does not necessarily mean that the child will become a delinquent. Studies done amongst boys who come from such areas have shown that these boys were favourably inclined toward school and later became good citizens.

2.3.3 Social-Behavioural Theory

Social-behavioural theories are making a strong impact on social work and are being used especially in group-work. This theory seeks to explain

behaviour in terms of the conditions that elicit behaviour and the consequences that the behaviour evokes.

Children learn from their parents the correct behaviour and react according to the stimuli the parents provide. Craig (1976:30) uses terms such as modelling, identification, copying and role-playing to describe the process when children learn by watching other people. If children are taught by their parents or members of society that the use of drugs is accepted and condoned, they will respond positive to these stimuli. This approach will reinforce positive stimuli and, therefore, rowdy behaviour or drunkenness will be accepted as normal.

Teenagers throughout the world find themselves in social situations where they must comply with social rules. In cultures practising abstinence the use of any drug is banned and heavy sentences imposed on the individual (or teenagers) who transgress these social rules. It is a fact that even in these modern times we find countries (especially the Arabic states), where life imprisonment or the death penalty is practised to deter drug smugglers and drug use. In these societies there exist no such phenomenon as drug abuse.

2.4 PSYCHOLOGICAL THEORIES

There are different psychological theories explaining the drug abuse phenomenon. Problem behaviour and planned behaviour theories are two psychological approaches that are useful for explaining adolescents' use and misuse of alcohol (De La Rey et al 1997:218). According to the problem behaviour theory, problem behaviour is any behaviour that departs from the social norms of society. Drinking, dagga- and cigarette-smoking and even non-church attendance can be seen as problem behaviour. According to the theory of planned behaviour adolescents' drinking behaviour can be

explained in terms of their perceptions about drinking or not drinking. Teenagers who drink, view it as a positive thing to do. The main prediction of this theory is that adolescents use drugs because they intend to, and have also the necessary access and resources. Here are some of the psychological theories:

2.4.1 Psychoanalytic Theories

These theories all explain drug abuse from a different view. These views can also be captured in all the psychoanalytic and Gestalt theories. According to Craig (1976:37) there is the Freudian view or also called the psychoanalytic tradition. According to Freud the development of the personality takes place in several psychosexual stages. Before a child reaches puberty there are 3 stages to pass. They are: oral, anal and the phallic stage.

Freud believed that sex and aggression were the primary forces behind human behaviour. If the child's parents make mistakes in toilet training (anal stage), this might affect the child. If parents approve aggression and drug use, this might serve as a tool for destruction for teenagers who will emulate their behaviour. There is a saying: "Like father, like son", which backs up the notion that teenage males will, like their fathers, use aggression when under the influence of drugs.

Craig (1989:39) disputes Freud's view that sexual activity consists of penetration of the vagina by the penis. The author states that sexual activity does not necessarily involves heterosexual genital intercourse amongst heterosexuals.

Secondly, there is the Adlerian View. Basically this view sees drug abuse as a struggle for power. Teenagers are in the adolescent phase where there is a lot of competition among peers for power.

Thirdly, there is the general psychoanalytic view that drug abuse is the result of some inner conflict between dependency drives and aggression drives.

2.4.2 Gestalt Theory

Gestalt theory is a merger of psychoanalytic and gestalt therapy. Turner (1986:653) sees the theory as an approach that is very well suited to clients interested in a total and integrated sense of self and use of self. This theory describes the alcoholic as an "adult suckling" suffering from oral-underdevelopment. He/she is seen as a person who wants his/her solutions to life to be in a liquid form so that he/she can avoid grappling with difficult tasks. (This symbolises the difficulty of moving from sucking to biting and chewing.)

However, the gestalt therapy insists that drug abusers take responsibility and become aware of their self-destructive manipulation. It is not the "how" of the drug users behaviour but the "why" that's important. This theory also makes the therapist/counsellor aware of the games drug abusers play in order to control or manipulate a situation.

So if a young person's needs have not been adequately met during the early childhood days, then that might lead to the development of a drug problem.

2.4.3 Humanistic - Phenomenological Theory

An important psychologist of the humanistic school is Abraham Maslow (Craig 1996:43). Maslow's theory of the self emphasises that lower needs

such as food and shelter and safety are important for the teenager. If these needs are fulfilled, then the teenager might spend time on self-expression activities like painting and music.

The focus of this theory is mainly on what the human being experiences and his drive towards self-fulfilment. The idea is that this awareness experienced by human beings will develop to its fullest under conducive conditions, while the opposite is also true, e.g. that negative conditions can harm development. Teenagers on the Cape Flats come from poor homes and to them the most important thing is to survive. In many cases this means mingling with gangs and using drugs.

Drug use in the context of this theory is seen as a manifestation of blocked awareness, or unwanted growth. The question of lack of integration (wholeness) must be considered in this theory (Poley et al 1979:38). To eradicate the drug problem, one needs to get in touch with oneself and one's surroundings. This theory emphasises that the final decision to take drugs rest with the person.

2.4.4 Cognitive Theory

The cognitive theorists have appeared relative recently on the psychological scene. Piaget is one of the main pioneers of this theory and he is well-known for the studies he did amongst children and adults. Sheafer et al (1994:64) sees this theory as useful in work on problems of depression, low self-esteem and self-defeating thoughts and behaviours. It can be used with children (age 10 and older) and adolescents.

This theory emphasises the individual's cognitive coping mechanisms. When an individual is faced with a problem, the more information he/she has will help in making a decision which will solve the problem. In simple terms if

people do not know the consequences of drug use or abuse they will not take heed to avoid drug use.

Knowledge is useful because it reinforces certain ideas that help the individual to withstand pressures to use drugs to become part of a group. The person's mental state is important in this instance. The professional (social worker, psychologist) working with children with a substance abuse problem should be familiar with children's language, cognitive and emotional development, as well as the relevant therapeutic issues.

Curriculum 2005 focuses on educational outcomes, which in theory will entail that drug education be taught to students. Children who receive drug information will when faced with a decision, in most cases know what to do. So basically this theory says that knowledge is a powerful tool when it comes to making decisions, and in the case of teenagers it is true. From surveys it has been found that teenagers without knowledge about the dangers of drugs, are prone to experiment with it.

2.5 SUMMARY

It is clear from these major theories that there are various factors that could explain the increase in drug use or misuse by young persons.

Young people form a large part of the South African population, and, therefore, it is understandable that the drug phenomenon will be more prevalent among them, especially those who are disadvantaged. It is also clear that causal factors hampering prevention programmes like TADA need to be eradicated in order to make an impact on the lives of young people.

In essence, these theories can help therapists in unlocking the feelings of ~~teenagers~~ offenders, so that they can understand their fears, joy, depression or excitement.

CHAPTER 3

THE TADA PROGRAMME AS A PREVENTATIVE MODEL

This Chapter deals with TADA as a preventative model of intervention. It also focuses on the origin and problems experienced in the implementation of the programme.

3.1 ORIGIN

In South Africa drug abuse was initially recognised as a problem amongst adults. With the increasing pressure of unemployment, broken homes, child abuse, exam stress, and sexual and political problems in the 1980s, it became clear that drug abuse was also increasing amongst young people.

The majority of drug programmes in the 1980s were aimed at adults and there were no programmes for young people. Students and young people involved in drug related crimes were given corporal punishment and sometimes referred to industrial or reformatory schools if their behaviour became delinquent.

Concerned groups, communities, welfare- and church organisations tried through certain efforts to alleviate the drug abuse problem amongst young people.

Keshwar and Louw (1993:12) state that the TADA programme started in 1986 when a group of pupils of Durban Girls College decided to do something about the drug problem. They had been addressed by Ms Adele Searle, a well-known campaigner against drug abuse.

The group of pupils from the above-mentioned institution who initiated this programme, discovered that surrounding schools and communities supported them. Through their efforts they were hoping to reduce the number of young people becoming drug addictive, and not only to focus on the individual, but the whole family and the community. For the first time teenagers could express their own feelings, fears and argue for preventative education in the field of drug abuse. These outcries were heard by several individuals, groups and organisations that wanted to come on board and help with the drawing up of a plan.

TADA grew because teenagers supported it and communities on the other hand agreed that drug abuse amongst young people needed to be addressed. Accordingly several plans were laid, however teenagers felt that it was up to them to decide what to do. Teenagers felt that the programme should be a self-help support group for teenagers and, therefore, run exclusively by teenagers.

The idea was to keep it a drug prevention programme that promotes the advantages of a healthy lifestyle in which drugs do not feature. This positive message was aimed specifically at teenagers to dissuade them from using drugs. From the KwaZulu-Natal region (formerly known as Natal) this programme spread to the various provinces. SANCA then later on took the initiative to promote this programme in schools as part of their prevention programme for teenagers.

3.2 TADA AS A PREVENTATIVE MODEL OF INTERVENTION

3.2.1 The Goals of TADA

TADA is a drug prevention programme aimed specifically at teenagers within the school set-up. As a preventative model the programme relies for its

success on the participation of teenagers. The basic theory underlying the TADA Programme can be described as peer group support, primary prevention and creative thinking.

More specifically the following objectives are promoted:

- learn the facts about drugs
- make informed decisions to avoid taking drugs
- help peers avoid the disasters of drug use
- play a role in educating other teenagers

The above goals promote the positive benefits of a healthy lifestyle without the use of drugs. It is, therefore, clear that the goals of this programme try to achieve the vision of drug free teenagers in society.

By achieving these goals, teenagers develop important skills that enable them to contribute towards society and become productive and peaceful members.

The skills that they require are:

- awareness skills (self-awareness, self-esteem)
- interpersonal skills (empathy, co-operation and communication)
- decision-making and problem-solving skills (the ability to choose positive vs negative lifestyles)
- awareness of family, work and community environments.

The Drug Advisory Board (1994:4) sets out the goals to which prevention programmes must adhere to. These programmes relate to providing education, promoting awareness, providing information on risks and providing drug-free environments. The goals of TADA are in line with the goals as set out by the above board.

The goals of this preventative model also recognises that teenagers will experiment with drugs due to the following reasons:

(i) peer pressure
(ii) curiosity
(iii) boredom
(iv) escape, and
(v) pleasure.

The goals of the TADA programme are to learn or inform teenagers how to tackle these issues. However it is sometimes difficult for teenagers to tackle drug related issues without professional advice or knowledge.

3.2.2 Target Group

The target group is mainly teenagers between 12 and 16 years of age. The target group consists of high school students (grade 8 - 12). A group will establish a TADA group if the need arises. The idea is then that established TADA groups render support to the newly established ones.

3.2.3 Implementation of The TADA Model

Currently the TADA groups are marketed nationally, through The South African National Council on Alcoholism and Drug Dependency offices. The modus operandi is to send social workers to various schools to launch the programme. After a school has formed a TADA group it will usually choose a teacher as a guardian of the group, who will facilitate the process but try not to dictate the way the group should function. The TADA group will then liaise with the local SANCA office with the aim to get information or receive some assistance when requiring speakers.

Sometimes TADA groups are formed through drug related incidents or issues on the school premises. These groups will approach nearby TADA groups for guidance and eventually link up with a SANCA office.

The TADA programme since its inception in 1986 has become popular within schools. During 1993 it was reported that more than 100 TADA groups existed with more than 7 000 members nationally (Keshwar & Louw, 1993:13).

TADA groups are run exclusively by teenagers and the aim is to promote self-esteem, leadership, confidence etc. amongst teenagers. The need of the group determines how regularly they will meet, however most groups are encouraged to meet at least once a week.

One of the criticisms against this programme is that it is not initiated widely through South Africa and some of the reasons are:

(i) teachers unwillingness to be involved (i.e. denying drug use within their schools)

(ii) unrest at some schools

(iii) the fact that SANCA through financial constraints and shortage of personnel cannot be actively involved in all the schools where there is still a need to establish TADA groups.

A second criticism is that the programme is not properly marketed by schools or SANCA. It is left up to each group to decide how it will promote the programme. Some groups come from disadvantaged communities where there are limited resources.

3.2.4 An Analysis of TADA Programme Activities

It is quite clear from their programmes that TADA groups do more than promote anti-drug abuse messages. This youth driven group provides their peers with information on how to choose a healthy lifestyle. It also seems as if it is difficult to keep teenagers interested in the programme. These reasons will be explored when discussing the problems encountered in the programme.

Each TADA group has its own schedule and plans according to its specific needs. Here are some of the activities TADA groups are involved in:

- Organising anti-drug campaigns at schools and communities
- Poster and slogan competitions
- Designing and marketing T-shirts which promote anti-drug messages
- Addressing pupils on the dangers of drug abuse
- Arranging debates and mini-conferences
- Organising drug-free discos and weekends
- Raising funds
- Writing one-act plays or rap songs to convey their anti-drug message
- Education and developing the skills of members.

Elainy and Rush (1992:10) state that prevention programmes should change the knowledge, attitudes, intentions, behaviours and skills of individuals. The activities which TADA groups launch try to do just that, and in this way hope to reduce the risk of teenagers becoming addicted.

The question often is asked why TADA address issues other than alcohol and drugs. The answer to this is that it will be foolish to ignore that teenagers face many issues and challenges other than drug abuse. Teenagers are vulnerable and can be influenced easily and often we find them turning

to drugs, in an effort to escape or solve problems like stress, parental divorce, communication and friendship.

By discussing these subjects teenagers are empowered and they make decisions that will prevent them from experimenting with drugs. Adolescence is a difficult phase and whether adults agree or not, teenagers have to make certain difficult decisions. From the programme contents it is clear that a wide variety of activities are launched. The question is do these activities have an impact on students? Currently TADA groups seem to be dwindling. In 1995 there were ± 30 groups, 1996 approximately 25 and in 1997 only 20 in the Cape Metropolitan Area. Is there something wrong in the way the message has been brought, or does public opinion and media messages discourage teenagers to partake?

The common goals of all these activities are to bring across a strong anti-drug prevention message - learn to say "no" to alcohol and drugs. However, in a society where media messages which portray fun, glamour and success with alcohol and drugs, it is difficult for TADA activities to try and change this perception. Teenagers openly admire role models who use drugs. According to Macridis (1980:2), it is through ideologies that people manipulate others, or manipulate themselves. Young people rather follow the modern trends where drugs are perceived to be cool, than be rejected by their peers. In this instance, peer pressure plays an important role.

The TADA activities are geared towards teenagers and by engaging in these activities they can provide information to fellow peer groups, develop life skills, create positive alternatives, train peer members and help change young people's attitudes towards drugs.

The philosophy behind the TADA model is to emphasise to teenagers that they should enjoy life without drugs and do exciting things to enrich their

lives as well as those around them. TADA members who adhere to the TADA philosophy firmly believes that substance abuse smothers life, prevents personal growth and restricts teenagers from living their life to the fullest.

When analysing the activities of TADA, it is clear that these activities are aimed at creating a society of educated, caring and responsible teenagers who can face difficult issues, without relying on drugs. (Educated young people are much more likely to choose a drug-free lifestyle and will, therefore, encourage others around them to do likewise.) Most of these, activities are launched by teenagers and on a temporary basis. There seem to be no long-term projects which will have an impact.

3.2.5 A Situational Analysis of TADA Groups in The Cape Metropolitan Area

1) In the Cape Metropolitan Area there were during 1996 approximately 25 TADA groups and in 1997 20 groups. These teenagers are from different areas like Athlone, Atlantis, Mitchell's Plain, Gugulethu, Kraaifontein - areas where substance abuse is rife. According to the TADA co-ordinator of SANCA (Western Cape Branch) the 20 TADA teams in the Cape Metropolitan Area are at the following schools:

1) BERGVLIET HIGH
2) SANSSOUCI HIGH SCHOOL FOR GIRLS
3) WITTEBOME HIGH
4) LIVINGSTONE HIGH
5) WINDSOR HIGH
6) CAMPSBAY HIGH
7) WESTERFORD HIGH
8) UXOLO HIGH
9) MANDELA HIGH

10) BULUMKO HIGH
11) BONTHEUWEL HIGH
12) BISHOP LAVIS HIGH
13) STRANDFONTEIN HIGH
14) CEDARS HIGH
15) MUIZENBERG HIGH
16) WYNBERG HIGH
17) SCOTTSDENE HIGH
18) SAREPTA HIGH
19) KASSELSVLEI HIGH
20) MOUNTVIEW HIGH

Currently (1998) there are only 13 TADA groups in the Cape Metropolitan Area.

The responsibility lies with SANCA as a controlling body to arrange an annual conference for TADA members. TADA groups from all the mentioned areas come to exchange ideas, highlight their projects and reinforce the idea that teenagers can lead a healthy life without drugs.

During 1996 the mass media highlighted the ongoing clashes between PAGAD and druglords in the Western Cape. It is, therefore, understandable that TADA members might find it difficult to bring across a message of saying no to drugs to their peers.

In most cases a TADA group consists of between 10 - 20 members all depending on the number of students interested in the programme.

Some TADA groups experience problems and later fizzle out. Some of the reasons given by TADA co-ordinators are the following:

- The group's dependence on one person (called a mover).
- Ridicule by peers and sometimes by teachers. This insensitivity especially that of teachers, discourages pupils.
- Unwillingness of teachers and school committees to recognise that a drug problem exists in a school.

Interviews with drug counsellors working with teenagers have indicated that many of them join TADA because one of their family members or friends experience a drug problem. Teenagers believe that through TADA they can solve some of the drug problems existing in their schools and families.

The experience of the drug counsellors is that TADA members are not equipped to deal or even give proper advice regarding drug problems. TADA peer counsellors need to be empowered with information so that they can do the right thing when giving advice or referring fellow-students to organisations.

TADA members are advised to refer pupils to experts who can deal effectively with drug problems. In schools with a total of 500 pupils or more there are often only 5 TADA members. This happens especially in schools that are situated in areas controlled by gangsters and drug lords. This group sometimes finds it hard to lobby for support and often when this core group disappears the TADA activities cease and the group disbands.

3.3 THE TADA PROGRAMME

In interviews with the director of SANCA, Western Cape and co-ordinators responsible for TADA, they have all acknowledged that financial constraints are one of their major problems. Other problems are that in some areas it is difficult to establish TADA group especially if there is a culture of drug abuse. On the other hand there is a realisation that if this programme is marketed properly it can counter the increase in drug abuse amongst teenagers.

For Morojele (1997:218) the majority of adolescents who drink alcohol do so mainly for the positive and immediate effects. Adolescents are at a very difficult time of their life where they will experiment with anything. Through friends and peer groups they come into contact with drugs at parties, nightclubs and shebeens. The reasons are various, i.e. it boost their confidence and hep them cope with shyness, boredom and fun.

Worldwide teenagers are attracted to drug related activities. With this in mind it is important that preventative models such as TADA exist which can make a special impact on teenagers and encourage them to say no to drugs. However it is clear that the TADA programme is not well known and that there are many problems which prevent this programme from being effective.

Here is an analysis of critical issues affecting the implementation of the programme.

3.3.1 High Expectations of Students

According to the project manager of TADA (Ms Christians - interview on 22 September 1997) and other drug councillors many students join TADA because of drug related incidents at home or school. These students join

with a high expectation to solve some of the drug problems. Students become disillusioned when they realise that drug problems cannot be easily solved. This sometimes leads to students withdrawing from any TADA activities. This is one of the reasons why at schools with a total of 500 students there are sometimes only 10 - 12 TADA members.

3.3.2 The Dependence on a Mover

During the establishment of a TADA group, a leader emerges and all responsibilities for organising TADA activities are placed on his/her shoulders. This person is also called a mover due to the fact that the group depends on his/her decisions and advice.

Unfortunately some members with good leadership qualities are sidelined for the more popular person (the mover). This generally leads to the group becoming smaller and depending heavily on the mover. When this mover disappears from the scene, the group ceases to exist. This does not auger well for TADA because it deters students from joining the group because nothing constructive has been done.

3.3.3 Ridicule by Teachers and Fellow Students

TADA is a prevention programme that is mostly school based and depends heavily on the support of students and teachers. Students who support this programme are sometimes seen by fellow students as weird and called funny names.

This makes it very difficult for TADA members to promote their activities, rather than to be seen as weird and called funny names they avoid involvement in the programme.

Sometimes it is even more difficult to implement the programme especially if uninformed teachers ridicule the programme and students involved. The lack of support from teachers encourages the majority of students to avoid active participation.

On the other hand, it is often school authorities that deny any drug problem on the school premises. The reason for this is to protect the school and avoid giving it a bad image. Especially schools with high academic achievements are often prepared to deny that any drug problem exists in order to attract more students.

Some teachers feel grieved because they are underpaid and, therefore, see their participation in this programme as extra work. Some reason that their primary business is teaching. In a way they are isolating themselves from important issues in society.

The Advisory Council on the Misuse of Drugs (1993:17) made the statement that there is no reason for schools not to address drug education. It is stressed that the role of the school is not only to teach specific academic subjects, but also provide pupils with general life skills that will equip them to handle daily life and prepare for adulthood.

This is in line with the current thinking in South African schools that teachers should be involved in teaching students drug education. Drug education or information does not necessarily mean that there should be separate subjects - it can be included in existing subjects such as Science or Health Education.

3.3.4 The Use of Shock Tactics or Strategies

It is a well-known fact that if tactics or strategies are well used, it will have a positive effect on a programme or project. Not only will the effectiveness of that programme increase, but it will also become popular.

It is a fact that sometimes TADA groups do employ shock tactics in an effort to draw more students. Temporarily the size of the group will increase but later the group will fizzle out. The co-ordinators of TADA have identified this as a problem, but could so far not come up with a solution to address it.

3.3.5 The Lack of Training

During a workshop on 22 October 1997 where various prevention programmes were discussed, the programme manager of TADA acknowledge that hardly any training is given to TADA members. It is expected of TADA members to act as peer counsellors, and it is then that they encounter difficulties. They do not have sufficient information and skills to perform this task. If they fail in this task, then it sometimes provides ample reason for members to leave TADA. Some TADA members have made it clear that they require basic training to develop their skills. With this they will not only be able to require basic knowledge, but also know how to do referrals to other experts i.e. social workers.

3.3.6 Lack of Exciting Programme Activities

SANCA as controlling body for TADA has acknowledged that teenagers are complaining about the lack of activities. The latter are all launched in environments not conducive to the fostering of positive relationships and memories. Future plans are to minimise classroom situations and to intro-

duce more outdoor activities, i.e. hiking trips, training camps, enrichment courses etc.

It is important that these activities have a lasting effect on members because they can then act as ambassadors for the programme. In this manner the programme will enjoy more popularity. Teenagers like to do exciting things and enjoy life. TADA should be a programme where teenagers learn certain experiences and enjoy themselves.

3.3.7 Funding Problems

SANCA as controlling body relies heavily on sponsors to fund the TADA programme. SANCA organises an annual conference and often they struggle to find donors. According to the current programme manager for TADA funds do play a critical role in the implementation of this programme. The current policy is that instead of depending on SANCA, TADA groups should raise their own funds. However, SANCA as the controlling body will support those groups who struggle to raise funds.

3.3.8 Victimisation of Students

The ongoing clash between PAGAD and CORE has made this a real problem. Parents are concerned that their children might land up in the firing line between the battle of these two organisations. Students are discouraged by their parents to join TADA. Already there are rumours that students belonging to TADA groups are seen as PAGAD and students using drugs as CORE. Within schools there are gangs and students who are against drugs and crime, they, in turn, become victims of the opposition party. Unfortunately it is not known how serious this problem is. However there have been incidents where pupils were hurt and attacked by school gangs.

3.3.9 Stigmatisation of the Name

There is also the impression that the name deters students from joining. Nowadays the emphasis is on using user-friendly terms or names. There is no conclusive proof that the name has a major impact on the programme. However, there are schools where the name TADA has a negative connotation due to the fact that schools are not prepared to accept that drug problems exist.

3.3.10 Marketing and Promotion

It is the task of SANCA to promote and market this programme. So far pamphlets, individual experiences and some articles in newspapers have been used to market the TADA programme. This seems to be insufficient because there are currently only 13 TADA groups in the Cape Metropolitan Area. In this area there are more than 200 high schools. If this programme is marketed extensively, more teenagers will be attracted and in the process prevention of drug abuse among teenagers can be addressed. One of the marketing strategies might be to involve high profile people (community leaders and politicians) who can identify themselves with this programme.

3.4 SUMMARY

TADA as a preventative model of intervention for teenagers, seem to concentrate on temporary activities which has no lasting effect or impact. If teenagers have experiences that are memorable and have a lasting effect, it is a well-known fact that they will become ambassadors for the programme. The current perception is that only a few TADA members are dedicated and, therefore, it is necessary to create a bigger awareness amongst teenagers involved in this programme. There is also the need for this model to focus

on programmes that will create intensive experiences. Globally youth preventative models are relying more on training camps and day courses to create lasting experiences. Manuals are also being used giving as much detail as possible to promote their programme.

The TADA programme started in 1986 and has spread to all the provinces. However, it is disappointing to realise that after so many years, no manual exists. The latter could perhaps have helped in solving some of the problems TADA is currently experiencing.

One of the criticisms expressed by adults is that TADA members do not know enough about drugs and their effects to be able to provide accurate information. There is some merit in this argument. The effectiveness of TADA is difficult to determine in quantifiable terms (as in the case with most prevention programmes) but the fact is that TADA groups in the Cape Metropolitan Area has decreased. This is proof that TADA has lost it's effectiveness and that a new initiative is needed. In this seemingly bleak drug abuse situation in which South Africa find itself, there is a need for the TADA programme.

CHAPTER 4

A GENERAL OVERVIEW OF TREATMENT PROGRAMMES FOR DRUG ABUSERS

This chapter will focus briefly on a historical overview of treatment, describe the aims and goals of treatment programmes and give a general overview of treatment programmes available for adults and young people.

4.1 BRIEF HISTORICAL OVERVIEW OF TREATMENT

Historically little has been recorded with regard to the use of drugs in South Africa. However, according to historians, indigenous people like the Khoisan used herbs such as dagga, which induced an euphoric state of mind. The use of indigenous plants, as well as alcoholic beverages were strictly controlled according to customs.

Grobler (1972:32) states that the first vineyard was planted in 1655 and in 1659 the first wine was made. This was the first organised attempt to produce wine in South Africa. Indigenous people who made contact with the White Settlers were later introduced to wine and needless to say this had a tremendous affect on their lives. In 1883 the Commission on Native Laws and Customs was formed and the recommendations of this commission led to the forming of the Liquor Licensing Act 28 of 1883. The selling of any alcoholic beverage to Black people was prohibited. This prohibition was later uplifted in 1961. In 1889 the Suid-Afrikaanse Matigheidsbond was formed to make the public aware of the dangers of alcohol and other drugs.

In 1949 Act 25 of 1949 (Act on Work Colonies) was passed and it made provision for the treatment of alcoholics. People with drug problems had to be treated in work colonies so that they could eventually become productive members of society.

In 1992 all the separate acts providing treatment for the different races were repealed, the Prevention and Treatment of Drug Dependency Act (Act 20 of 1992) was instituted. This act sets out the referral procedures of patients to treatment centres and many other issues relating to the treatment and prevention of drug abuse.

4.2 AIMS AND GOALS OF TREATMENT PROGRAMMES

Roper and Bartlett (1991:67) see the ultimate goal of substance abuse therapy as to terminate or reduce substance abuse and enable the substance abuser and his family to function well in the community. It is, therefore, understandable why the focus of treatment programmes is aimed at a holistic approach which bears in mind the spiritual, social, economic, psychological and physical dimensions of the patient.

Treatment programmes operating on the principle of holism widely accept that patients cannot be treated as isolated entities. Therefore, the help of communities and other support groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Alateen (a support group for teenagers whose parents are alcoholics).

The treatment offered by treatment facilities (residential and non-residential) are all geared towards achieving the following basic aims:

- **Changing behaviour**

Changing the behaviour is the ultimate aim of treatment programmes. The drug taking behaviour of the patient is a high priority because this often determines how successful the programme is. However, Roper and Bartlett (1991:67) make it clear that perfection should not be expected. Often patients who are abstaining are seen as well and those who are still using substance as ill. This view is too rigid because there are various degrees of substance use (abuse). For example, some heavy drinkers who were in treatment often drink less and some of them might cope with it for a number of years.

- **Modifying knowledge**

Treatment programmes provide information on the consequences of drug abuse and a whole range of educational information. The aim is to enhance patients' skills so that they can cope in environments where drugs are freely available.

Treatment centres often follow the Piaget (also known as the cognitive approach) when providing drug information. Craig (1976:387) points out that the cognitive theorists believe that the individual must have the ability to make rational judgements about what is right. Often patients are discharged from treatment due to a "lack of insight". In simple terms, it means that the patient, because of a low intelligence level, cannot internalise the information.

Young people often do not make a success of their treatment. This is because their intellectual abilities have not developed fully and, therefore, according to the researcher, they lack the ability to consider all the

consequences or implications. It is not strange to hear young people say that they tried drugs for fun, to relax, sleep and to gain courage.

- **Changing attitude**

All treatment programmes recognise the indigenous strengths and knowledge of patients. Within the treatment programme an attempt is made to change patients' attitudes so that they can have a different perspective of drug abuse. Patients' attitudes towards drugs are usually influenced by the media, communities, parents, etc.

Most of the goals of treatment programmes centre around providing information, education, coping skills, enhancing patients skills to deal with environments where drugs are used and dealing with relapses.

There are various treatment programmes aimed at the needs of drug dependents. It needs to be mentioned that most of the philosophies of treatment programmes are in line with the principles as set out in the National Substance Abuse Strategy on the White Paper for Welfare (1995).

The above is a brief summary of the goals of treatment programmes. Here-under are the overall objectives of treatment programmes for substance dependents:

- To optimally restore the patient's physical and mental health.

- To help the patient realise that treatment addiction can be treated.

- To help the person determine what factors led to his/her dependence.

- To help the patient develop insight into his/her drug problem.

- To help the patient find alternatives for the use of dependence producing substances.

- To prepare the patient for his re-integration into the community.

These objectives focus mainly on the psychological and physical complications which drug abuse causes. The alcoholic (substance abuser), according to Roper and Bartlett (1991:37), because of his behaviour, relies heavily upon defence mechanisms. The psychological defence mechanisms which substance abusers use are the following, i.e. denial, repression, projection and rationalisation.

The physical complications of substance abuse are the following: malnutrition, brain damage, hypertension and hormonal abnormalities. When treating children and adolescents these objectives will be utilised in a child-friendly manner and in the language of the child or adolescent.

4.3 TREATMENT PROGRAMMES FOR ADULTS

After the first democratic election in April 1994, South Africa was divided into nine provinces. Some provinces had the advantage that there were many treatment centres in their region. Others had to rely on the resources of neighbouring provinces. The task was given to the provincial governments to make special financial provision for combating alcohol and drug abuse, establishing treatment centres and launching prevention strategies. It is a fact that most provinces due to financial constraints could not support organisations who wanted to establish treatment centres.

Due to the scarcity of resources in some provinces a decision was taken on a national level that provinces should share each other's resources.

The Prevention and Treatment of Drug Dependency Act, 1992 (Act 20 of 1992) sets out most of the guidelines for the functioning and establishing of treatment centres. Out of this act the Drug Advisory Board was formed which has to advise the Minister on issues pertaining to alcohol and drug dependency. Note: Section 9 of the above Act was amended so that it could be in line with the National Drug Master Plan. The Central Drug Authority is now the body advising the Minister.

Treatment centres have their own methodological approach and each claims that their treatment programme is unique. However, there are basic components of treatment which are found in all treatment programmes.

Adults can receive treatment in an out-patient (non-residential) or in-patient facility (residential). It is important that accurate assessment of the patients and his family and his problem is done if treatment is to be effective. A social worker or any other referring agent (i.e. psychologist) can do the assessment.

4.3.1 In-Patient Treatment for Adults

In the Cape Metropolitan Area there are several treatment centres providing in-patient treatment, for example, De Novo-, Hesketh King-, and Ramot Treatment Centre. There are many treatment centres emerging, especially in the Southern Cape region, as drug abuse is increasing in this area. According to Foster et al (1997:301), in 1992 72% of the domestic violence in the rural areas in the South-Western Cape was estimated to be alcohol-related. This explains the reason why treatment centres are emerging in this area.

An adult in an in-patient facility can expect the following basic treatment:

- **Medical treatment**

All patients in a treatment centre have the basic right to medical treatment. On admission all patients undergo a medical examination and are placed in a sick bay area. Here patients will spend an average of five days depending on their health condition. If the health condition of a patient deteriorates, the patient will be sent to a nearby provincial hospital or medical facility, as most medical aid societies refuse to cover the costs incurred for the treatment of substance dependence.

During the medical treatment process patients receive vitamins and follow a balanced diet. This is to build up their body strength and help them over come the urge for drugs.

The majority of substance abusers go through withdrawal phases and sometimes urgently need to be detoxified. Some treatment centres provide a basic detoxification service which is aimed at stopping convulsions and other serious symptoms during withdrawal. An oral dose of medication is given i.e. valiums (diazepam), ativan (lorazepam) etc. N.B. each treatment centre often uses a different detoxification method. According to Roper & Bartlett (1991:60), clinicians throughout the world have not reached agreement upon standard detoxification regimens.

- **Social work services**

Social work forms one of the main disciplines in the treatment against drug abuse. Skidmore and Thackeray (1976:243) state that social workers in traditional settings often find it difficult to accept as a client someone using drugs. This is because drug abusers are difficult to handle and social

workers lack the skills of handling difficult situations. Therefore, social workers need to engage in further professional training to develop their skills to deal with drug abusers.

No one method of treatment is successful with all patients, however, for Sheafer et al (1994:48) social workers can select a framework. The latter should be consistent with social work values and allow the social worker to address critical issues in the patient's treatment programme. Some of these issues relate to the personal and environmental factors, building the patient's strengths, encourage the patient to use natural support networks and helping the patient making decisions. Within the treatment set-up individual (casework) and group counselling methods are used in an effort to help patients understand their problems and develop insight. In these counselling sessions the aim is to create an awareness, understand emotions, develop inner strength and skills in dealing with substance abuse problems as well as striving for a healthy lifestyle without drugs. In these interviews family therapy is also utilised to help family members as well as the drug abuser deal with important drug related issues i.e. dealing with relapses. Therapeutic videos are also shown to patients and discussed in group- or individual sessions

- **Pastoral treatment**

Prior to 1994 treatment centres following a particular religious-based treatment programme, could deny patients access to their programme. Section 15 of the Constitution of the Republic of South Africa (1996) states that everyone has the right to freedom of conscience, religion, thought, belief and opinion. This means that no treatment centre could turn patients away because of their religion.

Treatment centres nowadays realise the importance of religion in their treatment programme and employ pastoral counsellors who help patients deal with religious issues. Treatment centres embrace all types of religion and patients are allowed the freedom to engage in religious activities within the centre and in the community.

Pastoral counsellors (especially those who are not employed by the treatment centre) usually visit patients during the week and weekends. Pastoral counselling is aimed at restoring patients' faith, moral systems, ego-strengths and helping them accept responsibilities for their lives.

- **Psychological treatment**

According to Dunselman (1993:255), the addict is imprisoned in his own world, which is totally dependent on his addiction. This psychological imprisonment used by the addict leads to confrontation and he increasingly become isolated from his environment (friends, parents, community). The psychological aspects of treatment focus on the inner thoughts and feelings of patients, and in trying to do this, an attempt is launched to change their behaviour. Sheafer et al (1994:62) sees this as Perlman's problem-solving approach which is built around the ego of the person. In the treatment programme, psychologists with the aid of various therapists try to help patients achieve the following goals such as to reduce their substance abuse, improve their psychological, social and economic status.

Patients who present severe personality disorders are referred to psychiatric hospitals. In therapeutic group sessions patients are empowered to deal with their emotions, fears, low self-esteem and develop a positive image which helps them in their fight against substance abuse.

- **Work therapy**

Substance abuse has a negative affect on the business community through absenteeism, increased use of medical benefits, injuries and compensation claims. Foster et al (1997:302) mention that a study of sick leave patterns among workers in a sawmill in Tstitsikamma area found that 17% of sick days were alcohol-related.

The majority of drug abusers entering treatment are unemployed and sometimes homeless. Treatment centres, therefore, provide various work activities such as gardening, carpentry and cane work. The aim of these activities is to create an awareness of the importance of work, keep patients active and take their minds off drugs.

Treatment centres realise the importance of work and, therefore, engage their patients in work training courses offered by the Department of Labour. Some patients who have completed these courses, do after release find suitable employment.

- **Recreational treatment**

The Department of Welfare (1994:21) states in its working conference that recreation facilities must be accessible and that recreation programmes must be suitable for all age groups. On the contrary, patients in treatment centres come from disadvantaged communities where there are no recreation facilities. It is not common to hear patients blaming boredom and the lack of recreation as reasons for using substances.

In treatment, patients are taught that there should be a healthy balance between work and recreation. Patients are encouraged to do hobbies in their spare time. Items such as photo-frames, dolls and clothes are made.

There are also regular sporting events where patients, their family and other community members mingle. Treatment centres also have indoor games such as table tennis, darts, volleyball and various other activities to help the patient relax. It should also be mentioned that some treatment centres, due to financial constraints, can only afford to engage their patients in limited recreational activities.

- **Community treatment programmes**

Treatment programmes depend on the involvement of community-based organisations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Treatment centres rely heavily on these organisations to promote their programmes and to make sure it is a success amongst public members. Members of AA, Alcoholics Victorious, NA, anti-drug movements, recovering addicts are all involved in this community treatment. These people, organisations and individuals share their expertise, skills and knowledge with patients. This interaction between patients and communities is very effective because patients can identify with them. Patients are sometimes also allowed to visit some of these organisations and recommended to join them after their release.

In the Social Work Journal (August 1993, p. 26), Van Rooyen and Sewpaul emphasised that social work educators should take the necessary action to ensure that they are equipped to provide the necessary AIDS-related education. Within the past few years there have been a tremendous focus on AIDS.

When treatment centres were confronted with AIDS-related problems, not only did they provide their staff with AIDS training, but decided to join forces with organisations promoting AIDS awareness. Nowadays treatment

personnel, together with patients who have HIV/AIDS, present programmes to schools on the consequences of sex under the influence of alcohol and HIV/AIDS issues.

4.3.2 Out-Patient Treatment for Adults

An out-patient treatment programme has the advantage that patients are kept in their normal environment while they receive treatment. Other advantages include (i) that patients who are employed, can continue with their jobs and most importantly, it is less expensive than residential care.

South Africa with its limited residential care for addicts, realises the important of out-patient treatment facilities. The National Department of Welfare, Pretoria has compiled a Draft Document for a Community Based Model for Substance Abusers which is currently being discussed by all relevant role-players. This draft document emphasises community-based treatment as an alternative to in-patient treatment.

Non-residential facilities operate at least 5 days per week and provide approximately 4 hours of counselling per day. Here are a few out-patient facilities in the Cape Metropolitan area i.e. Cape Town Drug Counselling Centre, Hottentots Holland Drug Centre, Stikland Hospital Drug Unit and SANCA with its alcohol and drug centres in Mitchells Plain, Grassy Park and Cape Town.

The out-patient treatment programmes vary in scope of services provided. A patient can expect the following treatment services at an out-patient treatment centre: (Note: the information hereunder was taken from brochures received from the out-patient facilities.)

- **Group or individual counselling**

Group or individual counselling sessions are executed by psychologists, social workers and psychiatrists. These group sessions deal with the psychological causes of addiction and attempt to change the character and personality of the addict.

The out-patient facilities utilise recovering addicts (also called substance abuse counsellors) in their group and individual sessions. According to them it is proven that these counsellors have made a major contribution in helping patients achieve sobriety. This trend is used worldwide and has so far been a success.

Besides providing information in the counselling sessions, patients are also taught to recognise their defence mechanisms and learn to deal with them. The diagnosis of patients is formed on the basis of how patients plan and think through their problems. According to Craig (1976:36), this is a cognitive approach.

- **Vocational and social counselling**

Patients attend vocational training classes while dealing with their problems of sobriety. Those patients who are employed also benefit from these classes and learn to appreciate their jobs. Social counselling aims to enable the patients to develop their skills and learn to cope with their social situation. In the group discussions patients are asked to perform certain tasks and later report back to the group about their experience.

- **Family counselling**

It is said that one addict affects about 16 people. The people immediately affected are the family members. The aims of family therapy are to educate, repair and improve relationships and communication. Turner (1986:281) emphasises that tasks within the sessions should involve family members in face-to-face problem-solving efforts which are facilitated by the practitioner. The latter must help family members improve their skills in problem-solving communication. Role-play and live family enactments are used in these sessions.

The aim of family counselling is to equip families with skills which will help them deal with the addict's problem and avoid blaming themselves when the patient experiences a relapse.

- **Education and training**

This includes education of the patient and family about drug abuse as a disease, it also includes parent effectiveness training and other training to enhance personal behaviour in specific areas (i.e. assertiveness training).

- **Medical treatment**

According to Foster et al (1997:300), a study of assault and vehicular injuries at the Tygerberg Hospital Trauma Unit found that 67% of the patients had blood alcohol concentrations in excess of 0.08g/100ml. These patients often, due to pressure from family members and employers, contact out-patient facilities for help.

The out-patient facilities do not have the necessary resources and, therefore, refer patients with serious medical problems to hospitals or nearby

medical facilities. However, there are out-patient facilities that, through the sponsorship of companies, are able to utilise acupuncturists and physiotherapists.

Some treatment centres use acupuncture to relieve withdrawal symptoms.

- **Relaxation treatment**

Most substance abusers hardly ever think of relaxing. Drugging is sometimes seen as part of their relaxation. Out-patient facilities provide basic relaxation treatment in an effort to steer the addict away from drugs.

In out-patient treatment centres relaxation treatment may include self-hypnosis, meditation of different types, exercise classes and desensitisation techniques. The goal here is to help the patient relieve muscle tension, insomnia, anxiety and other psycho/physiological problems associated with early phases of return to sobriety. Out-patient facilities, due to a lack of personnel, depend heavily on community members to deliver relaxation treatment to patients. These community members are volunteers, but committed to their tasks.

- **Self-help programmes**

Self-help programmes are a new approach and can be considered as an important part of the treatment plan in both residential and out-patient settings. De Miranda (1994:35) emphasises that communities should take a firm stand on alcohol and drug-related matters, that they should form committees, and that community leaders work out a policy for their area.

Communities through the help of community developers and non-governmental agencies, have already developed several self-help

programmes. These programmes play a pivotal role in educating addicts and their family members, as well as community members, about drugs and other related diseases.

The goal of these self-help programmes is to return the patients to abstinence and help them retake control over their lives. There are a wide range of programmes addressing all types of addictions i.e. Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous and Co-dependents Anonymous.

The principle features of these self-help programmes are voluntary confessions, mutual support, anonymity, confidentiality and a spirit of fellowship. There is a great need for more community involvement in these programmes to ensure the minimising effect of drugs and other related problems in communities. Currently business organisations, due to the risk involved, i.e. attacks from gangster, are reluctant when it comes to sponsoring projects in disadvantaged areas.

4.4 TREATMENT PROGRAMMES FOR YOUTH WITH DRUG DEPENDENCY PROBLEMS

The question is often asked when do young people start using drugs and what type of drugs? Ziervogel (1986:47) found that adolescents, while establishing an identity, engage in drug experimentation. This is true because many young people due to peer pressure to experiment with drugs. According to Foster et al (1997:296), studies done amongst 340 high school pupils by the Medical Research Council (MRC) and the University of Cape Town, indicated that drugs commonly used are alcohol, dagga and solvents. As they get older, these pupils move later on to harder drugs.

Currently there is the tendency amongst especially the youth to attend "rave" (music) functions where especially the drug ecstasy is used. According to studies done, ecstasy was becoming more popular, and there are numerous variations of the drug on the market (Parry & Bhana, 1997:49). These studies were done in the Cape Metropolitan Area where ecstasy was known as the "new generation drug" amongst teenagers.

The types of drugs young people use all depend on the social circumstances, social attitudes and availability. On this issue Gumede (1995:82) points out that alcoholic beverages have traditionally been a taboo activity for African adolescents, the only exception was at the end of circumcision ceremonies where it served as a sign or belonging to the group. (In this case the adult males.)

Foster et al (1997:292) mention that studies done among high-risk groups (especially youth) have shown an increase in drug use among urban and rural youth. The urban youth use a combination of alcohol, dagga and mandrax, while rural youth use mostly alcohol. The reason for this is that dagga and mandrax are less available for rural youth, while alcohol as a legal drug is available at shebeens and liquor outlets.

As mentioned earlier, the drug trade in the Western Cape is between R1-R2 billion per year. The drug lords have already drawn many young people to the drug industry and nowadays more young people are involved. In the process they become addicted and need treatment. Youth with dependency problems can be treated within in-patient or out-patient settings. The latter is an option that most people prefer because while young people are treated, they remain within their community.

4.4.1 Out-Patient Treatment for Youth with Drug Dependency Problems

These treatment programmes are primarily prevention programmes aimed at addressing the specific needs of the youth, in the process recognising the rights of children. There are centres such as Cape Town Drug Counselling, Hottentots Holland Centre and various SANCA alcohol and drug centres located within the Cape Metropolitan region.

The treatment programme components for young people are besides minor changes, the same as that of the adults. Young people can expect the following treatment at out-patient facilities:

- **Group or individual counselling**

The needs of young drug abusers differ from that of adults. Counselling is more concentrated on group-orientated treatment activities. Counsellors focus on developing young drug abusers social-competency skills and helping them deal with peer pressure. Positive peer relationships are also enhanced in such a way that young drug abusers can refuse drug offers.

The worker should, through techniques of confrontation, help the group (or individual) accept responsibilities for their attitudes and behaviour. In doing so, common interest is pursued and the individuals/group will understand their functioning in the social environment.

For those who are still attending school, the focus is also on the school environment. The aim here is to strengthen student bonding and enhance academic performance.

- **Group therapy**

In-depth group therapy sessions are done with young drug abusers and their peers, as well as their family. During therapeutic sessions the young drug abusers, parents and family members are taught skills which will better their communication, help them develop discipline and understand their problems. The group worker helps the group concentrate on issues relating to the reality, by doing so the focus is also on the defence mechanisms of the group.

- **Multiple educational activities**

This can include educational videos where young drug abusers learn about drug related and youth development issues. Real life scenarios are sometimes also enacted. Discussions are also focused on case studies, values and attitudes towards a healthy lifestyle.

There are also workshops where both parents and children participate and learn a wide range of personal and social skills.

- **Recreation and leisure activities**

Educating young people about the negative effects of drugs is good, but it is also important to help them utilise their leisure time positively. Young people who are engaged in positive recreation and leisure activities are usually well adjusted. Young drug abusers are introduced to a wide range of activities that can help take their minds of drugging.

- **Medical and psychiatric treatment**

Patients are medically and psychiatrically assessed. The aims here are to improve health, determine the patient's educational needs, help reduce the criminal behaviour and treat psychiatric disorders and psychological problems. If the latter are serious, patients will be referred to a psychiatric hospital.

- **Vocational counselling**

Vocational assessment helps determine if young drug abusers are ready to enter the labour market. Some already have jobs and to those some vocational counselling is given. In the Western Cape Province, especially unemployed young people, are attracted to the drug industry by drug dealers. Young adulthood is a difficult development stage of life and program planners realise that new innovative ideas will have to be implemented.

According to the past Director of Cape Town Drug Counselling Centre, Mr Scott Lindsay (interview on 9 July 1998) it is only now that treatment centres realise the tremendous challenges that lie in treating young people with addiction problems. The mentioned centre is one of the leading role-players treating young drug abusers. They have a schools drug awareness programme. This programme is community based and involves both schools and communities. The key components of the programme consist of:

(i) **A teachers training course:** Teachers, children as well as staff of the centre are involved in this course. Workshops in participative training geared towards drug education needs are conducted.

(ii) **Pupils workshops:** Pupils from the age of 10 - 14 years are engaged in these workshops. Guidance teachers co-facilitate the workshops and the aim is to create drug awareness among this target group. Each teacher uses a drug awareness workbook.

(iii) **Parents introductory workshop:** This programme focuses on the parents of the children who are involved in the treatment programme.

(iv) **Educational videos:** Drug related information is presented in an effort to empower children to resist drugs.

Each programme co-ordinator will after the treatment programme continue to liaise with a school and provide professional support for a period of six months. This follow-up support is pivotal because many treatment programmes for young people are done on a once-off basis and no follow-up proceeds thereafter.

4.4.2 In-Patient Treatment Programmes for Youth With Dependency Problems

As mentioned earlier the South African government started focusing on prevention programmes as a solution to the problem of drug abuse amongst the youth. Besides prevention it is also necessary to provide in-patient treatment for young people.

Morojele (1997:227) emphasises that treatment is necessary for a minority of adolescents who abuse alcohol and/or develop a dependence on alcohol. These individuals seem to differ from most adolescent drinkers, in that they tend to use alcohol or drugs, to deal with social and emotional problems.

There are in-patient treatment centres who do accept young people from 16 years for treatment. These young people when admitted receive basically the same treatment as the adult patients.

In the Cape Metropolitan region as well as in the Western Cape Province, there is no in-patient treatment centre catering specially for the needs of young people. Currently (1997) Magaliesoord Treatment Centre situated in Cullinan, Gauteng Province, is the only state institution catering for youth (16 years and older) with dependency problems.

The Department of Social Services has decided to pilot a juvenile treatment programme. The De Novo Treatment Centre has been identified as the venue where juveniles will be treated. Certain sections of the building have been renovated to make them child friendly.

4.5 MOTIVATION FOR OPENING A JUVENILE TREATMENT CENTRE

Statistics that the Department of Social Services (Western Cape) received from the South African Police, indicated that approximately 40 young people are arrested each month in the Western Cape Province for drug-related criminal offences. Some of these young offenders are suitable candidates for a drug treatment programme. The motivation for this treatment lies in the fact that no in-patient treatment facility exists for young people. By treating young people with drug dependency problems they are given a chance in life to better their lives.

4.5.1 Target Groups

Morojele (1997:210) reports that ninety per cent of adolescent drinkers have their first drink by the age of 14 years, the others reported drinking before

the age of 10 years. The Department of Social Services, therefore, decided to target young people between 12 and 17 years of age.

In the report of the International Seminar on "Children in Trouble with the Law" (1993:27), it was reported that a great majority of children picked up by the police were under the influence of substances such as glue, benzine or alcohol. These children needed some sort of treatment, but instead they were tortured, abused and beaten by police. These children lived in the streets and were seen by the police as "small criminals" in the making. The Department of Social Services, therefore, made it clear that this treatment centre will be child-friendly and the rights of the child protected.

4.5.2 Procedure and Treatment Period

The treatment period will be three weeks. Young people who come in conflict with the law due to their drug-related crimes, will be diverted from the court's procedures by the prosecutors. This is where the prosecutors of the Department of Justice play an important role. They will have to liaise with the treatment centre, and should the juvenile not complete the treatment, alternative sentences will have to be enforced.

Juveniles will only be accepted after an in-depth assessment by a psychiatrist and a medical doctor.

4.5.3 Goals of the Treatment Programme

According to the Department of Social Services the broad goals of this treatment programme are:

- To help young people who come into conflict with the law due to drug related crimes.

- To fulfil a much-needed gap in the in-patient treatment of young people with serious drug problems who cannot afford to pay for treatment.

- To provide an alternative sentencing option to the courts in dealing with young offenders.

- To render a specialised and professional service to the youth with a dependency problem.

4.5.4 Treatment Components of the Juvenile Treatment Programme

According to Morojele (1997:227), the treatment of adolescents should consist of group and individual therapy, counselling, social skills training, educational components, occupational therapy and sessions of relaxation and meditation. The juvenile treatment and programme contains some of the above methods and is in line with the modern concept of treatment.

The young person who enters this treatment programme, will undoubtedly be exposed to a wide range of treatment methods and activities. To the young person some of these methods and activities might be helpful or merely interesting.

The treatment programme comprises of the following:

- **Drug education**

In this treatment programme drug education includes information on the effects of drugs on a physical, psychological and social level. The aim is to provide information, empowerment and help the young person make informed choices. In the group sessions the basic rules of the treatment

centre are explained, and the young people can then relay their expectations regarding treatment. During the drug information sessions videos are shown and drug related issues discussed. Through drug counselling it is hoped to achieve goals such as enhancing coping skills, improving relationships, facilitating the client's potential and promoting decision-making.

The Advisory Council on the Misuse of Drugs (1993:7) define drug education as education about illegal drugs, misuse of medicinal products, volatile substances (this includes gases and solvents such as glue).

- **Medical treatment**

An in-depth medical assessment of each young person by a medical doctor and a psychiatrist is conducted before admission occurs. In the treatment centre the young persons will receive all the necessary medical treatment.

- **Therapeutic activities**

This includes group-, individual- and family therapy. The purpose is to empower the young person and to help with his/her reintegration into the family and community. There will also be vocational as well as life skills group counselling.

- **Recreational activities**

Young people will partake in sport activities at the treatment centre as well as outside the centre. Activities such as physical exercises, games etc. will be presented.

- **Pastoral treatment**

This will be done in line with the young persons sense of religion. Care workers as wel as pastoral counsellors will be responsible for the young persons religious needs. In the programme therapeutic group counselling will be done so that young people can learn more about one another's religion.

- **Community treatment programme**

It is vital that the young person maintains contact with the world outside the treatment centre. It is here where individuals and organisations play a pivotal role. Lectures and life skill training will be given by organisations or individuals. There will also be a parent programme co-ordinated by care workers, social workers and other staff. Young drug abusers will not only have contact with their own parents, but also adults and parents from other communities. Parent events will be organised and lectures given to young drug abusers and their parents.

In summary there seems to be sufficient treatment programmes for adults. It was only during the 1990's that the harsh realities dawned on all South Africans - the fact that young people are becoming increasingly addicted to drugs. The government has in combating drug among young people, focused on prevention programmes.

However, it is clear that young people also need in-patient treatment, which will suit their special needs. The Department of Social Services has committed itself to piloting an in-patient programme for juveniles. This comes at a time when there is a dire need for in-patient treatment for young people. Note: The treatment programme was launched in September 1999.

CHAPTER 5

FIELD RESEARCH AND DISCUSSION

5.1 RESEARCH METHODOLOGY

The main purpose of this research was to describe the implementation of the TADA programme and, therefore, the exploratory and descriptive research methodology was used. Grinnel (1988:229) states that all research contains four essential ingredients which are: manipulation of the independent variable, random sampling, random assignment and control over intervening variables. The author also mentions that the second main category of research designs is the descriptive designs, sometimes referred to as the quasi-experimental designs.

There are 13 schools where the TADA programme is still implemented. Six schools were randomly selected. Open- and close ended questionnaires were provided to class teachers. The latter were all involved in the TADA programme.

The questionnaires contained questions relating to the TADA programme, i.e. when it was started, by whom, students' reasons for joining, reasons for students leaving and problems TADA students experience.

The class teachers were instructed to provide the questionnaires to TADA members and non-TADA members and ensure that students complete it. After completion the questionnaires were given to the class teachers and they returned it to the researcher.

In total 120 questionnaires were completed by 60 TADA students and 60 non-TADA students. According to Grinnell (1988:74) we must never discuss

research details informally with family, friends, colleagues or representatives from the media.

The researcher therefore made it clear to students that the information given was confidential. The co-operation of the 6 schools was excellent and all 120 questionnaires were completed.

5.2 RESEARCH FINDINGS

The main objective of this research was to describe the TADA programme and determine how it is implemented at high schools. Two separate questionnaires were used, one for TADA members and one for the control group (non-TADA members). The data emanating from the two questionnaires was analysed separately. Hereunder are the findings based on responses from TADA members.

TABLE 4.1: RESPONSES FROM TADA MEMBERS ON HOW THEY BECAME AWARE OF TADA

RESPONSES	NO. OF TADA MEMBERS	%
THROUGH A TADA MEMBER/ GROUP	25	41.7
TEACHER	14	23.3
FRIENDS	19	31.7
OTHER	2	3.3
TOTAL	60	100

When asked how they became aware of TADA, TADA members replied as above. A total of 25 TADA members indicated that they became aware through TADA members/or groups. This is a worrying factor because in

most of these schools the TADA programme has been functioning for more than 5 years. (See Table 4.2 for when the programme was started.)

In all the schools where the TADA programme is implemented a teacher is involved. The expected result should then be that more students would have been made aware by teachers. However, 14 of the TADA members became aware of TADA through teachers. Nineteen of the TADA members became aware through friends. These friends were not only school friends, but also friends in their communities. It was further found that 2 of the TADA members became aware through "other". The latter was named as SANCA.

These findings indicate that SANCA, as a controlling body, besides initiating the TADA programmes, did not do adequate follow-up and backing. In its report "Drug Education in Schools" (1993:21) the Advisory Council on the Misuse of Drugs states that organisations providing prevention programmes should encourage active pupil participation and back it up with adequate teacher supervision, regular visits to maximise the effectiveness and advise pupils/teachers on how to handle problems in the programme. If this was done, then the majority of TADA members would have been made aware through SANCA.

TABLE 4.2: RESPONSES TO THE YEAR IN WHICH TADA WAS STARTED IN SCHOOLS

RESPONSES	NO. OF TADA MEMBERS	%
1997	0	0
1996	2	3
1995	31	52
1994	7	12
1993	4	7
1992	0	0
1991	0	0
1990	6	10
APPROXIMATELY 10 YEARS AGO	10	16
TOTAL	60	100

The majority of TADA members, which is 31 in total, recalled that TADA started in their schools in 1995. A total of 10 believe the programme started about 10 years ago, the third largest total of 7 said in 1994, and the other group consisting of 6 indicated in 1990. The minority of 4 and 2 were of the opinion that the programme started respectively in 1993 and 1996. From the above information it seems clear that TADA programmes started in 1995.

TABLE 4.3: RESPONSES FROM TADA MEMBERS REGARDING WHO STARTED THE PROGRAMME IN THEIR SCHOOL

RESPONSES	NO. OF STUDENTS	%
TADA MEMBER/STUDENT	16	26.7
TEACHER	15	25
OTHER [SANCA]	29	48.3
TOTAL	60	100

Table 4.3 indicates that the majority of TADA programmes were started by officials of SANCA. This programme is run by SANCA and it is, therefore, no surprise that the large majority of 29 indicated that the programmes were started by that organisation. Respectively, 16 and 15 indicated that TADA members and teachers were responsible for starting the programme in their schools. Students and teachers can, with the permission of the principal, start a TADA group.

TABLE 4.4: REASONS FOR JOINING TADA

RESPONSES	NO. OF STUDENTS	%
TO MEET NEW FRIENDS	4	7
TO LEARN MORE ABOUT DRUGS	4	7
TO LEARN HOW TO FIGHT DRUGS AND HELP OTHERS	50	83
OTHER	2	3
TOTAL	60	100

Table 4.4 indicates that 50 of TADA members join in an effort to learn how to fight drugs and help others. Two indicated under "other" that they were unsure about their reasons for joining. Of the remaining students 4 wanted to meet new friends and the other 4 to learn more about drugs. The results prove that the majority of students join TADA in an effort to solve or help others with their drug problems.

TABLE 4.5: NUMBER OF TADA STUDENTS IN SCHOOL

RESPONSES	NO. OF TADA MEMBERS	%
UNSURE	15	25
1 - 10	5	8.3
11 - 20	31	51.6
21 - 30	4	6.7
31 - 40	0	0
41 - 50	1	1.7
51 - 60	4	6.7
51 - 70	0	0
TOTAL	60	100

The above table indicates that the number of TADA students range from 11 - 20. Thirty-one of the TADA members confirmed the latter, Fifteen TADA members were unsure about how many TADA students were in their schools. As expected in most schools, the total number of TADA students range from 11-20. Most of these schools have a high number of students

(from 500 - 1500), therefore one would expect more students to join as drug problems were prevalent in their schools.

TABLE 4.6: RESPONSES TO THE DECREASE/INCREASE IN TADA MEMBERS

RESPONSES	NO. OF STUDENTS	%
DECREASE	54	90
INCREASE	3	5
UNSURE	3	5
TOTAL	60	100

The data in this table clearly indicates that the TADA membership has decreased. The reasons given by students (in no specific order) were as follows:

- No innovative programme activities.
- Students find TADA boring/dull.
- Lack of commitment from TADA members.
- Apathy of students.
- No strategies to mobilise or encourage students to join.
- Active TADA members leaving school and no replacement being found.
- Lack of some form of guidance/training for TADA members.
- Lack of support from teachers.
- Ridicule of TADA members by teachers and students.

As indicated in the above table there is a drastic decrease in membership, which seriously impacts on the programme. Analysing the above reasons it seems clear that members are not dedicated and do not enjoy being part of TADA. The lack of activities, commitment, ridicule by teachers and students, apathy, lack of training/guidance, has rendered this programme ineffective.

The increase of 3 in the membership was only prevalent in one school where there were a few dedicated TADA members. The 3 TADA members who indicated that they were unsure were from two schools.

De Vos (1998:389), states that when analysing the identified problems one should ask: "What conditions need to change to establish or support needed change? At what level should the problem be addressed?". From Table 4.6 it can thus be said that by analysing the large decrease in membership, that something seriously is wrong with the implementation of the programme.

More specifically what changes need to be effected in order for students to support the programme and make it effective within schools and the broader community.

TABLE 4.7: REASONS FOR TADA MEMBERS LEAVING

RESPONSES	NO. OF TADA MEMBERS	%
YES	50	83
NO	7	12
UNSURE	3	5
TOTAL	60	100

A total of 50 students indicated that members left TADA. Some of the explanations were that they found it boring, uninteresting, members started fading out and that there was a lack of seriousness.

Respectively, 7 and 3 of the TADA members replied "no" and others were unsure. As expected, members are leaving in huge numbers. This programme clearly needs support.

TABLE 4.8: EXTENSION OF TADA PROGRAMMES TO SCHOOLS

RESPONSES	NO. OF TADA MEMBERS	%
YES	55	91.7
NO	0	0
UNSURE	5	8.3
TOTAL	60	100

As shown in this table a large number of TADA members responded positively to extending this programme to other schools. Only 5 were unsure. It is therefore quite clear that students would like the TADA programme to be extended to more schools.

Foster et al (1997:299) quoted the Western Cape MEC for Police as stating in 1996 that there were more than 80,000 gangsters in the province, many of whom were involved in the drug trade. Bearing this in mind and the fact that most of the pupils come from disadvantaged areas, it stands to reason that they would like this programme to be extended to more schools. However, the fact is that TADA membership is decreasing as shown in Table 4.6.

TABLE 4.9: TADA MEMBERS' RESPONSES TO THE PROBLEMS THAT TADA EXPERIENCE

RESPONSES	NO. OF TADA MEMBERS	%
LACK OF LEADERSHIP	12	20
DECREASE IN NUMBERS	35	58
RIDICULE FROM STUDENTS/TEACHERS	6	10
OTHER	7	12
TOTAL	60	100

A majority of 35 students saw the decrease in student numbers as a major problem. The decrease in numbers could perhaps be one of the reasons why TADA groups find it difficult to organise meetings. The lack of leadership and ridicule by students/teachers indicate that these problems were perhaps not seen as serious by TADA members. However, it does exist, and has an influence on the programme. Only 7 TADA members were unsure.

TABLE 4.10: TADA MEMBERS' RESPONSES TO MEETING TIMES

RESPONSES	NO. OF TADA MEMBERS	%
ONCE PER WEEK	25	42
ONCE EVERY SECOND WEEK	4	6.6
UNSURE	11	18.3
ONCE A MONTH	5	8.2
ONCE PER QUARTER	12	2.0
ONCE PER YEAR	1	1.6
OTHER	2	3.3
TOTAL	60	100

In the above table 25 of the TADA members indicated that meetings were held once a week. A total of 12 members indicated that meetings take place once a quarter. According to SANCA, meetings should take place once a month to keep TADA students up to date with developments. A total of 11 members were unsure. The findings clearly indicate that there is no majority consensus on when meetings should take place.

TABLE 4.11: INVOLVEMENT OF TEACHERS

RESPONSE	NO. OF STUDENTS	%
YES	57	95
NO	3	5
TOTAL	60	100

In the above table 57 of TADA members responded positively to more teacher involvement in an effort to make the programme more effective. Only 3 said no which is perhaps an indication that this group wanted the minimum involvement of teachers. The TADA programme is currently run exclusively by students, with a minimum involvement of teachers.

The conclusion is that the TADA members' response to the involvement of teachers indicate that this programme has lost its members, and perhaps with the help of teachers more members could be recruited. The positive reaction for more teacher involvement could perhaps be linked with the idea of the more teachers involved, the more accepted the programme will be by teachers and students.

TABLE 4.12: TADA STUDENTS' KNOWLEDGE OF DRUGS

RESPONSE	NO. OF STUDENTS	%
YES	24	40
NO	19	31.7
UNSURE	17	28.3
TOTAL	60	100

Both groups were asked whether they think that TADA students know enough about drugs to explain it to their fellow students. A large group of respondents (TADA members as well as non-TADA members) indicated that

students engaging in TADA activities are not familiar or knowledgeable about drugs.

For this purpose only the TADA members' responses will be discussed. From the above table 24 TADA members believe that students involved in TADA have some knowledge about drugs. Respectively, 19 and 17 TADA members responded "no" and "unsure".

Edmonds and Wilcocks (1994:6) state that adolescents are in the process of finding their own identity. They often are unsure and will assume the values and beliefs of their peer groups. This perhaps explain why the majority students responded negatively and unsure. Besides this, perhaps the criticism expressed by adults that TADA members do not know enough about drugs is proved right. To the defence of the students, it must be mentioned that little or no drug education is provided in schools.

TABLE 4.13: BIOGRAPHICAL DETAILS OF TADA MEMBERS

Gender	No. Of students	%	Average Age	Average School Grade	MAGISTERIAL DISTRICTS						
					Cape Town	Wynberg	Athlone	Mitchells Plain	Kuilsriver	Bellville	Goodwood
Female	53	88.3	16.7	10	13	9	9	16	5	1	
Male	7	11.7	13.4	10	2	1	1	2	1		

Both TADA members and non-TADA members were asked to provide the following information, i.e. age, gender, home area and grade.

In Table 4.13 the biographical details pertaining to the TADA members group was analysed in terms of the average age, average school grade, and the magisterial area from which TADA members came.

Before discussing Table 4.13, below follows an explanation of the areas which fall within these magisterial districts as indicated in the mentioned table.

1. Cape Town Magisterial District

The students came from the following areas that fall within this district i.e. Cape Town, Salt River and Woodstock.

2. Wynberg Magisterial District

In this district students came from areas such as Wynberg, Claremont, Wetton, Lansdowne, Hanover Park, Grassy Part, Lotus River, Ottery and Kenwyn.

3. Athlone Magisterial District

Areas such as Athlone, Belgravia and Crawford fall within this district.

4. Mitchells Plain Magisterial District

Strandfontein and the whole Mitchells Plain area fall within this district. It is interesting to note that the majority of students live in the magisterial district of Mitchells Plain. The explanation here is that some of the students attend schools outside the Mitchells Plain district while they live in the magisterial district of Mitchells Plain. This magisterial district is known for gangsterism

and drugs. Therefore students from this area who are aware of the dangers of drugs, will join a TADA group if there is one at their school.

5. Kuilsriver Magisterial District

Students from areas such as Kraaifontein, Northpine, Scottsdene and Eerste River fall within this district.

6. Bellville Magisterial District

Here there were only two students and they came from the Durbanville and Bellville-South areas which falls within this district.

7. Goodwood Magisterial District

There was only one student from Bonteheuwel and the latter falls within the above-mentioned district.

Table 4.13 shows that 53 of the TADA members were female and 7 male. This information is significant because it seems that female students, who are in the majority, take the initiative in establishing TADA groups and recruiting members.

The average grade of the TADA members is grade 10 which indicates that students from lower grades are less likely to be involved in the TADA programme.

The TADA programme targets students within the schools set-up and it is no surprise that the average age for females and male students fall beneath the age of seventeen. The female students are in the majority, therefore the average age of 16.7. On the other hand the male students are in the

minority and the average age of 13.4 indicates that younger male students tend to join TADA.

5.2.1 Reasons for Establishing the TADA Programme

This was one of three open-ended questions where TADA members had to express reasons why the programme was established. TADA members' responses on why the programme was established, varied and the most popular answer was to promote drug awareness. There were also responses of the following, i.e. to fight drugs, inform friends, combat drug problems at school, learn about drugs and educate students about drugs and drug-related problems.

5.2.2 Views on the TADA Programme

The majority of views from the TADA members reflected that the programme was uninterested and boring. Twenty-one students did not express their views. Only 3 students said the programme was good and that it promoted drug talks.

5.2.3 Types of Activities TADA Groups Engage in

The majority of TADA members reported that TADA groups engage mostly in drug awareness days (26 June – The International Day Against Drug Abuse and Illicit Trafficking and the Annual SANCA Awareness Week), film shows, plays and anti-smoking campaigns.

However, there were 15 students who responded that no TADA activities exist at their schools. From the majority responses it was clear that most activities were around awareness campaigns. These activities took place at

a certain time of the year. This in turn meant that TADA programme activities were minimum and was reported non-existent in some schools.

5.2.4 Suggestions to Gain More Support

The TADA members gave the following suggestions:

* Ongoing promotion campaigns to target non-TADA students.

* To involve dedicated and committed TADA students and teachers.

* Community outreach activities targeting not only schools but also groups.

* Innovative programme activities which focuses on a variety of issues. The latter could be teenage problems, aids, sexuality, crime, teenage pregnancies, woman abuse as well as a whole range of other social issues. This will attract students who would not otherwise have joined because they believe that TADA dealt with only drug related issues.

* Create more enrichment periods where TADA related activities can be discussed. In the manual of Teenex A Youth Drug Prevention Programme (1989:3) it is mentioned that this programme tries to tackle issues related to the youth such as curiosity, boredom, pleasure and peer pressure. By addressing these issues young people themselves are given the opportunity to come up with creative ideas for the programme.

A discussion on the information gained from non-TADA members follows next.

TABLE 4.14: RESPONSES FROM NON-TADA STUDENTS OF HOW THEY BECAME AWARE OF TADA

RESPONSES	NO. OF NON-TADA MEMBERS	%
THROUGH A TADA STUDENT/MEMBER	**25**	**41.7**
TEACHER	**13**	**21.7**
FRIENDS	**17**	**28.3**
OTHER	**5**	**8.3**
TOTAL	60	100

A total of 25 non-TADA members indicated that they became aware of TADA through TADA members or TADA groups. This proves that a large majority of non-TADA members are aware of TADA and that they do not join TADA.

However, 13 non-TADA members became aware through teachers. In all schools where the TADA programme is implemented a teacher is involved. The expected result should then be that more students would have been referred by teachers.

On the other hand, a large number (17 students) became aware through friends. In this case not only school friends, but also friends in their communities made them aware. Only 5 of the non-TADA members were made aware through SANCA.

Once again, the expected result would have been that more non-TADA members would have been made aware through SANCA. The latter is responsible for promoting the TADA programme and ensuring that students join the programme.

TABLE 4.15: NUMBER OF NON-TADA STUDENTS IN SCHOOL

RESPONSES	NO. OF TADA MEMBERS	%
UNSURE	34	56.8
1 – 10	8	13.3
11 – 20	11	18.3
21 – 30	5	8.3
31 – 40	0	0
41 – 50	0	0
51 – 60	2	3.3
61 – 70	0	0
TOTAL	60	100

A large majority of non-TADA members (34) were unsure and 11 indicated that there were between 11 - 20 TADA members in the school. Respectively, 5 and 2 non-TADA members indicated between 21-30 and 51-60.

See Table 4.5 where TADA members confirmed that the number of TADA students ranges from 11-20. These findings indicated that the majority of non-TADA members were unsure. This, in turn, shows the lack of support or knowledge of TADA amongst non-TADA members in schools.

TABLE 4.16: NON-TADA STUDENTS VIEWS OF THE TADA PROGRAMME

RESPONSES	NO. OF NON-TADA MEMBERS	%
IT CATERS ONLY FOR STUDENTS WITH DRUG PROBLEMS	**25**	**41.7**
TADA STUDENTS KNOW NOTHING ABOUT DRUGS	**9**	**15**
OTHER (EXPLAIN BRIEFLY)	**26**	**43.3**
TOTAL	60	100

The majority of non-TADA members (26) indicated under "other" their views as follows. Two did not comment and one did not know. The rest saw TADA as an informative group, a group which helps deal with peer pressure and drugs.

In total 25 non-TADA members saw TADA programme as catering only for students with drug problems. From this information it is clear that there is a stigma around the programme and therefore it is understandable why students do not want to join. They do not want to be seen as "druggies" or in simple language, students with drug problems. Only 9 students indicated that TADA students knew nothing about drugs.

TABLE 4.17: NON-TADA MEMBERS' RESPONSES TO ENCOURAGE STUDENTS TO JOIN TADA

RESPONSES	NO. OF TADA MEMBERS	%
YES	45	75
NO	1	2
UNSURE	14	23
TOTAL	60	140

From this table it is clear that 45 of the non-TADA members were in favour of encouraging students to join TADA. This positive reaction can perhaps be relayed to the fact that the majority of these students came from disadvantaged areas where drugs and drug-related problems exist and, therefore, demonstrating that a group like TADA needs support.

Respectively, 14 and 1 replied "unsure" and "no". The one non-TADA member who said no, explained that the TADA programme was dull and boring. Those who were unsure, is perhaps an indication of how some students felt towards TADA and therefore they could not align themselves with the programme.

TABLE 4.18: EXTENSION OF TADA PROGRAMMES TO SCHOOLS

RESPONSES	NO. OF NON-TADA MEMBERS	%
YES	56	93.3
NO	1	1.7
UNSURE	3	5
OTHER (EXPLAIN BRIEFLY)	0	0
TOTAL	60	100

In this table the majority responded positively to extending the TADA programme to other schools. One said no and three were unsure. It is therefore quite clear that non-TADA members, like TADA members (see Table 4.8), would like the programme to be extended to more schools.

TABLE 4.19: TADA STUDENTS' KNOWLEDGE ABOUT DRUGS

RESPONSES	NO. OF NON-TADA MEMBERS	%
YES	23	38.3
NO	14	23.4
UNSURE	23	38.3
TOTAL	60	100

The same question was asked to TADA members (see Table 4.12). Like the TADA members, a large number of non-TADA members believe that students involved in TADA have some knowledge about drugs. As in the case of TADA members, the majority non-TADA members responded negatively and unsure. These findings show that both groups responded similarly.

TABLE 4.20: NON-TADA MEMBERS' THOUGHTS OF THE TADA PROGRAMME

RESPONSES	NO. OF NON-TADA MEMBERS	%
NO COMMENT	23	38.3
GOOD	13	21.7
NO IMPACT	15	25
POOR	9	15
OTHER COMMENTS	0	0
TOTAL	60	100

The above table reveals that 23 of non-TADA students preferred not to comment on the TADA programme, while 15 thought it had no impact and 9 that it was poor. Only 13 of the non-TADA students indicated that the programme was good. These students came from schools where although minimum, TADA activities were still held.

These findings show that a total of 47 of the non-TADA members did not comment, or said that the programme was poor or had no impact. O'Connor (1998:156) mentions that peer group influences play a powerful role amongst young people and that it can influence results. This maybe explains why the majority of non-TADA members did not comment, in a way they tried to perhaps steer away from conflict or were just not interested. In conclusion, the TADA programme has a low profile in most of the schools. This might be one of the reasons why in some schools consisting of 1000 students, only between 20 or less are TADA members.

TABLE 4.21: BIOGRAPHICAL DETAILS OF NON-TADA MEMBERS

Gender	No. of students	%	Average Age	Average School Grade	MAGISTERIAL DISTRICTS						
					Cape Town	Wynberg	Athlone	Mitchells Plain	Kuilsriver	Bellville	Goodwood
Female	49	81.7	16	10	14	9	3	19	2	1	1
Male	11	18.3	16.5	10	3	3		4	1		

Table 4.21 when compared with Table 4.13, shows the following similarities. Females are in the majority, and secondly, they live in the magisterial district of Mitchells Plain. Contrary to the TADA members, the average age of male non-TADA members is 16.5 as to that of TADA members which is 13.4.

As explained in Table 4.13, two of the schools were girls' only schools, and where the TADA programme exists, it seems that females take the lead.

5.2.5 Attitudes of Fellow Students Towards TADA

The non-TADA members had to explain what the attitudes of fellow students were towards TADA. The majority consisting of 33 non-TADA members did not know; 1 indicated that students saw TADA as helpful and another one was unsure.

The rest of the responses, in specific order, ranged from "stupid, junk, joke, simple, not useful and don't care". These findings indicate that the majority of non-TADA members did not know the attitudes of fellow students, or perhaps they were just careful not to be critical of TADA. Analysing this

data, it comes to the fore that TADA is not well-known in schools and that there is a lack of support for the programme.

5.2.6 Need for TADA in School

Fifty-six of the non-TADA members were of the opinion that there is a need for TADA in schools. Their reasons were that the programme helps students; make them aware of drugs and that it stops the risk of taking drugs. Only 3 responded negatively and 1 unsure.

These findings indicate that the majority of non-TADA members are in agreement that there is a need for TADA, however, it is also clear as indicated in Table 4.20 that they have negative thoughts about the programme.

5.2.7 Suggestions to Improve the TADA Programme

A large number of non-TADA members suggested that confidentiality be improved. The fear seems to be that information were not kept confidential and that, in turn, deters students from joining TADA and bringing innovative ideas.

Other suggestions were to engage in constructive activities such as enrichment periods, workshops and inviting prominent speakers to promote the programme. There were also suggestions such as a separate lesson for TADA activities where the entire school is involved, linking school projects to TADA activities and massive mobilisation of students.

5.3 DATA INTERPRETATION AND ANALYSIS

As mentioned, two separate questionnaires were administered to the two groups. Five of the same questions were given to both groups. The latter will be analysed separately.

From the data collected from TADA members the following were prevalent:

* TADA programme activities were minimum and in some schools non-existent. (See Section 5.2.3.)

* Students generally see TADA as boring or dull. (See Section 5.2.3.)

* Programme implementation is being hindered by TADA students leaving, as well as ridicule by students and teachers.

* There is little support for TADA and, therefore, the decrease in membership.

* Programme contents is not innovative and do not attract students or target groups outside the schools.

* The current programme activities seem to be done in a loose manner and there is seldom regular meetings with TADA members and student bodies.

* No outreach programme activities which will have a lasting effect on members.

* TADA students' basic knowledge about drugs is generally poor due to the fact that they do not have basic guidance or training.

* TADA members are unsure about the total number of members in their schools because no data is collected and distributed to them.

In analysing the TADA programme, it can be said that it is dwindling in schools because of the above reasons. The agency responsible for TADA cannot, due to financial constraints, employ paraprofessionals or volunteers in an effort to make this programme more effective. The main idea is that ultimately teenagers must be in charge of the programme.

However, it is clear that this programme needs support from teachers, other professionals, etc., to make its implementation effective. Currently TADA programmes within high schools in the Cape Metropolitan Area, have lost track of teenagers by not implementing innovative programmes, secondly that various factors within the school set-up are not conducive to the programme and thirdly there is no outreach programme/activities promoting TADA and encouraging not only students, but other youth group, teachers and volunteer professionals to join TADA.

McWhirter et al (1998:126) emphasise that prevention programmes should provide alternative activities such as adventurous recreational activities, service-related community and group projects. Other activities include support for law enforcement efforts linked to drugs and environmental issues.

According to McWhirter et al (1998), studies done by Hawkins and Catalano have proved that these comprehensive efforts are popular in programme planning and do make it easier for organisations to access funding.

From the data collected from non-TADA members the following were prevalent:

- Non-TADA members see the TADA programme as poor and is of the opinion that it has no impact.
- A large majority of non-TADA members see the TADA programme as catering only for the needs of students with drug problems. This perception creates problems because students joining TADA are seen or labelled as "druggies". This deters non-TADA students from joining.
- Non-TADA students responded positively to encouraging students to join TADA.
- Non-TADA members have no knowledge of the attitudes of fellow students towards the TADA programme. This indicates a liassez-faire attitude amongst non-TADA members.
- Non-TADA members are positive about the need for the TADA programme in schools.
- Suggestions from non-TADA members include the improvement of confidentiality, engaging in constructive activities, workshops, as well as TADA lessons for all.

In analysing the responses of the TADA members, they were very critical of the TADA programme.

The suggestions (see Section 5.2.7) to improve the programme are practical. Non-TADA members would like all students to partake in the TADA programme so that it can be accepted by everyone.

There is also the perception that non-TADA members do not want to identify themselves with the TADA programme. This has largely to do with the fact that in some schools the programme is inactive and that there is a stigma

attached. Non-TADA members see TADA members as "druggies" and do not want to be labelled as such.

Both groups were given the same 5 questions based on, i.e. how they became aware, how many TADA students there are, extension of the programme to other schools, their views of the programme and lastly, if they through TADA members know about drugs to explain it to fellow students.

Analysing the information from both groups, it was clear that they agreed that the TADA programme be extended to other schools. The main reason for extending the programme was the fact that drug abuse was prevalent in schools, hence the idea not to condemn the TADA concept.

The majority of both groups became aware of the TADA programme through TADA members or groups. This meant that most students in schools knew about the programme, but they did not support the programme. If there was support for the TADA programme, more students should have joined and eventually would have had a positive effect in schools.

On the question of how many TADA students there were in their schools, both groups had different opinions. The TADA members responded that there were between 11-20 TADA students. On the other hand, a large majority of non-TADA members' responses indicated that they were unsure.

This prove that the TADA programme does not reach most students, even those in the same school. Therefore the non-TADA members were unsure about the total TADA students, because they were not informed, or perhaps because there were no TADA programme activities in their schools.

On the views about the TADA programme, it was clear that the majority of TADA members saw the programme as boring and uninteresting. In their

views a large majority of non-TADA members indicated that the programme catered only for students with drug problems. There was definitely a labelling of students belonging to TADA.

On the question of TADA students' knowledge of drugs, both groups responded mostly negatively and unsure. In analysing the responses (see tables 4.12 and 4.19), it proved that TADA students had minimum or no knowledge and that no basic training was given.

In the final analysis, it is clear that TADA programme implementation should be given special attention so as to eliminate negative factors. This will call for a different and new programme implementation plan or policy, which will not only involve the students, but teachers and the community as a whole. The real action will have to take place not only at schools, but also at community level.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

This chapter provides some concluding remarks and recommendations.

6.1 CONCLUSIONS

The research problem stated in Chapter 1, regarding the ineffectiveness of the TADA programme have been confirmed by this study.

* The programme has no major impact on students in high schools and fails to reach out to youth outside the school setting.

* The results of this study have shown that the participation of students in the TADA programme is decreasing in high schools.

* There is a lack of support from the majority of students. This makes it difficult for TADA students to launch programmes because there is hardly any support from students.

* Various factors contribute to this decrease making it very difficult for students to promote the programme.

Some of the factors contributing to this are the following:

* A large majority of non-TADA students do not want to join the programme because of the stigma attached. They do not want to be labelled as students with drug problems.

* The students also perceive the programme as dull and boring because there are no innovative programme activities. This problem has not been addressed and it has led to the current situation.

* There are no clear guidelines or training for students which will help them deal not only with substance abuse issues, but also with other issues such as sexuality, crime and violence. Guidelines for the handling of the above are important and should be drawn up.

The study confirms that TADA students want more teacher involvement in the programme. Currently this programme is run and supported by a few students. It is clear that although this is a youth-driven prevention programme, continuous and ongoing support from teachers and other para-professionals is important for the survival of the programme.

It seems reasonable to conclude that TADA programmes have little or no effect, due to the fact that only drug information is disseminated and life and coping skills are not taught or incorporated into the programme.

6.2 RECOMMENDATIONS

Here are a few recommendations that may help the TADA programme operate effectively within high schools and the broader community.

6.2.1 Developing a Drug Policy

A drug policy for a school is a priority and TADA members, the school and parent bodies, can be involved in developing such a policy. This drug policy will need to be conveyed to all members of the school community (students, parents, teachers and the governing body) as well as the surrounding community.

The drug policy must clearly state that it opposes the inappropriate use of any alcohol and other drugs. This policy should be applicable:

* On school grounds.

* At functions, excursions or any activity organised by the school or broader community.

* When members are representing the school at community functions.

In the policy it should be stated that students will not be permitted:

* To use prohibited substances.

* The inappropriate use of prescribed or non-prescribed medicines.

* The consumption of alcoholic beverages, the smoking of tobacco or the use of any other drug.

* The possession of drug related paraphernalia such as cigarette paper, pipes, etc.

If the above stated policy of the school is contravened, the school governing body in conjunction with TADA could possibly consider the following steps:

* Appropriate punishment to ensure that the students will be deterred from using any substance, which can be detrimental to them or the image of the school.

* Drawing up of a contract between the student (and parents or guardian) and the school.

* Such a contract can contain certain conditions which students must adhere to.

* Temporary suspension.

* In serious cases possible expulsion of students. The last two options should be handled with great care and students must be given every possibility to change their behaviour.

Such a drug policy can be drawn up and signed by the offending student (parent or guardian), the principal and TADA members as witnesses.

6.2.2 The Need for a Registration Form

There is no consensus on how many students belong to TADA, and therefore the need for a registration form to help solve this problem. This will give TADA easy access to how many students are members. A registration form has been developed. (See Annexure D.)

6.3 PROPOSED FRAMEWORK FOR THE EFFECTIVE IMPLEMENTATION OF THE TADA PROGRAMME

One of this programme's goals should be to provide effective prevention activities which will not only promote the programme, but will be of benefit to both the students and the community at large.

The programme must be relevant and also adaptable to changing times and circumstances.

The implementation plan of TADA can consist of the following:

6.3.1 A Policy Statement

The policy statement is important because members need to identify with it. This policy should be embraced by all and can entail the following statements:

* TADA sees itself as part of a greater community.

* TADA is in partnership with parents/guardians, students to ensure the best for all youth concerned or involved in the programme.

* TADA strives to equip young people so that they are less vulnerable to substance abuse and better equipped to deal with life and its challenges.

* Substance misuse and other abuses, are detrimental to humans on various levels (social, psychological, physical, mental, etc.)

This policy statement must be accepted by the school, and the latter must also be active in propagating it amongst students and surrounding communities.

6.3.2 Guidelines: Enabling Effective Programme Planning and Implementation

Guidelines can be helpful to TADA programme planners when planning various projects. The guidelines can be divided into three broad categories i.e. programme planning, programme comprehensiveness and programme strategies.

6.3.2.1 Programme planning

The lack of adequate implementation ultimately contributes to poor outcomes of many prevention programmes. Therefore, TADA programme planners must be realistic in establishing goals and remember that to effect behaviour change also requires long-term commitment and a community-wide effort.

TADA programme planners have to look at multiple goals, which incorporate long and short-term goals. Here are a few examples for short-term planning:

* present prevention and information sessions to all pupils, parents/guardians and community groups.

* Make training available to teachers and students.

* Make the school and broader community aware of the school's drug policy.

* Organise functions, excursions or any activity which will have a long-lasting effect on students (This can be educational camps, tours, etc.).

* Involve outside organisations and individuals on a consultational basis as part of a team approach.

Some of the long-term planning can be:

- Support the founding of positive peer groups.
- Evaluate the drug policy and philosophy of TADA and adapt it, if and when necessary, according to changing circumstances and conditions.
- To develop and implement student support programmes within communities.

Other aspects important in programme planning are evaluation instruments, flexibility and marketing. If the programme contents are relevant and innovative the implementation process will run smoothly. Effective marketing can also lead to the success of the programme.

6.3.2.2 Strategies

The success of prevention programmes like TADA depends heavily on the strategies it follows. Strategies must be relevant and of interest to the audience. Strategies must aim at providing the following:

* Information. This information must lead to the learning of new behaviours and creating new attitudes. The information must also be ethnic/cultural sensitive and appeal to young people's interests and TADA groups.

* Life Skills. This will incorporate the following life skills i.e. communication, problem-solving, critical thinking, general assertiveness, resistance skills, and peer selection. There are besides the mentioned skills also others i.e. low-risk, choice making and self-improvement.

* Training. The trainer should have the following attributes i.e. communication and facilitation skills, supportive, well prepared and honest. Training should also be directed at helping TADA students understand and address cultural norms and promote school success.

6.3.2.3 Programme comprehensiveness

The causes of substance abuse are multiple and, therefore, the TADA programme must focus on many target groups and activities. In a comprehensive approach the TADA programme must target the following:

* Whole communities. Community-wide programmes involving i.e. marital problems, diseases etc. will play a significant role in changing community members behaviour.

* Target all youth as opposed to only identified "high-risk" youth. Adolescence is a high-risk time for all youth in terms of experimenting with substance abuse and sexuality.

The activities in a comprehensive programme must focus on ensuring the following:

* Integration of prevention activities into family, classroom, school and community life.

* Enable a supportive environment that encourages participation and responsibility.

In this study a special effort was made to give a descriptive overview of TADA as a prevention programme, identify some of the negative factors impacting on the implementation process and providing possible solutions. It is hoped that the recommendations which results from this study will be taken up seriously by the relevant organisation and timeous action plans introduced to prevent the programme from losing impetus in the future.

BIBLIOGRAPHY

Advisory Council on the Misuse of Drugs (1993). **Drug Education in Schools : The Need for New Impetus**. London: HMSO Publications Centre.

African National Congress (1994). **The Reconstruction and Development Programme - A Policy Framework**. Johannesburg: Umanyano Publications.

Bloom, F.E. and Kupfer, D.J. (1995). **Psychopharmacology: The Fourth Generation of Progress.** New York: Raven Press.

Craig, G.J. (1976). **Human Development**. Englewood Cliffs, New Jersey: Prentice-Hall Inc.

De La Rey, C., Duncan, N., Shefer, T. and Van Niekerk, A. (1997). **Contemporary Issues in Human Development : A South African Focus**. Johannesburg: International Thomson Publishing (Southern Africa) (Pty) Ltd.

De Miranda. S. (1994). **A Bridged Overview of Proceedings. Working Conference on the Prevention of Alcohol and Other Drug Abuse Amongst the Youth**. Presented by the Drug Advisory Board.

De Miranda, S. (1987). **Drugs and Drug Abuse in Southern Africa**. Pretoria: van Schaik Publications.

Department of Welfare (1994). **Working Conference on the Prevention of Alcohol and Other Drug Abuse Amongst the Youth Within the Context of the Reconstruction and Development Programme**. Presented by the Drug Advisory Board. Pretoria.

Department of Welfare (1995). **Second Draft - National Substance Abuse Strategy**. Pretoria: Government Printers.

Department of Welfare (1995). **Second Draft: National Substance Abuse Strategy on the White Paper**. Pretoria: Government Printers.

Department of Welfare (1998). **The Draft National Drug Master Plan** - July 1998. Pretoria: Government Printers.

Department of Welfare (1999). **The National Drug Master Plan**. Pretoria: Government Printers.

De Vos, A.S. (1998). **Research at Grassroots. A Primer for the Caring Professions.** Pretoria: van Schaik Publications.

Drug Advisory Board (1994). **National Strategy Against the Abuse of Alcohol and Other Drugs**. Pretoria.

Dunselman, R. (1993). **In Place of the Self and How Drugs Work.** London: Hawthorn Press.

Edmonds, L. and Wilcocks, L. (1994). **Teen Drug Scene in South Africa.** Pine Gowrie: Aspene Oaks.

Elainy, M. and Rush, B. (1992). **How Effective are Alcohol and Other Drug Prevention and Treatment Programs?** Canada: Health and Welfare.

Foster, D., Freeman, M. and Pillay, Y. (1997). **Mental Health Policy for South Africa**. Published by the Medical Association of South Africa. Multimedia Publications.

George, V. and Wilding, P. (1976). **Ideology and Social Welfare.** London: Routledge and Kegan Paul.

Grinnel, R.M. (1988). **Social Work Research and Evaluation.** U.S.A: F.E. Peacock Publishers, Inc.

Grobler, J. (1972). **Dwelmmiddels Vyand Nr. 1.** Pretoria: J.P. van der Walt en Seun (Edms.) Bpk.

Gumede, M. (1992). **Programmes and Services for the South African Situation**. Report: Working Conference on the Implementation of the National Plan to Prevent and Combat Alcohol and Drug Abuse in South Africa. Pretoria: Nabor.

Gumede, M. (1995). **Alcohol Use and Misuse in South Africa : A Socio-Medical Problem**. Pietermaritzburg: Reach Out Publishers.

Kaufman, J.M. (1981). **Characteristics of Children Behaviour Disorders** (Second Edition). Columbus, Ohio: Charles E. Merill Publishing Company.

Keshwar, E. and Louw, O. (1993). No Adults Allowed, Unless Under the Supervision of a Teenager. **Salus**, Vol. 16, No. 4, October 1993.

Macridis, R. (1980). **Contemporary Political Ideologies.** Cambridge, Massachusetts: Winthrop Publishers, Inc.

McWhirter, J.J., McWhirter, B.T., McWhirter, A.M. and McWhirter, E.H. (1998). **At-Risk Youth. A Comprehensive Response**. Pacific Grove: Brooks/Cole Publishing Company.

Morojele, N. (1997). Adolescent Alcohol Misuse. In: De La Rey, C. Duncan, N., Shefer, T. and Van Niekerk, A. (Ed.). **Contemporary Issues in Human Development. A South African Focus**. International Thompson Publishing (Southern Africa) (Pty) Ltd.

O'Connor, J. (1978). **The Young Drinkers. A Cross-National Study of Social and Cultural Influences**. London: Tavistock Publications.

Parry, C. (1994). **Urbanisation and Alcohol Misuse**. Urbanisation and Health Newsletter.

Parry, C and Bhana, A. (1997). **South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Abuse Trends**. Proceedings of Report Back Meeting, 27 February 1997 (Volume III) (July – December 1996). Parow: MRC.

Parry, C and Bhana, A. (1999). **South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Abuse Trends**. Proceedings of Report Back Meetings 16 – 19 March 1999. Phase 5 July – December 1998.

Poley, W., Lea, G. and Vibe, G. (1979). **Alcoholism - A Treatment Manual.** New York: Gardner Press.

Reconstruction and Development Programme (1994). **A Policy Framework**. Johannesburg: ANC Umanyano Publications.

Report of the International Seminar on "Children in Trouble with the Law". Held in Cape Town (15-17 October 1993). Athlone Industria 1: Esquire Press (Pty) Ltd.

Rocha-Silva, L. (1992). **Alcohol/Drug Related Research in the R.S.A.: Meeting the Challenge of the 1990's.** Pretoria: Human Sciences Research Council.

Rocha-Silva, L. (1995). **Alcohol/Drug Use and Related Matters : You Black South Africans (14-21 years)**. Pretoria: Human Sciences Research Council.

Roper, I. and Bartlett, G. (1991). **The Drug Wise Manual – The Pharmacist's Guide to Substance Abuse.** Pietermaritzburg: The Natal Witness Printing and Publishing Company (Pty.) Ltd.

Sheafer, R.W., Horejsi, C.R. and Horejsi, G.A. (1994). **Techniques and Guidelines for Social Work Practice**. London: Allyn and Bacon.

Skidmore, RA and Thackeray, MG. 1976. **Introduction to Social Work.** (Second Edition). Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Social Work Journal, August 1993. Volume 29, No. 3. Published by the Department of Social Work, University of Stellenbosch.

Teenex A Youth Drug Prevention Programme (1989). A Cedar Project. London Borough of Hounslow. Printed by Co-operative Resources Centre, Feltham.

The Constitution of the Republic of South Africa (1996). Act 108 of 1996. Typeforce Media.

The Finance Week 15-21 August 1996. Jihad vs Junkies. p.35.

The Prevention and Treatment of Drug Dependency Act (Act 20 of 1992). Pretoria: Government Printers.

The South African Institute of Race Relations. (1998). The South African Survey 1997/1998. Pretoria.

The Tygertalk 10 July 1997. Municipal restructuring: Non-payment still plays a role.

The Weekend Argus 10-11 August 1996. War on Gangs: The Crusade Continues.

The Weekend Argus 24-25 August 1996. Call for Joint Action on Drug Abuse.

The Weekend Argus 13 September 1997. SA Drug Smugglers Rotting in Prisons Around the World.

Turner, F.J. (1986). **Social Work Treatment : Interlocking Theoretical Approaches**. New York: Free Press.

Van der Burgh, C. (1981). **Report of the Conference: Alcohol in Perspective held on 12-14 October 1981**. Johannesburg: Director-General, Health and Welfare.

Van der Spuy, J. (1994). Home Violence? Some Data from the National Trauma Research Programme. **Trauma Review**, Vol. 2, No. 3.

Willis, J.H. (1969). **Drug Dependence - A Study for Nurses and Social Workers.** London: Faber and Faber Limited.

Ziervogel, C.F. (1986). Substance Abuse in Adolescents. **SA Journal of Continuing Medical Education.** Volume 4. September 1996.

ANNEXURE A

STUDENT: MR E BANDA

RESEARCH TOPIC: A DESCRIPTIVE STUDY OF THE T.A.D.A. PROGRAMME AS IMPLEMENTED AT HIGH SCHOOLS IN THE CAPE METROPOLITAN AREA

COURSE: M.A. SOCIAL WORK (UWC)

TO WHOM IT MAY CONCERN

TEACHERS/STUDENT

I am a student and as the topic of my research indicates, I want to study the T.A.D.A. programme within schools. One of the aims of this research is to determine how this programme can expand to more schools.

Please complete the questionnaire (one for only T.A.D.A. members and the other for non-T.A.D.A. members). All information will be treated confidentially.

Please contact me should you need any clarification.

Mr E Banda
- 483-4612 (work)
- 987-0444 (home)

Thank you

MR E BANDA

ANNEXURE B

QUESTIONNAIRE FOR TEENAGERS AGAINST DRUG ABUSE [T.A.D.A.] MEMBERS

WHERE APPLICABLE PLEASE MARK WITH AN X IN THE APPROPRIATE RECTANGLE

1. How did you initially become aware of T.A.D.A.?

Through a T.A.D.A. member/ Group	Teacher	Friends	Other [Explain briefly]

2. Do you know when the T.A.D.A. programme was started in your school?

1997	1996	1995	1994	1993	1992	1991	1990	± 10 years ago

3. Who started the programme?

Students	Teacher	Organisation (SANCA)	Other

4. Do you know the reasons for establishing this programme?

.....

.....

5. What were your reasons for joining T.A.D.A.?

To meet new friends	To learn more about drugs	To learn how to fight drugs and help others	Other [Explain briefly]

6. Do you know how many students in your school are T.A.D.A. members?

Unsure	0 - 10	11 - 20	21 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Other (Give the total)

7. Is there an increase or decrease in T.A.D.A. members in your school? Yes/No. (Please explain.)

.....

.....

.....

8. Did any members leave T.A.D.A.? If yes, explain why.

.....

.....

.....

9. Do you know what the views of students from your school are regarding T.A.D.A.? Yes/No. (Please explain.)

.....

.....

.....

10. Do you think T.A.D.A. should be extended to more schools?

YES	NO	Unsure	Other [Explain briefly]

11. What are the problems your T.A.D.A. group is experiencing?

Lack of leadership	Decrease in numbers	Ridicule from students/teachers	Other [Explain briefly]

12. How often are T.A.D.A. meetings held in your school?

Once per week	Once every second week	Unsure	Once a month	Once per quarter	Once per year	Other [Explain briefly]

13. What type of awareness campaigns [activities] do your T.A.D.A. group organise?

.....

.....

.....

14. Do you think T.A.D.A. will be more effective within your school if teachers become more involved?

Unsure	YES	NO	Other [Explain briefly]

15. Do you think T.A.D.A. group knows enough about drugs to explain it to fellow students?

Unsure	YES	NO	Other [Explain briefly]

16. Besides alcohol and drugs, which other topics would you like T.A.D.A. to discuss?

.....

.....

.....

17. What do you think T.A.D.A. should do to gain more support.

Please provide the following information. {Please do not give your name}.

Age:

Sex: (Male/Female)

Home Area: (i.e. Eerste River/Mitchells Plain/Cape Town)

Grade:

ANNEXURE C

QUESTIONNAIRE FOR STUDENTS NOT INVOLVED WITH TEENAGERS AGAINST DRUG ABUSE [T.A.D.A.]

WHERE APPLICABLE PLEASE MARK WITH AN X IN THE APPROPRIATE RECTANGLE

1. As a non-member are you aware of T.A.D.A.? Yes/No. If yes tick below.

Through a T.A.D.A. student/ Member	Teacher	Friends	Other [Explain briefly]

2. Do you know how many students in your school are T.A.D.A. members?

Unsure	0 - 10	11 - 20	21 - 30	31 - 50	51 - 60	61 - 70	Other (Give the total)

3. What are your views of the T.A.D.A. programme?

It caters only for students with drug problems	T.A.D.A. students know nothing about drugs	Other [Explain briefly]

4. Will you as a non-member encourage students in your school to join T.A.D.A.?

YES	NO	UNSURE

5. If your answer to the above is no, please explain.

.....

.....

.....

6. Do you know what the attitudes of fellow students are towards T.A.D.A.? Yes/No. (Please explain.)

.....

.....

.....

7. Do you think there is a need for T.A.D.A. in your school? Yes/No. (Please explain.)

.....

.....

.....

8. Do you think T.A.D.A. should be extended to more schools?

NO	YES	Unsure	Other [Explain briefly]

9. Do you think T.A.D.A. students know enough about drugs to explain it to their fellow students?

Unsure	YES	NO	Other [Explain briefly]

10. Are you aware of any T.A.D.A. activity in your school? Yes/No. If yes, please explain?

.....

.....

.....

11. What do you think of the T.A.D.A. programme at your school?

No comment	Good	No impact	Poor	Other [Explain]

12. Have you got any suggestion how T.A.D.A. can improve?

.....

.....

.....

Please provide the following information. {Please do not give your name}.

Age:

Sex: (Male/Female)
Home Area: (i.e. Eerste River/Mitchells Plain/Cape Town)
Grade:

ANNEXURE D

TADA MEMBER REGISTRATION FORM

Please forward to:

TADA

.....

.....

.....

For Office Use:

Date Received:

.....

Registration Number:

.....

1. This application has two parts:
   Part I – to be completed by applicant.
   Part II – to be completed by parent/guardian. (If applicant is under eighteen years of age))

PART I – APPLICANT

Full Name: .....
Male/Female ..... Date of Birth .....
Postal Address .....
.....
Post Code ..... Telephone Number .....

Name of School [College/Youth Club if applicable] .....

Circle year in school/college at present:

First Year	Second Year	Third Year	Fourth Year	Fifth Year

Why are you interested in joining the TADA?
.....

.....

What knowledge or skills do you hope to gain from TADA?
.....

.....

What relevant school, church or community activities have you been involved in? [Please be specific]
.....

.....

I have examined the given details of the TADA programme. I also agree to share with others in my school/college, or community, as best I can, the knowledge and skills I gain at TADA.

Signed .....
(Applicant)

PART II – PARENT/GUARDIAN (IF YOU ARE UNDER EIGHTEEN)

Name(s): .....

Postal Address .....

..... Post Code .....

Telephone Number (Home/Work) .....

I have examined the TADA programme and agree to allow my son/daughter (name) .....

.....

to participate.

Signed .....
(Parent/Guardian)