PRACTICE GUIDELINES FOR CULTURALLY SENSITIVE DRUG PREVENTION INTERVENTIONS

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DECLARATION:
In accordance with Rule G4.6.3, I hereby declare that the above-mentioned thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

V.M. Goliath

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ABSTRACT

South Africa has experienced a notable increase in adolescent drug use during the country’s transition from apartheid to democracy (Central Drug Authority [CDA], 2006). These findings are verified by epidemiological studies and two national youth risk behaviour surveys, highlighting the need for effective drug prevention interventions. Whilst drug use spans across age, gender and social strata, the rapid increase in both legal and illicit drug use among adolescents in the Northern Areas communities of Port Elizabeth has been particularly pronounced. The South African Community Epidemiology Network on Drug Use (SACENDU) statistics, which reflects on racial demographics in accordance with the Population Registration Act of 1950 (South Africa, 1950), reports that, in the year 2011, the ‘Coloured’ population constituted 62% of those individuals seeking treatment for drug abuse, compared to 15% ‘African’ treatment seekers in Port Elizabeth (Dada, Plüddemann, Parry, Bhana, Vawda & Fourie, 2012:44). Furthermore, methamphetamine use by persons under the age of 20 years in Port Elizabeth increased fivefold in a three-year period, i.e. from 7% in 2008 to 39% in 2011 (Dada et al., 2012), with the ‘Coloured’ population group accounting for the majority of methamphetamine users. These statistics reinforce a long-standing racial stereotype that associates ‘Coloured’ racial identity with an enhanced susceptibility to drug use.

The National Drug Master Plan (South Africa, 2012a), and the Prevention of and Treatment for Substance Abuse Act (Act no 70 of 2008) propose that drug prevention programmes should address the values, perceptions, expectations and beliefs that the community associates with drug abuse (South Africa, 2008b). This view emphasises the importance of drug prevention interventions that are culturally sensitive and contextually relevant. The current study was guided by two conceptual frameworks, i.e. the Social Constructionist Framework and the Ecological Risk/Protective Resilience Framework, and focused on the Northern Areas of Port Elizabeth, a historically marginalised community inhabited by a predominantly ‘Coloured’ indigenous/ethnic group. The goal of the study was to enhance understanding of the socio-cultural meaning attributed to cultural identity, drug use, non-use and drug prevention in the
Northern Areas of Port Elizabeth, with the view to developing guidelines for drug prevention interventions that are culturally sensitive and contextually relevant.

The following objectives were formulated in order to achieve the goal of the study:

- To explore adolescent narratives regarding the constructs ‘Coloured’, drug use, non-use and drug prevention programmes of three distinct groups of adolescents (drug users, non-users, and TADA peer mentors) from the Northern Areas.
- To explore and describe the social service practitioners’ (social workers and social auxiliary workers’) constructions of drug use, non-use and drug abuse prevention in relation to adolescents from the Northern Areas, and how such constructions inform the drug prevention services rendered to adolescents from these communities.
- To review the data collected from the adolescent narratives and the social service practitioners’ reflections on their drug prevention programmes against existing theory and models for drug prevention.
- To synthesise the above information with a view to developing guidelines for culturally sensitive drug prevention programmes relevant and responsive to the specific social constructions of adolescents from the Northern Areas.

A qualitative research approach, located in a narrative tradition of inquiry research design, was employed to achieve the goal of the study (Riessman, 2008). The study was conducted in two phases. The first phase involved an empirical study with the four sample groups (i.e. adolescent drug users, adolescent non-drug users, Teenagers against Drug Abuse [TADA] peer mentors and social service professionals (i.e. social workers and social auxiliary workers)). Phase two involved the co-construction of the practice guidelines for culturally sensitive and contextually relevant drug prevention interventions. Phase one started with the informal exploration of community stakeholders’ views on the identified research problem and the process of gaining access to the research population. Several gatekeepers (i.e. teachers, social workers, the Families Against Drugs [FAD] Support Group representatives, a minister of religion and a community stakeholder) were engaged to assist in recruiting participants from the
four sample groups. A non-probability purposive sampling method was employed to purposively recruit 29 adolescent non-drug users and ten adolescent peer mentors (via the TADA Programme at one school). The same sampling method, followed by a snowball sampling technique, was employed to recruit the two remaining sample groups of ten adolescent drug users (in the recovery process) and nine social workers and social auxiliary workers respectively. The sample sizes were determined by the principle of data saturation.

The data generation method used in respect of the non-users took the form of semi-structured written narratives, administered in a group context during school time, followed by a second round of data generation. The life-grid (Wilson, Cunningham-Burley, Bancroft, Backett-Milburn & Masters, 2007:144), a qualitative visual tool for mapping important life events, was employed to guide the co-construction of the biographical narratives generated during the individual semi-structured interviews with the sample of adolescent drug users. Focus group interviews were used to enhance an understanding of the peer mentors and social service practitioners’ views on the construct ‘Coloured’ and their existing drug prevention programmes. Each of the individual and focus group interviews was audio-recorded, transcribed and complemented by the field notes. Informal data gathering occurred through participant observation of two drug prevention programmes, attendance of a FAD Support Group meeting, and interviews with community volunteers and the South African Police Services (SAPS) Youth Development Forum.

Both the content and the context of the narratives were analysed to arrive at the research themes, sub-themes and categories. The content of the narratives was analysed by employing categorical content analysis, whilst the form of the narratives (i.e. how the stories were told) was analysed by using the socio-cultural approach to narrative analysis (Grbich, 2007:130).

The journey metaphor emerged from the adolescent drug users’ narratives, depicting a prototypical storyline of a drug use journey, starting with experimentation and
culminating in abuse and dependence for some and an early exit from the journey for others. The conclusions that can be drawn from these findings illuminate key protective factors and processes at a multisystemic level that can be strengthened to enhance the adolescents’ resistance to drug use and/or delay the onset of use. Embedded in the participants’ narration of the drug use journey were nuances relating to internalised stereotypes of ‘White’ supremacy and ‘Coloured’ inferiority as an explanatory framework for venturing onto and prolonging the journey.

The two themes that emerged during the process of content and narrative analysis of the qualitative data (from both adolescent drug users and non-users) were as follows: Constructing drug use as a ‘Coloured’ phenomenon and reconstructing ‘Coloured’ identity; Risk and protective factors located at individual, family, peer, school, community and societal domains. The four themes that emerged during the data analysis of the peer mentors and social service practitioners’ narratives were as follows: Construction of ‘Coloured’ identity; socio-cultural meaning construction about the reasons for drug use amongst adolescents from the Northern Areas; description of drug prevention services rendered in the Northern Areas; and reflection on barriers to rendering drug prevention interventions.

The conclusions that were drawn in relation to these themes were as follows: The narrations by the majority of participants across the four sample groups reinforced the stereotypical, historical association of drug use with ‘Coloured’ identity, which further enhances the internalisation of this ascribed inferiority and underachievement. The non-users and peer mentors’ views were predominantly in a second person voice, suggesting that they excluded themselves from these largely debilitating social constructions. In addition, their attempts to challenge the negative constructions of ‘Coloured’ identity, juxtaposed against a positive reconstruction of ethnic and community identity, ironically perpetuated further stereotyping.

The conclusions derived from these themes are that the adolescents’ susceptibility to drug use in the Northern Areas was facilitated by an interaction of a number of risk
factors cutting across the various concentric circles associated with the systemic risk/protective resilience framework. These included impulsive and risk-inducing personality traits, poor coping skills, poor self-management, internalised inferiority, pro-drug use attitude, experienced negative life events (including loss of attachment figures), compromised moral development, emotionally absent parents, harm inducing socialisation, poor family relationships, parental drug abuse, high risk family environment (including stressors associated with single parenthood and blended families), association with older (drug using) peers, alienation by prosocial peers, low commitment to school due to scholastic difficulties and low value attached to education, negative teacher attitudes, absence of sport and after-school cultural activities, a high-risk school environment, which included access to drugs on the school premises, normalisation of drug use in the community, low community cohesion, lack of recreational facilities, living in marginalised communities, socio-economic stressors linked to increasing levels of inequality, and the fact that the media glamorise drug use.

In contrast, adolescent non-drug use was facilitated by protective processes that served as buffers against or navigation around these risk factors. These included having a vision and long-term goals for the future, self-control and decision-making skills, strong religious and spiritual beliefs, anti-drug attitudes, the belief that they were susceptible to addiction, positive parenting, supportive family environments, associating with pro-social peers, mobilising peer advocacy groups, positive peer influence skills, enjoying support from teachers, collaborative relationships between parents and school, positive, protective school environment, community cohesion, pro-social community outlets, community mobilisation, deterrent effect of witnessing drug-related harm in the community, equality in socio-economic opportunities, and recognising opportunities to extract positive learning from the media.

Additional conclusions derived from the social service practitioners’ findings are that the stereotypical, problem-saturated constructions of the Northern Areas obscured practitioners’ abilities to uncover implicit stories of resilience and resistance during their drug prevention interventions. An alternative story advocating for positive parental
control, enhanced community cohesion, nurturing the power of positive peer influence, growing children’s talents, providing information and education in order to diffuse power imbalances between practitioners and community members, emerged as the building blocks to the alternative story during the data generation process.

Current drug prevention interventions presented to adolescents from the Northern Areas are mostly once-off presentations, informational in nature and presented in response to requests from community organisations. There is little to no prior screening of the audience; therefore, programmes are not tailored to make them culturally and contextually relevant. The format and content of these programmes are predominantly didactic sessions, with the peer mentors illustrating the inclusion of more experiential activities during their presentations. Prevention education and information sessions focus on the dangers of drugs, rather than on how to prevent the onset of drug use and how to promote and access healthy alternatives. In addition, the prevention programmes fail to problematise the social constructions that normalise drug use and their associated deficit-oriented stereotypes directed at and internalised by the target community. Ex-drug users frequently conduct the information sessions in the form of motivational talks, and practitioners’ narratives evidence no awareness of the limitations attached to the employment of this strategy. Drug prevention interventions are also seldom formally evaluated.

Concluding from the themes and sub-themes emanating from the participants’ recommendations for drug prevention interventions, the following emerged: dissemination of information about drugs; prevention education for children, focusing on the promotion of concept of self, control and character; prevention education for parents; mobilising positive peer influence; promoting collaboration between parents and teachers; providing constructive community alternatives; enhancing protective community-based processes and positive environmental influences; and lastly, early identification of problems and referral for treatment.
The trustworthiness of the data and the verification of the research process were achieved by subscribing to the four characteristics of qualitative research (Yardley, 2000). These entailed remaining sensitive to the context, employing commitment and rigour, transparency and coherence and, lastly, enhancing the impact and importance of the findings. Four philosophical principles guided ethical conduct in the research, namely autonomy and respect for the dignity of participants, nonmalificence (avoidance of harm), beneficence, and social justice.

The empirical study and literature review culminated in an enhanced understanding of the socio-cultural constructions of ‘Coloured’, drug use, non-use and drug prevention of the research participants. These new insights formed the basis for the construction of the practice guidelines for culturally sensitive drug prevention interventions and were juxtaposed against the review of existing interventions premised on the social constructionist and ecological systems theoretical frameworks. The focus of the practice guidelines was located in the domain of primary or universal drug prevention, although a more accurate description would be positive holistic development as an integral way of life.

The practice guidelines, embedded in a comprehensive multisystemic strengths-based drug prevention approach, were founded on two goals: i) To promote the development of prosocial, health promoting behaviours and social competencies in adolescents; ii) To promote protective peer, school, family, community and societal processes which, through collaborative interaction, will contribute towards the delay and reduction in the onset of drug use and culminate in the development of stronger, supportive and cohesive social systems. The strategies clearly reflect that the practice intervention originates from co-constructing information pertaining to the participants' socio-cultural contexts and needs, and progresses to the referral for secondary prevention.

In concluding the research report, the researcher reflected on the limitations inherent in the study and proposed recommendations for future research, which included operationalising the practice guidelines in collaboration with a panel of drug prevention
experts and community stakeholders. Recommendations are also offered for practice, policy, professional training and continuing education of social service professionals.

**Key words:**
Adolescent
‘Coloured’, Contextual relevance, Cultural sensitivity, Culture
Drug prevention, Drug use, Drug non-use
Identity
Narratives
Positive youth development, Practice guidelines, Protective factor
Race, Resilience, Risk factor
Social construction
TABLE OF CONTENTS

Declaration........................................................................................................................................ii
Acknowledgements...........................................................................................................................iii
Abstract................................................................................................................................................iv
List of tables.........................................................................................................................................xvii
List of figures ........................................................................................................................................xviii
List of acronyms and abbreviations ....................................................................................................xix

CHAPTER 1 GENERAL OVERVIEW OF THE STUDY ............................................................................ 1
1.1 Introduction and context of research.............................................................................................. 1
1.2 Problem statement.......................................................................................................................... 9
1.3 Motivation for study ...................................................................................................................... 11
1.4 Research questions....................................................................................................................... 13
1.5 Research goal and objectives........................................................................................................ 14
1.6 Conceptual framework.................................................................................................................. 15
1.7 Overview of research methods ..................................................................................................... 19
1.8 The journey metaphor ................................................................................................................ 22
1.9 Conceptual definitions.................................................................................................................. 24
1.10 Outline of thesis............................................................................................................................ 33
1.11 Chapter summary.......................................................................................................................... 35

CHAPTER 2 LITERATURE REVIEW AND THEORETICAL PERSPECTIVES ON DRUG PREVENTION .......................................................................................................................... 37
2.1 Introduction ..................................................................................................................................... 37
2.2 What is meant by prevention, and why is this so important?........................................................... 38
2.3 Tracking history of prevention approaches and their theoretical lenses ...................................... 47
2.4 Primary conceptual frameworks that framed the study ................................................................. 52
2.4.1 Social constructionist conceptual framework .......................................................................... 52
2.4.1.1 Sociocultural theory........................................................................................................... 53
2.4.1.2 Revisiting definition of cultural sensitivity ....................................................................... 55
2.4.1.3 Cultural sensitivity in drug prevention ............................................................................ 56
2.4.1.3.1 Cultural factors which promote drug use .................................................................... 56
2.4.1.3.2 Cultural factors that protect against drug use ............................................................ 60
2.4.1.4 Drug prevention approaches informed by sociocultural theory ..................................... 61
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4.2</td>
<td>Risk/protective resilience conceptual framework</td>
</tr>
<tr>
<td>2.4.2.1</td>
<td>Individual domain</td>
</tr>
<tr>
<td>2.4.2.2</td>
<td>Family domain</td>
</tr>
<tr>
<td>2.4.2.3</td>
<td>Peer domain</td>
</tr>
<tr>
<td>2.4.2.4</td>
<td>School domain</td>
</tr>
<tr>
<td>2.4.2.5</td>
<td>Community domain</td>
</tr>
<tr>
<td>2.4.2.6</td>
<td>Societal domain</td>
</tr>
<tr>
<td>2.4.2.7</td>
<td>Chapter summary</td>
</tr>
</tbody>
</table>

**CHAPTER 3 DESCRIPTION OF THE RESEARCH METHODOLOGY**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Introduction</td>
</tr>
<tr>
<td>3.2</td>
<td>Acknowledging a social self and locating purpose of present research journey</td>
</tr>
<tr>
<td>3.2</td>
<td>Social research as vehicle for meeting purpose of study</td>
</tr>
<tr>
<td>3.4</td>
<td>Description of paradigmatic lens that served as framework for study</td>
</tr>
<tr>
<td>3.5</td>
<td>Motivation for the qualitative research approach</td>
</tr>
<tr>
<td>3.6</td>
<td>Research design and methods</td>
</tr>
<tr>
<td>3.6.1</td>
<td>Research population, sample and sampling method</td>
</tr>
<tr>
<td>3.6.2</td>
<td>Gaining access to study area and cooperation from settings</td>
</tr>
<tr>
<td>3.7</td>
<td>Method and process of data generation</td>
</tr>
<tr>
<td>3.8</td>
<td>Analysis of data</td>
</tr>
<tr>
<td>3.9</td>
<td>Field notes: reflections on research process</td>
</tr>
<tr>
<td>3.10</td>
<td>Ensuring trustworthiness</td>
</tr>
<tr>
<td>3.10.1</td>
<td>Sensitivity to context</td>
</tr>
<tr>
<td>3.10.2</td>
<td>Commitment and rigour</td>
</tr>
<tr>
<td>3.10.3</td>
<td>Transparency and coherence</td>
</tr>
<tr>
<td>3.10.4</td>
<td>Impact and importance</td>
</tr>
<tr>
<td>3.11</td>
<td>Ethical considerations</td>
</tr>
<tr>
<td>3.12</td>
<td>Chapter summary</td>
</tr>
</tbody>
</table>

**CHAPTER 4 PRESENTATION OF NARRATIVES FROM TRAVELLERS’ JOURNEYS OF DRUG USE, NON-USE AND DRUG PREVENTION**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Introduction</td>
</tr>
<tr>
<td>4.2</td>
<td>Meeting the travellers</td>
</tr>
<tr>
<td>4.3</td>
<td>Invitation to travellers to share their journey</td>
</tr>
</tbody>
</table>
7.4 Conclusions and inferred recommendations derived from the findings ............................. 385
7.5 Summary and conclusions derived from the findings from the narratives of all four participant groups .................................................................................................................................................. 359
7.5.1 Theme 1: Summary and conclusions derived from the participants’ sociocultural meaning construction of ‘coloured’ identity ........................................................................................................... 390
7.5.2 Conclusions drawn from findings depicting risk and protective factors in the individual domain ................................................................................................................................................. 391
7.5.3 Conclusions drawn from findings reflecting risk and protective factors located in family domain ................................................................................................................................. 392
7.5.4 Conclusions drawn from findings reflecting risk and protective factors located in peer domain ................................................................................................................................................. 393
7.5.5 Conclusions drawn from findings reflecting risk and protective factors located in school domain ................................................................................................................................................. 395
7.5.6 Conclusions drawn from findings reflecting risk and protective factors located in community domain ............................................................................................................................... 396
7.5.7 Conclusions drawn from findings reflecting risk and protective factors located in societal domain ................................................................................................................................................. 397
7.6 Summary and conclusions about peer and practitioner navigators’ delivery of drug prevention interventions ............................................................................................................................................ 397
7.6.1 Summary and conclusions about navigators’ current drug prevention services rendered in the northern areas communities ........................................................................................................... 397
7.6.2 Summary and conclusions about format and content of navigators’ current drug prevention interventions ................................................................................................................................................. 398
7.6.3 Summary and conclusions about audience’s response to drug prevention programmes ................................................................................................................................................. 399
7.6.4 Summary and conclusions about the barriers to drug prevention interventions as identified by the navigators ....................................................................................................................... 400
7.7 Participants’ recommendations for drug prevention interventions ................................... 401
7.7.1 Strategy 1: Dissemination of information ........................................................................ 402
7.7.2 Strategy 2: Prevention education ..................................................................................... 407
7.7.2.1 Prevention education with children /adolescents ..................................................... 407
7.7.2.2 Strategy 2: Prevention education at family level ..................................................... 410
7.7.2.3 Strategy: Prevention education at peer level ......................................................... 414
7.7.2.4 Strategy: School based drug prevention .................................................................. 418
7.7.3 Strategy 3: Alternative activities ................................................................. 422
7.7.4 Strategy 4: Community based processes .................................................... 426
7.7.5 Strategy 5: Environmental influences .......................................................... 431
7.7.6 Strategy 6: Problem identification and referral .......................................... 438
7.8 Practice guidelines for culturally sensitive drug prevention interventions ...... 439
7.8.1 Preface ........................................................................................................ 439
7.8.2 Revisiting conceptual definitions ................................................................. 440
7.8.3 Focus of intervention ................................................................................. 440
7.8.4 Comprehensive, multisystemic drug prevention .......................................... 441
7.8.5 Theoretical basis and practice principles of practice guidelines ............... 444
7.8.6 Required knowledge, skills and attitudes of prevention practitioner .......... 447
7.8.7 Practice guidelines .................................................................................... 449
7.8.7.1 Assessment and planning of drug prevention services ......................... 450
7.8.7.2 Practice guideline 1: Co-construction of information ............................ 451
7.8.7.3 Practice guideline 2: Promoting positive youth development ............... 458
7.8.7.4 Practice guideline 3: Promoting family, school, peer, community and environmental protective processes ........................................................... 467
7.8.7.4.1 Promoting family protective processes ............................................. 472
7.8.7.4.2 Promoting school protective processes .......................................... 474
7.8.7.4.3 Promoting peer protective processes ............................................. 477
7.8.7.4.4 Promoting community and environmental protective processes ......... 480
7.8.7.4.5 Promoting involvement in constructive health promoting activities .... 484
7.8.7.5 Practice guideline 4: Problem identification and referral .......................... 488
7.9 Conclusion of the practice guidelines for culturally sensitive drug prevention interventions ........................................................................................................ 491
7.10 Chapter summary ....................................................................................... 491

CHAPTER 8 SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS .... 492
8.1 Introduction .................................................................................................... 492
8.2.1 Summary: Research methodology implemented in study ....................... 493
8.2.2 Conclusions relating to research methodology ........................................ 496
8.2.3 Limitations relating to research methodology ........................................... 497
8.3 Summary: Theoretical perspectives and models from literature relating to drug prevention ........................................................................................................... 498
8.4 Summary: Practice guidelines for culturally sensitive drug prevention interventions. 499
8.5 Recommendations ........................................................................................................... 501
8.5.1 Recommendations relating to research methodology employed ......................... 501
8.5.2 Recommendations relating to practice, policy, professional training, and continuing education ........................................................................................................... 501
8.5.3 Recommendations related to future research ......................................................... 503
8.6 Concluding remarks ....................................................................................................... 504

REFERENCES .......................................................................................................................... 505

APPENDIX A: Letter from the Research Ethics Committee-Human (REC-H) ................. 553
APPENDIX B: Letter and Informed consent form for the parents of adolescent participants .. 554
APPENDIX C1: Information letter to adolescent participants ......................................... 557
APPENDIX C2: Informed assent form for the adolescent participants ......................... 559
APPENDIX C3: Data gathering protocol: Life grid Interview ............................................ 560
APPENDIX D: Written narrative guideline (in Afrikaans) .............................................. 561
APPENDIX E1: Information letter to service providers of drug prevention services ........ 562
APPENDIX E2: Informed consent form for the social work/social auxiliary work/TADA peer mentors ..................................................................................................................... 563
APPENDIX E3: Data gathering tool for focus group interview with social work and social auxiliary work practitioners/TADA peer mentors ...................................................... 564
APPENDIX F: Lyrics of songs (Roar by Katy Perry and 'Tik Monster' by Shaido) .......... 565
APPENDIX G: Participants socio-cultural meaning construction of drug use and non-use .... 568
APPENDIX H: Road map of the travellers’ journey .............................................................. 570
LIST OF TABLES

Table 2.1: Matching of level of drug use with scope of intervention .................................. 41
Table 2.2: Overview of history of drug prevention practice approaches .................................... 46
Table 2.3: Categorisation of drug prevention programmes ...................................................... 47
Table 2.4: Theories of drug addiction ....................................................................................... 51
Table 2.5: Summary of subsystems constituting ecological model .......................................... 66
Table 2.6: Key competencies of positive youth development .................................................. 73
Table 2.7: Three core pillars of family resilience ...................................................................... 77
Table 2.8: Summary of SFP 10-14 programme ....................................................................... 80
Table 2.9: Strengths, weaknesses and functional elements of SPF 10-14 Programme ............... 82
Table 2.10: Summary of Familia Adelante (FA) Programme .................................................. 83
Table 2.11: Strengths, weaknesses and functional elements of the Familia Adelante Programme .................................................................................................................. 84
Table 2.12: Summary of Preparations for the Drug Free Years (PDFY) .................................... 86
Table 2.13: Strengths, weaknesses and functional elements of preparing for Drug-free Years (PDFY) .................................................................................................................. 87
Table 2.14: Summary of the SAAF Programme ..................................................................... 88
Table 2.15: Strengths, weaknesses and functional elements of the SAAF ................................. 89
Table 2.16: Guidelines for constructing family-based drug prevention programmes ............... 90
Table 2.17: Summary of adolescent development stages ....................................................... 91
Table 2.18: Summary of peer intervention components .......................................................... 98
Table 2.19: Guidelines for constructing effective peer interventions in drug prevention ......... 99
Table 2.20: Guidelines for Prevention and Management of Drug Abuse in all Public Schools and Further Education and Training Institutions .................................................. 101
Table 2.21: Summary of healthwise Programme ................................................................... 104
Table 2.22: Strengths, weaknesses and functional elements of healthwise Programme ........... 105
Table 2.23: Guidelines for school-based drug prevention programmes .................................. 107
Table 2.24: Guidelines for community-based drug prevention interventions .......................... 116
Table 3.1: Description of methods of data generation ............................................................. 146
Table 3.2: Synergy between two types of outcomes of qualitative data analysis ...................... 156
Table 3.3: Example of theme illustrating categorisation of data ........................................... 158
Table 3.4: Quantitative and qualitative notions of objectivity ............................................... 164
Table 4.1: Race of patients younger than 20 years (Port Elizabeth) ........................................ 175
Table 4.2: Thematic labelling of the phases of the journey ................................................................. 179
Table 4.3: Biographical profile of travellers ..................................................................................... 180
Table 5.1: Gender distribution of the two adolescent sample groups ............................................ 250
Table 5.2: Overview of themes, sub-themes, categories and sub-categories ................................. 253
Table 6.1: Biographical detail of the practitioner navigators ......................................................... 324
Table 6.2: Overview of themes, sub-themes, categories and sub-categories .................................... 326
Table 6.3: Summary of drug prevention interventions offered by the three sample groups .... 358
Table 6.4: Outline of the sub-theme’s three categories ................................................................. 371
Table 7.1: Conclusions derived from empirical findings ................................................................. 389
Table 7.2: Assumptions and practice principles inherent in the practice guidelines ....................... 446
Table 7.3: Proposed questions and rationale for focus group with community representatives ................................................................. 454
Table 7.4: Goals for positive youth development with inhibiting and enabling factors .................. 462
Table 7.5: Goals and objectives inherent to practice guideline 3, combined with required knowledge base and practical suggestions for implementation ........................................ 472
Table 7.6: Characteristics of healthy families in general and healthy blended families in particular .......................................................................................................................... 473
Table 7.7: Inhibiting and enabling factors pertaining to constructive health promoting activities for adolescents ........................................................................................................... 485

LIST OF FIGURES
Figure 2.1: Continuum of care model .................................................................................................. 40
Figure 2.2: Bronfenbrenner’s Ecological System’s theory .............................................................. 65
Figure 2.3: How neighbourhoods influence youth development .................................................... 109
Figure 7.1: Range of prevention interventions ................................................................................ 444
Figure 7.2: Functional elements inherent in the concept Control .................................................. 463
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
<td>AFYD</td>
<td>African Youth Development Fund</td>
</tr>
<tr>
<td>CARB</td>
<td>The Centre for Addictions Research of British Columbia</td>
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<td>Central Drug Authority</td>
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<tr>
<td>DCS</td>
<td>Department Correctional Services</td>
<td>DOE</td>
<td>Department of Education</td>
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<td>DOH</td>
<td>Department of Health</td>
<td>DSD</td>
<td>Department of Social Development</td>
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<tr>
<td>ECDSD</td>
<td>Eastern Cape Department of Social Development</td>
<td>FAD</td>
<td>Families against drug abuse</td>
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<td>FBO</td>
<td>Faith Based Organization</td>
<td>FET</td>
<td>Further Education and Training</td>
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<td>HSRC</td>
<td>Human Science Research Council</td>
<td>MRC</td>
<td>Medical Research Council</td>
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<td>NDMP</td>
<td>National Drug Master Plan</td>
<td>NGO</td>
<td>Non-Government Organization</td>
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<td>NIDA</td>
<td>National Institute for Drug Abuse</td>
<td>NSC</td>
<td>National Steering Committee</td>
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<td>NYC</td>
<td>National Youth Commission</td>
<td>NYS</td>
<td>National Youth Service</td>
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<td>SACENDU</td>
<td>South African Community Epidemiology Network on Drug Use</td>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<td>SANCA</td>
<td>South African National Council for Alcoholism and Drug Dependence</td>
<td>TADA</td>
<td>Teenagers against drug abuse</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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CHAPTER ONE

GENERAL OVERVIEW OF STUDY

1.1 INTRODUCTION AND CONTEXT OF RESEARCH

A grave concern exists, at both national and international levels, around adolescent drug abuse and its related effects, which can continue to impact on numerous functional domains into adulthood. Its impact on relationships, marital and employment stability (Liddle & Rowe, 2006:474), physical and mental health, morbidity and mortality has been well documented in both national literature (Parry, Plüddemann & Bhana, 2009; Plüddemann, Parry, Flisher & Jordaan 2008; Plüddemann, Myers & Parry, 2008; Brook, Morojele, Pahl & Brook, 2006; Brook, Morojele, Brook & Rosen, 2005) and international research (World Health Organisation [WHO], 2011; National Institute on Drug Abuse [NIDA], 2003; Loxley, Toumbourou & Stockwell, 2003). The Global Status Report on Alcohol and Health (WHO, 2011) makes reference to the harmful use of alcohol, citing that more than 60 major types of diseases and injuries are alcohol related. Similarly, a 2006 report by National Institute on Drug Abuse (2003) reflects that 48.2% of all Grade 12 learners from the United States of America who participated in the study reportedly consumed some or other form of illegal drug in their lifetime.

Whilst Johnston and colleagues, cited in McNeese and DiNitto (2013:235), report on a steady decline in adolescent substance abuse in the United States (US), they expressed concern about the findings of a study on the prevalence of illicit drug use in a 30-day period, which was reportedly highest among 12th graders (22%). Supporting the report of a decline in adolescent legal and illicit drug use in the US, The Healthy People Report (United States, 2010:26.2) cites statistics on high school learners who never consumed alcohol, as having increased from 19% to 28% between 1998 and 2009. Similarly, the percentage of learners who resisted the onset of illicit drug use increased from 46% to 53%. This offers a promising picture and may suggest that drug prevention interventions, particularly in the US, are yielding positive results.
The scenario in South Africa is distinctly different for adults and adolescents alike. Of South Africa’s estimated 50.59 million citizens (Statistics South Africa, 2011), approximately 270 991 use (illegal) drugs, and a further 1.97 million use alcohol in a harmful way (South Africa, 2008a:25, 31). It is noteworthy that a significant increase in drug use amongst South African adolescents occurred during the country’s transition from apartheid to democracy (Central Drug Authority [CDA], 2006; United Nations Office on Drugs and Crime (UNODC), 2004). The factors contributing to the country’s increased vulnerability to illegal drug use include: ‘its trade links with Asia, Western Europe, and North America (hailed as major consumer markets); the country’s geography; porous borders as well as long-standing and worsening income disparities’ (Peltzer, Ramlagan, Johnson & Phaswana-Mafuya, 2010:2).

It is indisputable that prevention is more affordable than treatment and also has the potential to prevent a myriad drug-related problems. This is evident from reflecting on the drug use statistics cited in the second South African Youth Risk Behaviour Survey [SAYRBS] (Reddy, James, Sewpaul, Koopman, Funani, Sifunda, Josie, Masuka, Kambaran & Omardien, 2010:56-67). Of the 10270 scholars who participated in this survey, 29% reported life-time prevalence rates of cigarette smoking; 12.7% for dagga use; 49.6% for alcohol use; 6.2% for heroin use; and 6.6% for methamphetamine use. The bi-annual surveillance reports by the South African Community Epidemiology Network on Drug Use (SACENDU) reflect equally high rates of drug use amongst youth under the age of 20: ‘with 20% in the Eastern Cape and 28% in Kwazulu-Natal receiving treatment’, (Dada et al., 2012:2). These alarming trends underscore the importance of prevention interventions that would reduce the onset of new users and reduce the harm on existing users.

Drug prevention approaches (dating back to the early 1930’s in the US) have evolved from strong regulatory approaches, involving the banning of drugs, to an increase in taxes (McNeece & DiNitto, 2013:171-174), to scare tactics employed during drug awareness campaigns in the 1960’s (Rhodes & Jason, 1988), and affective educational and behavioural interventions (involving life-skills training), community involvement and, ultimately, harm reduction approaches (Van Wormer & Davis, 2008). Harker, Myers and Parry (2008:3) state that prevention in its ‘narrowest sense, targets individuals and their
peers, and at the broadest level it takes the form of international treaties, conventions and other structural interventions’. Cultural sensitivity in drug prevention refers to the extent to which the content and presentation of drug prevention programmes reflect the target population’s norms, beliefs, ethnic/cultural characteristics, and other environmental and social dynamics (Resnicow, Soler, Braithwaite, Ahluwalia & Butler, 2000:272). The authors cite the following three empirically validated explanations as to why drug prevention programmes should be tailored to the needs and context of the target audience:

- Differences in the prevalence rates and patterns of drug use across racial/ethnic groups.
- Differences in the prevalence of the risk factors for drug use across racial/ethnic groups.
- Differences in the predictors of drug use across groups.

These three explanations concur with the rationale for the present study; however, with an acknowledgement that data has often been ‘racialised’ and the proposal that the terms cited above, that is, ‘racial/ethnic’, and ‘groups’ be substituted with the broader term ‘cultures’ which, in the case of this study, will include ‘adolescent culture’, ‘community culture’, and ‘social class culture’. A second key difference I wish to propose in this study is that the debilitating associations emanating from these social constructions be interrogated and deconstructed. The discussion of cultural sensitivity in drug prevention and the social constructionist conceptual framework is furthered in Chapter Two, following on the history of drug prevention approaches and the related theories underpinning the different approaches.

Gernetzky (2012) calls for a new approach to the prevention of drug and alcohol abuse, questioning the effectiveness of awareness and educational campaigns. This critique followed on a study among 4 346 Grades 8-12 pupils in the Gauteng Province, in which almost 80% of the pupils admitted to using alcohol regularly, whilst 26,9% admitted to using illegal drugs. The conclusions of the study highlighted that an increasingly younger population of substance users have relatively easy access to legal drugs.
(alcohol in particular), and that the increased consumption is closely associated with the developmental changes and stressors associated with adolescence.

This call for a new approach to drug prevention was made despite the existence of the Ke Moja Programme, which is South Africa’s national drug prevention programme, run under the auspices of the National Department of Social Development (African Youth Development Fund (AYDF), 2007) The limited information obtained on this Programme is reviewed in Chapter Two of this study.

A study commissioned by the Eastern Cape Department of Social Development on the risk and protective factors associated with substance abuse amongst a sample of 908 youth (16-21 years) confirmed the concern about the earlier onset and extent of drug use, as well as the consequences of drug use amongst the youth. The conclusions emerging from this study point to the need for drug prevention interventions that incorporate strategies aimed at reducing the demand for and the supply of drugs (Potgieter, Goliath & Pretorius, 2010:45). The need for the introduction of a comprehensive, integrated approach to drug prevention is reiterated in international literature (Medina-Mora, 2005) and endorsed by researchers and policy makers in the Western Cape, and also underpinned in South Africa’s legislative guidelines pertaining to drug prevention, i.e. the National Drug Master Plan (2012-2016) (South Africa, 2012a). Moreover, it resonates with the resolutions adopted at the Second National Biennial Conference on Substance Abuse in 2011, which culminated in an Anti-substance Abuse Programme of Action (2011-2016) (South Africa, 2011a), aimed at:

- developing and reviewing legislation directed at regulating the supply of drugs;
- actively implementing policy and legislation to reduce the web of crime (and harm) associated with drugs;
- educating and raising awareness about drug abuse, with a view to reducing the demand for drugs;
- promoting equal access to resources across South Africa;
reviewing institutional mechanisms to prevent and manage alcohol and drug use in the country. This would include structural changes and mobilising communities to become active partners in the fight against drugs.

The Annual Report (2010/2011) of the Province of the Eastern Cape Department of Social Development [ECDSD] (South Africa, 2011b:64) clearly illustrates that the primary forms of drug prevention are awareness raising and educational campaigns, which are contrary to the recommendations for more comprehensive drug prevention approaches and the objectives of the National Anti-Substance Abuse Programme of Action. The ECDSD Report (South Africa 2011b:64) reflects that a total of 1 480 awareness campaigns were conducted, reaching a total of 34 035 individuals (including both in-and-out-of school youth). A further 5000 people were reached on 17 July 2010 in East London during an address by the National Minister of Social Development on International Day Against Drug Abuse. The Report makes reference to a Community Mobilisation Campaign on drug abuse, which was implemented in the Amathole, Chris Hani and O.R. Tambo districts. Although this involved a community engagement element, its focus was reportedly mainly on raising awareness about the effects of drug abuse. The Report makes reference to the existence of thirty-six (36) Local Drug Action Committees (LDACs) that were operational and implementing drug abuse programmes in all 24 local areas; however, the Report offers no detail on the nature of these activities. The Report is also silent on whether these prevention interventions were tailored to the specific context in which they were delivered. The intention with the present study was to contribute towards the objectives of reducing the demand for drugs and the harm associated with drugs in a particular socio-cultural context.

The present study was located in the Northern Areas of Port Elizabeth, located in the Eastern Cape Province of South Africa. The Northern Areas is a geographical area that developed around the late 1960’s and early 1970’s, when communities were compelled by the Apartheid government, in terms of the Group Areas Act No. 41 of 1950 (South Africa, 1950), to move from what were then declared ‘White Suburbs’. The Northern Areas subsequently grew and soon took on the added racialised meaning of a ‘Coloured Area’ – depicting the main race group that populated the area. The Northern Areas is stratified according to socio-economic hierarchies, evident from the differences
in the size of houses and stands, access to running water and basic ablution facilities. The inequality in the distribution of basic resources is apparent in what could otherwise have been misconstrued as a homogenous geographical community. The focus of the present study was predominantly on the lower income section of the Northern Areas, as socio-economic status has been construed as the most consistent common denominator in the early onset of drug use (Brook, Morojele, Brook & Zhang, 2006; Elliot, Menard, Rankin, Elliot, Wilson & Huizinga 2006; Morojele et al., 2006; Botvin, Griffin, Diaz & Ifill-Williams 2001; Johnson, Pentz, Weber, Dwyer, Baer, MacKinnon & Hansen 1990).

A long-standing racial stereotype associates ‘Coloured’ racial identity with an enhanced susceptibility to drug use. Reflecting on the historical link between race and substance use, London (1999:1408) describes how the infamous dop system was utilised by ‘White’ agricultural employers in the 19th century as a remuneration system among mostly ‘Coloured’ farm labourers. This became a powerful oppressive practice through which farmers secured cheap labour, and the labourers secured a job and their daily dop. Ironically, the consumption of the daily dop ‘created a social movement in which farmers could not share, and a social focus around which farm workers could construct their own cultural identity’ (Scully in London, 1999:1409). This independent cultural space became a functional survival mechanism in a rather hostile social environment. It is these practices (and subsequent continuation in the rural towns of the Western Cape, where domestic or gardening work is still remunerated with alcohol) that, in part, contributed to the social perception that ‘Coloured’ people are inherently alcoholic (Mayson in London, 1999). The narratives of several of the people who were dispossessed of their homes as a result of the Group Areas Act (No. 41 of 1950) contain frequent allusions to the fact that they attributed their problematic drinking to the consequences of Apartheid (Du Plessis, 2013).

Another humiliating racial stereotype that associates substance use with ‘Coloured’ identity is the idiom, ‘So dronk soos ‘n Kleurling-onderwyser’, which was scrapped from the earlier version of the Afrikaans Dictionary, following vehement opposition from the late Prof Jakes Gerwel, an anti-apartheid activist. In a perpetuation of this social construction of ‘Coloureds’ as ‘drunkards’, Blackman Ngoro, the Political Advisor of the
Mayor of Cape Town at the time, asserted this view on a political website, adding that ‘Africans’ were ‘culturally superior to Coloureds’ (Hendricks, 2005:2). ‘Coloured’ racial identity and neighbourhoods are often equated with gangsterism (Kinnes, 2011). Shebeens/taverns and unlicensed residential bars have proliferated in predominantly ‘Black’ and ‘Coloured’ neighbourhoods, which are characterised by unregulated and under-age drinking, noise pollution, poorer hygiene due to public urination, excessive consumption, and a lucrative space for drug trade and unsafe sexual practices (Herrick, 2012:1048). The harmful consequences of these deeply entrenched racial stereotypes are illustrated in both local and international literature.

The perpetuation of these racial stereotypes is upheld by surveillance and research statistics. Whilst substance use spans across age, gender and all segments of society, the rapid increase in both legal and illicit substance use among adolescents in the Northern Areas (confirmed by statistics from SACENDU) has been particularly pronounced. SACENDU statistics, which reflect on racial demographics (South Africa, 1950), report that, in the year 2011, the ‘Coloured’ population constituted 62% of those seeking treatment for substance abuse, compared to 15% ‘African’ treatment seekers in Port Elizabeth (Dada et al., 2012:44), which furthers the racialisation of data. Furthermore, methamphetamine use by persons under the age of 20 years in Port Elizabeth increased fivefold in a three-year period, i.e. from 7% in 2008 to 39% in 2011 (Dada et al., 2012), with the ‘Coloured’ population group accounting for the majority of methamphetamine users.

The findings from the second South African National Youth Risk Behaviour Survey (SANYRBS) (Reddy, James, Sewpaul, Koopman, Funani, Sifunda, Josie, Masuka, Kambaran & Omardien, 2010) conducted among 10 270 scholars highlight that, compared to other race groups, the ‘Coloured’ high school learners demonstrated the highest prevalence of cannabis use (i.e. 23.2%, as opposed to 11.2% amongst ‘Black’ learners; 15.7% amongst ‘White’ learners; and 18% amongst ‘Indian’ learners). The survey furthermore highlighted the use of alcohol on school property (15.1%), the use of cannabis on school property (11.5%), and the accessing of drugs at school (10.8%) as more prevalent amongst ‘Coloured’ learners nationally. Comparative figures for ‘Black’ learners for the risk behaviour cited were 12.5%, 7.5% and 8.8% respectively. Similarly,
the prevalence of learners who had ever used methamphetamine (a central nervous stimulant, which goes by the street name Tik) involved significantly more ‘Coloured’ (10.2%) than ‘Black’ (6.2%) and ‘Indian’ (1.9%) learners (Reddy et al., 2010). These statistics, together with the direct and indirect cost of drug-induced harm at biopsychosocio-environmental and economic levels (South African Community Epidemiology Network on Drug Use, 2012) further highlight the need for effective drug prevention interventions to reduce the onset of drug use, especially amongst younger children, and in communities in which there appears to be a higher prevalence of use.

These alarming reports resonate with recent newspaper articles on drug-related offences by adolescents in the Northern Areas (Luthuli, 2011:1 & De Jager, 2011:4). Local media reports, representing the voices of primary and secondary school principals in the Northern Areas, describe how drug dealers target scholars on a daily basis by lurking around the schools during break-times to sell drugs (Luthuli, 2011:1). The media reports furthermore highlight the grooming mechanisms drug dealers employ to affect children’s addiction and eventual recruitment as drug peddlers; with the reward system consisting of a regular supply of drugs and expensive branded clothing. The chairperson of a community advocacy group (Families Against Drug Abuse (FAD)), which was formed in response to the drug scourge in the Northern Areas), verified that the trade in and the use of drugs were reaching alarming proportions, and that the vast majority of adolescent drug users reportedly access drugs from other users at school (De Jager, 2011:4).

The picture that emerges, suggests an identity (Mcintosh & McKeganey, 2000) for adolescents from the Northern Areas of Port Elizabeth that restricts the likelihood of positive youth development (White, 2004). Again, a social construction emerges, which seems convincing when measured against the number of school drop-outs, teenage pregnancies and crime statistics for adolescents from this geographical community (Statistics South Africa, 2008). These findings, and the high relapse rate of adolescents in treatment, raise questions about the effectiveness of drug prevention services in South Africa (Burnhams, Myers & Parry, 2009), especially for people from historically marginalised low-income communities. The logical inference to be drawn from these reports is that drug prevention approaches need to extend beyond the scope of drug
awareness campaigns, and calls for a comprehensive understanding of ‘high-risk communities’ and specific socio-cultural groups, if one is to effectively mobilise for a reduction in the demand for and supply of drugs.

A review of the literature evidenced no longitudinal studies on the effectiveness of drug prevention programmes in South Africa. I came across numerous studies exploring the prevalence and impact of substance abuse amongst South African scholars (Feldtmann, 2010; Brook et al., 2006), but only one by Schönfeldt (2007), who conducted an evaluation of a school-based substance prevention programme in Tshwane. The conclusions of her study were that whilst the school-based prevention programme (Project Alert) resulted in an increase in substance related knowledge amongst the learners, no lasting behavioural change was evident as a result of the programme. The author recommends the incorporation of practical oriented tasks, as opposed to didactic methods of presentation, as the former have proved to be more effective among learners. An audit of prevention programmes in the Cape Town Metropole was undertaken by the Medical Research Council (Harker et al., 2008:20-44). The findings from this audit were that 91% of prevention programmes in the Metropole were educational in nature, with some focusing on the development of psychosocial skills. Whilst most participating organisations confirmed that their prevention programmes were age and gender sensitive and incorporated material that was culturally sensitive, very few could describe the culturally sensitive practices they employed. In contrast, several US research studies have attested to the effectiveness of culturally sensitive drug prevention programmes, based on the longitudinal evaluations of these programmes (Hecht, Marsiglia, Elek, Wagstaff, Kulis, Dustman & Miller-Day, 2003; Gosin, Marsiglia & Hecht, 2003; Botvin et al., 2001; Botvin, Schinke, Epstein & Diaz, 1994).

1.2 PROBLEM STATEMENT

The scourge of drug abuse in South Africa (especially following the country’s transition from apartheid to democracy) Central Drug Authority (CDA), 2006; United Nations Office on Drugs and Crime (UNODC), 2004) and the earlier onset of drug use have serious implications for adolescents and the country as a whole (Parry et al., 2009,
Longitudinal research suggests that drug abuse in adolescent years can have broad and far-reaching consequences that can extend into adulthood, and ‘continue to impact numerous functional domains, including relationships, marital and employment stability’ (Liddle & Rowe, 2006:474). Drug use also compromises the future of the country, if future leaders continually fall victim to the abuse of drugs.

Whilst multiple common risk and protective factors are associated with drug use and non-use among adolescents, which operate not only in mutually exclusive and reciprocal but also autonomous ways, there are also unique factors related to social, economic and cultural contexts (Myers, Harker, Fakier, Kader & Mazok, 2008). The findings from several local and international research studies reveal that unemployment, poverty and the deleterious socio-economic circumstance, prevalent amongst ethnic groups with historically minority status are inextricably linked to adolescents’ involvement with drug use (Swahn, 2012; Potgieter et al., 2010; Brook et al., 2006; Botvin et al., 2001; Fitzpatrick & LaGory, 2000).

This alarming scenario is particularly notable for adolescents and children who are growing up in an increasingly multicultural South African context (Reddy et al., 2010), where the slow rate of economic and social transformation has the potential to reproduce experiences of social and economic exclusion (Peltzer et al., 2010:2), especially in what is perceived to be historically marginalised communities. One such geographical community is the Northern Areas in Port Elizabeth, which is populated by a largely ‘Coloured’ ethnic group. This community is similar to several others in South Africa, characterised by high poverty levels, low levels of opportunity, poor education, limited employment opportunities, and other manifestations of social marginalisation, effected through deliberate social engineering by the Apartheid government and the failures of the present post-apartheid government (Motala, 2013).

The interest in the specific geographical community was triggered by a growing awareness of a prevailing, deeply entrenched racial stereotype that associates ‘Coloured’ identity with an enhanced propensity for substance use (Hendricks, 2005; London, 1999). These social constructions are reinforced by epidemiological data, for example from SACENDU (Plüddemann, Hon, Bhana, SANCA PE, Potgieter, Gerber,
SANCA EL, Petersen & Parry, 2008) and the second SANYRBS (Reddy et al., 2010), which in turn appear to have become explanatory of what is perceived as an inferior ethnic identity, characterised by a lack of academic achievement, low aspirations, and low self-esteem. The apparent ineffectiveness of current drug prevention approaches, and the similarities between the Northern Areas communities in Nelson Mandela Bay in the Eastern Cape and the Western Cape communities, both occupied by largely ‘Coloured’ ethnic groups, beckoned an inquiry into the participants’ own construction of drug use, non-use and drug prevention, from a social-cultural perspective, in order to inform culturally sensitive drug prevention interventions.

1.3 MOTIVATION FOR STUDY

It is indisputable that drug prevention is more affordable than treatment and also has the potential to prevent a myriad of drug-related problems. The call for drug prevention has been echoed by several sources in the last decade, especially as the link between drug abuse and other public health diseases and mortality rates has become evident (refer to World Drug Report, 2011; World Health Organisation, 1993).

The focus of the study and the selected theoretical framework were in synergy with the country’s regulatory framework that informs its drug prevention strategy, viz the National Drug Master Plan (South Africa, 2012a), and the Prevention of and Treatment for Substance Abuse Act (70 of 2008:15) (South Africa, 2008b). The policy and legislation propose that the prevention programmes address the values, perceptions, expectations and beliefs that the community associates with drug abuse. In the absence of a longitudinal evaluation of drug prevention programmes in South Africa, and the rising statistics in drug use cited earlier in the chapter, a fair assumption is that the current drug prevention programmes are failing to yield significant changes in drug abuse amongst adolescents, since they are incongruent with the meaning and social constructions these young people have of drug use in their communities. A second assumption is that current prevention programmes fail to challenge or interrogate and problematise the social constructions that normalise drug use and their associated deficit-oriented stereotypes, directed at and internalised by the target communities. These assumptions are supported by the rapid and earlier onset of drug use, as
reflected in more recent epidemiological statistics from SACENDU (Plüddemann et al., 2008) and the South African National Youth Risk Behaviour Survey (2010), as well as a review of drug-related South African studies (Peltzer et al., 2010). The reported effectiveness of culturally sensitive drug prevention programmes tailored to the needs of African-American and Latino-American target audiences (Pettigrew, Miller-Day, Krieger & Hecht, 2011; Brody, Murry, Gerrard, Gibbons, Molgaard, McNair, Brown, Wills, Spoth, Luo, Chen & Neubaum-Carlan, 2004:901; Hecht et al., 2003; Molgaard & Spoth, 2001), highlights to the gap in South African research, which the present study proposed to address.

‘Coloured’ identity and adolescents have been associated with very similar stereotypical social constructions, having been described as an ‘endangered and dangerous group – at risk from others, to themselves, and to the fabric of communities’ (Adhikari, 2005; Kim, Zane & Hong, 2002:566). It is against this backdrop that the present study aimed to invite a deconstruction of these problem-saturated normative social descriptions (Pilkington, 2007:219; London, 1999:23) and, in its place, facilitate a reconstruction or restorying that would characterise positive adolescent development and cultural and community resilience. It was anticipated that the findings from the study would present the building blocks for culturally sensitive drug prevention guidelines that would be transferable to diverse target populations, subject to being tailored to their needs.

The decision to include peer mentors and social service practitioners who deliver drug prevention programmes to the targeted research community was informed by the increasing call for drug prevention programmes to be grounded in best practice methods, and guided by research or evidence of its effectiveness (United Nations Office on Drugs and Crime (UNODC), 2004). The field of drug prevention and treatment has been recognised as a specialist field (South Africa, 2012a; Harker et al., 2008; Atkinson, cited in Myers et al., 2008) that requires programme implementers who are adequately trained (Myers et al., 2008; Ennett, cited in Myers et al.,2008:18). Hence an inquiry into the programme implementers’ own construction of drug use, non-use and prevention in the identified community was necessary. Programme implementers are also in the powerful position to serve as co-authors of reconstructed stories of hope and
development (White & Epston, 1990) which, in the context of this study, refer to guidelines for culturally sensitive drug prevention interventions.

1.4 RESEARCH QUESTIONS

The three research questions that provided direction for the study, are as follows:

- **What are the social constructions of the concept ‘Coloured’, as articulated by adolescents and social service practitioners living and working in the Northern Areas of Port Elizabeth?**

- **What is the socio-cultural meaning of drug use, non-use and drug abuse prevention for adolescents from the Northern Areas of Port Elizabeth?**

- **How do the social constructions of social service practitioners of drug use and non-use influence the drug abuse prevention services that they render to adolescents from the Northern Areas of Port Elizabeth?**

**Sub-questions**

The following sub-questions were formulated for the purpose of this study:

- **How are drug use, non-use, and drug abuse prevention services constructed by adolescents from the Northern Areas of Port Elizabeth, who are volunteers of TADA?**

- **What are the social constructions of drug use, non-use, and drug abuse prevention among non-drug using adolescents from the Northern Areas of Port Elizabeth?**

- **What are the social constructions of drug use, non-use and drug abuse prevention among adolescents from the Northern Areas of Port Elizabeth, who have reduced their use of drugs?**
• How is meaning about drug use, non-use and drug prevention constructed by social service practitioners who render drug abuse prevention programmes to adolescents from the Northern Areas communities of Port Elizabeth?

1.5 RESEARCH GOAL AND OBJECTIVES

The overall goal of this study was to enhance an understanding of the socio-cultural meaning attributed to cultural identity, drug use, non-use and drug prevention in the Northern Areas of Port Elizabeth, with the view to developing guidelines for drug prevention interventions that are culturally sensitive and contextually relevant.

The following objectives were formulated in order to achieve the goal of the study:

• To explore adolescent narratives regarding the constructs ‘Coloured’, drug use, non-use and drug prevention programmes of three distinct groups of adolescents (drug users, non-users, and TADA peer mentors) from the Northern Areas communities.

• To explore and describe the social service practitioners’ constructions of drug use, non-use and drug abuse prevention in relation to adolescents from the Northern Areas communities, and how such constructions inform the drug prevention services rendered to the adolescents from these communities.

• To review the data collected from the adolescent narratives and the social service practitioners’ reflections on their drug prevention programmes, against existing theory and models for drug prevention.

• To synthesise the above information with a view to developing guidelines for culturally sensitive drug prevention programmes relevant and responsive to the specific social constructions of adolescents from Northern Areas communities.
1.6 CONCEPTUAL FRAMEWORK

Two main conceptual landscapes guided the present study. The first is the social constructionist framework, which proposes that there is no objective reality. Instead, the theory postulates that reality is constructed by persons during their social interaction (Jankowski, Clark & Ivey, 2000:241-244). In these social interactions, people not only act in accordance with their reality, but also seek confirmation of that reality (Van Niekerk & Prins, 2001). According to the author, constructionism also acknowledges that dissimilar realities may coexist alongside each other, and while they may both be valid, the one may be more functional than the other. In the context of the present study, the belief that using the concept ‘Coloured’ reinforces race talk, may coexist with an alternative construction that the use of the concept invites an opportunity to oppose race talk and deconstruct its associated meanings. This example illustrates the argument by Gergen (2005) that events, objects and identity do not have a predetermined meaning, but rather take on a particular meaning in the context of social interaction with others and through the language that is used to describe them (Gergen, 2005). A social constructionist framework is underpinned by the following key assumptions:

- **Assuming that ‘taken-for-granted’ knowledge is a myth:**
  The social constructionist framework opposes the view that there are universal truths about human nature and human behaviour. Accordingly, it contests the ‘objective study’ of human nature, claiming that the researcher’s subjective perception of the phenomenon under study will shape his or her view of the phenomenon. However, since there is no universal truth, the researcher assumes a ‘not knowing’ stance, which levels the hierarchy and reduces the power differential between the researcher and the participants (Jankowski et al., 2000:242). The purpose of the present study was specifically to understand what meaning the participants constructed and co-constructed of the constructs ‘Coloured’, drug use, non-use and drug prevention. As I had my own perceptions of these constructs, I guarded against formulating the data generation questions in a way that would impose my view and lead the conversation in a particular direction.
Social constructions are located in historical and cultural narratives:
According to the social constructionist theory, people’s understanding of the world is informed by the social, historical and cultural norms prevalent in their social context (Creswell, 2007:20-21). Hunt and Barker (2001:179) echo this view, stating that ‘substances circulate in specific cultural and historical milieus where they are produced, exchanged, and consumed.’ The social construction that drug use is automatically associated with ‘Coloured’ ethnic identity dates back to the pre-colonial era in South Africa, when the dop system was employed as a method of remuneration (refer to earlier discussion in this chapter).

Knowledge is created and perpetuated by social processes:
According to social constructionism, it is through social interaction that our understanding of the world is constructed and new meaning is created. By implication, these social constructions can be challenged, deconstructed and reconstructed when they are found to be harmful or reinforce narrow, debilitating self-descriptions (Morgan, 2000:43). My observation was that drug use (amongst an increasingly younger population) has become a normalised phenomenon in large parts of the Northern Areas of Port Elizabeth. In accordance with the critical stance of social constructionism, my assumption was that this social construction of normalised drug use could be deconstructed.

Knowledge and social action go together:
The social construction that people hold of their world, determines how they respond to their world. Pryce (2006:10) explains that ‘each social construction invites a different kind of action from individuals in the world’. In applying it to the present study, the social construction that drug use is a normative occurrence in Northern Areas communities may result in parents permitting their children’s use of legal drugs, with the hope that it would deter them from the use of illegal drugs (refer to sub-theme 2.2 in Chapter Five). In contrast, the establishment of the Families Against Drug Abuse (FAD) support group was the result of social action by parents who have suffered the consequences of their children’s addiction to drugs.

The application of the social constructionist conceptual framework to the present study is further illustrated under the concept definitions (refer to Section 1.9 of this chapter).
The second conceptual framework, i.e. the risk/protective resilience framework, embedded in an ecological systems framework, aims to address the limitations of the social constructionist perspective. The application of the latter framework may result in people’s individuality being ignored, in favour of assumed homogeneity in specific socio-cultural contexts (Straussner in McNeece & DiNitto, 2013:286). The risk protective/resilience framework (located in post-modernist theory) accounts for the fact that people’s meaning constructions are informed not only by their socio-cultural context, but also by factors in their micro and macro ecological spheres, and that there is a systemic interplay between these different contexts/spheres. All of these should be considered when designing tailored, culturally sensitive drug prevention interventions.

McNeece and DiNitto (2013:171) report that the developers of prevention programmes have only recently begun to address theoretical issues that cut across common areas of concern regarding alcohol, tobacco and illicit drugs for adolescents. Concepts like risk and protective factors suggest that there is no simple formula for predicting the effect of drugs on youth or for understanding the reasons for the onset of drug use. However, several research studies (cited below in more detail) have confirmed the value of focusing drug abuse prevention on reducing risk factors associated with the onset of drug use, and enhancing protective factors that reduce the individual’s likelihood of drug use. Myers et al. (2008) also confirm that this approach is consistent with principles for evidence-based practice approaches.

Risk factors have been defined as those factors that enhance the likelihood that a person will engage in drug abuse or become dependent. These are associated with harmful or otherwise negative outcomes for the person (McWhirter, McWhirter & McWhirter, 2007). Protective factors, on the other hand, refer to those factors associated with reduced potential for drug abuse, or variables that mitigate against or buffer the effects of risk factors. These factors may be autonomous with no corresponding risk factor, or may be the direct opposite of a risk factor, and their presence can enhance, interact with or moderate other protective factors, leading to more or less drug use (Liddle & Rowe, 2006; Kim et al., 2002). The relationship between the number and type of risk and protective factors can hence determine the likelihood of a person’s vulnerability to drug use.
Both risk and protective factors can be categorised in five domains or settings, namely individual, family, peer, school or community domains (McWhirter et al., 2007; National Institute on Drug Abuse (NIDA), 2003). These factors interact with the individual processes of receiving, elaborating, interpreting and responding to stimuli. This categorisation differs slightly from that of Herrick’s (2012), who suggests that societal factors should be specified to reflect national policy as well as the influence of global, political and economic systems. A detailed discussion of each of the six domains of the risk/protective resilience framework will be presented in Chapter Two.

International studies demonstrate that risk and protective factors may be influenced by age, gender, ethnicity, culture and environment (Zucker, Donovan, Masten, Mattson & Moss, 2009; Thatcher & Clark, 2008; Lidia, Oscar & José, 2006; Swart, Panday, Reddy, Bergstrom & De Vries, 2006; Gilbert, Carlos & Lee, 2008; National Institute on Drug Abuse (NIDA), 2003); hence highlighting the need for a thorough investigation of the risk and protective factors associated with target groups, to ensure that programmes are culturally sensitive and developmentally appropriate (Potgieter et al., 2010; Stajduhar, Funk, Shaw, Bottorff, & Johnson, 2009; Harker et al., 2008:18; Elliott et al., 2006; Johnson et al., 1998).

Similarly, studies conducted confirm that although there are common determinants of drug use among South African adolescents, there are also unique factors related to social, economic and cultural contexts (Potgieter et al., 2010:58; Myers et al., 2008; Panday, Reddy, Ruiter, Bergström & De Vries, 2007). The earlier studies on risk and protective factors pertaining to drug use confirm that multiple, interactive and interrelated factors contribute to drug use and, furthermore, as the number of risk factors increase, so the potential for drug use increases (Newcomb & Bentler, 1988). The value in targeting more proximal as opposed to distal risk factors to bring about change in adolescent drug use has been reported (Potgieter et al., 2010; Brook et al., 2006). The South African research studies cited above were primarily quantitative in nature and were located predominantly in the Western Cape, pointing to a dearth in research in the Eastern Cape, and in particular from a qualitative approach. This is one of the gaps that the present study aimed to fill.
Secondly, aligned to the social constructionist framework, the concepts of risk and protective factors are regarded as socially constructed phenomena, i.e. a risk factor for some, may be viewed as a protective factor for others. To this extent, drug use by a parent may serve as a deterrent to one of his children, who constructs it as undesirable behaviour, whilst another child may be attracted to the perceived disinhibiting effect of the drugs and subsequently associate with peer circles in which drug use is constructed as a normalised part of peer culture.

The concept resilience has been defined in many different ways but, in essence, involves the portrayal of (often unexpected) adaptive outcomes in the presence of adversity, and originates from studies in developmental psychology in the 1950s (Catalano, Berglund, Ryan, Lonczak & Hawkins, 2002; Garmezy, 1991; Masten, Best & Marney, 1990). The concept was further explored by positive psychologists who built on Antonovsky’s focus on salutogenesis, as opposed to pathogenesis. Other authors have also emphasised the importance of distinguishing between resilience and resiliency, with the latter referring to a personality characteristic of an individual, and the former to a dynamic adaptive developmental process, that involves interactions between risk and protective factors across multiple levels of an individual’s lived experience (Oliver, Collin, Burns & Nicholas, 2006:1). The relevance of resilience theory to the present study is located in the growing evidence that young people adopt a greater sense of ownership, control, meaning and connectedness when they are actively involved in decisions that affect them (Stajduhar et al., 2009; Canvin, Canvin, Marttila, Burstromb & Whitehead, 2009; Oliver et al., 2006; Smokowski, Reynolds & Bezruczko, 2000). Similarly, resilience can be strengthened at family, school, community and societal levels (discussed in more detail in Chapters Two and Six of this thesis).

1.7 OVERVIEW OF RESEARCH METHODS

The section that follows provides a short overview of the research methods employed in the study. Chapter Three provides a more in-depth description of the research approach, design and methodology implemented in the study.
A qualitative research approach was employed for the purpose of this study. The aims of qualitative research are to gain an in-depth understanding (or thick description) of situations as they are constructed by the research participants, to uncover the silences in narratives, and often concentrate only on a specific aspect of human experience (Henning, Van Rensburg & Smit, 2004; Weis & Fine, 2000; Woods, 1999). The qualitative approach was most applicable to the present study, as I wished to learn about the meaning that the research participants attributed to their experiential worlds on which they were experts (Donalek & Soldwisch, 2004:356). In particular, the purpose of the present study was to explore the narratives of adolescents and social service practitioners around the use and non-use of drugs, as well as drug prevention in a community and cultural context dominated by a narrative of racial stereotypes and associated with drug abuse and dependence (Plüddemann et al., 2008). The decision to include four different sample groups (adolescent drug users, non-users, adolescent peer mentors and social service practitioners) resonates with the contention by Blaike (2000:251) that the qualitative approach allows the researcher to uncover whether there is shared knowledge or meaning construction surrounding the same phenomenon in a social context. The adolescents’ meaning constructions were subsequently triangulated with an exploration of the social constructions of the social service practitioners (social workers and social auxiliary workers) who offer drug prevention programmes to adolescents in the Northern Areas communities.

The narrative tradition of inquiry was employed for the purposes of achieving the aim of this study. De Vaus (2001:8-9) describes a research design as the structure or the plan that is required to guide the research process and ensures that the research findings that are generated respond to the initial research question as unequivocally as possible. The concept ‘narrative inquiry’, was used in this thesis to describe the research design for the study with the social service professionals, peer mentors and

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1 The terms drug users and non-drug users are used to facilitate the ease of writing and reading of the thesis. The alternative would be to refer to ‘those participants who use drugs and those who do not’ which would make the reading tedious. There is no intention to label the participants nor to suggest a scripting of their identity. As these descriptions have the potential to evoke negative connotations, the reader is reminded that I uphold the view of identity as something that is both found, in terms of what we have become, and made, in terms of how this can be reconstructed into what we are yet to become” (Burkitt, 2008:188).
non-users, whilst the biographical narrative inquiry would describe the design of the study for the sample of adolescent drug users. A narrative inquiry allows for a more complete story of the studied phenomenon, contextualised in culture and social context, and over a span of time. This view is supported by Riessman (1994:114), who suggests that:

*Narratives allow us to create who we are and to construct definitions of our situations in everyday life ... a near universal form of ordering our worlds, narratives allow us to make connections and thus meaning by linking past, present, self and society.*

Roberts (2003:176) defines biography as an account of a person’s life written by another. In this context, I assumed the role of biographer of the participants’ experiences with drug use and their views on drug prevention. The decision to include adolescent participants from the same geographical and cultural community, whose journey with drug use had been of a varied nature, was informed by the interest to hear the differences and similarities in how these stories ‘lived and told’ would be constructed by the range of participants.

In acknowledging the view of Bruce (2007) with regard to the emancipatory potential of narrative inquiries, my intention was to facilitate a conversation that would contribute to the participants questioning the dominant, internalised, culturally stigmatising and marginalising story of drug use amongst the research community. Accessing these narratives would offer them the opportunity to uncover implicit stories of resistance and resilience, which may otherwise have remained a silent voice in their lives (Etherington, 2006; White & Epston, 1990). Likewise, it had the potential for a transformational effect on the social service practitioners who participated in the study, which in turn could have a direct impact on professional practice (Hardy, Gregory & Ramjeet, 2009).

I employed three different methods of data collection among the four different sample groups. The adolescent drug users expressed their views through individual biographical research interviews, whilst the adolescent non-users’ views were accessed through written narratives. The adolescent peer mentors and social service professionals’ social constructions were elicited in the context of focus group interviews.
I employed methodological triangulation by applying two methods of data analysis, i.e. content analysis and thematic narrative analysis, to make sense of the rich data generated by the four sample groups.

1.8 THE JOURNEY METAPHOR

My decision to present the analysed narratives of the drug users in the form of a journey metaphor was informed by a number of factors. The idea first arose during the conceptualisation of the study, when I recalled how several of my previous clients, battling drug addiction, would refer to drugs altering the course of their life journeys on. I anticipated that the data generation among the sample of adolescent drug users might be difficult, prejudiced by my narrow assumptions, rooted in addiction counseling, that people with drug related challenges were generally resistant and in denial. Rerouting to my epistemological assumption to have an interrelated, transactional relationship, void of any power differentials between the participants and myself (Healy, 2005:203), I started exploring ideas that would help me achieve this aim.

A second factor that informed my decision to employ the journey metaphor was my own journey in the research process and my narrative interpretation of the participants’ stories. Reisfield and Wilson (2004:4024), who describe metaphors as vehicles for understanding, state that: ‘When metaphors enter our conceptual system, they alter that system and the knowledge, attitudes, and behaviour to which the system gives rise’ (Reisfield & Wilson, 2004:4024). I was acutely aware that I became an active participant in the participants’ stories. As I continued to examine my experiences and interpretations of their stories, I found myself sharing these with the participants in an ongoing process to better understand the stories they told me (Chan in Creswell, 2013:320; Jensen, 2006:2). The research methodology chapter is therefore also presented in accordance with this analogy, depicting the research journey I have undertaken.

The decision to use the ‘life as a journey’ metaphor was furthermore informed by its resonance with the research data collection tool (the Life Grid), and by the ubiquity of
the metaphor (Clandfield, 2002:3). Lakoff and Johnson (1980:60-61) elaborated on the metaphor as follows:

‘Our understanding of life as a journey uses our knowledge about journeys. All journeys involve travellers, paths travelled, places where we start, and places where we have been. Some journeys are purposeful and have destinations that we set out for, while others may involve wandering without any destination in mind, consciously or more likely unconsciously, a correspondence between a traveler and person living life, the road traveled and the ‘course’ of a lifetime, a starting point and a time of birth, and so on’.

It was evident from the manner in which the participants narrated their stories that they were familiar with metaphors, as they frequently used phrases that resonated with the chosen metaphor. These will become evident in the verbatim quotes that will be presented in Chapters Three and Four of this research report. The use of the metaphor also cohered with the theoretical framework of the study, as the participants pointed out a complex interplay between homogenous danger zones on their pathways (i.e. the socially constructed meanings of drug use); and individual potholes or smooth pathways depicting unique micro risk and protective factors, which either facilitated or inhibited the onset of drug use. In keeping with the metaphor, the drug users will be coined ‘the travellers’. The non-users will be called ‘observers’, as they purportedly had particular views on the drug use journey and drug prevention, informed by their observation of other travellers in their neighbourhoods and their own experience of non-use. The TADA peer mentors, social workers and social auxiliary workers will be referred to as peer and practitioner navigators respectively, as they were frequently consulted when the travellers required redirection on their course of the drug use journey. The term navigators may give the impression of the ‘powerful’ or the experts or knowing navigating the way for the ‘powerless’, which may appear incongruent with my ontological stance. Foucault (cited in Healy, 2005:203), however, urges us to recognise the productivity of power. In other words, that people submit to power because it serves a particular purpose for them. Having said that, one limitation of the study was indeed the process I followed in constructing the journey metaphor. Although the research supervisor formed part of the co-construction of the metaphor, the participants should
have been invited to assign ‘titles’ to their positions on the journey, instead of me simply adopting the generic travel metaphor, in terms of which a journey constitutes of travellers, observers and navigators.

1.9 CONCEPTUAL DEFINITIONS

The social constructionist framework purports that concepts can take on different meanings, depending on the context in which they are used. Each of the key concepts will now be defined and explained, and its application to the present study illuminated.

Freeman (1998:101) describes narratives as cultural forms, sense-making tools or discursive resources that help us navigate through social life. In the context of the present study, narratives will refer to the verbal and written discourses that emerged from the research participants’ engagement in the data generation process.

The concepts ‘drugs’ and ‘substances’ are used interchangeably in this chapter of the thesis and subscribe to the guidelines proposed in the National Drug Master Plan (2012-2016), in which these are defined as ‘terms of varied usage’ (South Africa, 2012a). In medicine, a drug refers to any substance with the potential to prevent or cure diseases or enhance physical or mental welfare and, in pharmacology, to any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In everyday language, the term refers to psychoactive drugs and often, more specifically, to illicit drugs. The preferred concept for the purpose of the present study will be drugs, to enhance coherence in the writing, and to cohere with the concept preferred by the research participants. The concept drugs will be used to refer to both licit (legally available) and illicit (legally prohibited) drugs. A number of prevention researchers draw a distinction between alcohol, tobacco and other drugs, and frequently use the acronym ATOD in discussing their findings (Faggiano, Vigna-Taglianti, Versino, Zambon, Borraccino & Lemma, 2008; Ledoux, Miller, Choquet & Plant, 2002). This acronym will be used in the present study only when such studies are cited.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5R) draws a clinical distinction between drug abuse and drug dependence (American Psychiatric
Drug abuse refers to a persistent or periodic excessive drug use, inconsistent with or unrelated to acceptable medical practice.

Drug dependence refers to the use of drugs, to the extent that it is difficult or even impossible for the user to refrain from taking the drug without help after having taken it regularly for a period of time. The dependence may be physical or psychological, or both. Some authors make a distinction between four levels of use. Each of these is presented below, with its corresponding description:

Drug use – referring to once-off use or experimentation
Misuse – referring to social and recreational use
Drug abuse – referring to symptomatic or harmful use
Drug dependence, which is also described as addiction (McNeece & Di Nitto, 2013; Myers et al., 2008; Medina-Mora, 2005) and concurs with the DSM-5s definition cited above.

The definitions proposed above resonate with the disease or fix medical model of addiction (Fisher & Harrison, 2005:37-52), as it implies that the progressive use of drugs may eventually result in a loss of control. By contrast, the social constructionist framework suggests that the specific context and social interaction in the context will determine whether drug use is condoned, as well as when the level of misuse or abuse is reached, if at all.

Anthropological studies in the 1980s on alcohol use by Native Americans suggested that alcohol use was constructed as a ‘socially appropriate, culturally comprehensible event that was not necessarily pathological’ (Marshall, 1984:26). Substances acquire different cultural values as they pass from one sphere to another. White (2004:12) echoes this description, emphasising that the meaning drug users construct around drug use in these contexts guides their goal-directed action to use or abstain from use. Glover (2004:63) concurs, stating that the social constructionist theory accounts for the
meaning that people ‘recognize, produce, and reproduce through their social actions and the intersubjective understanding of specific life circumstances that they come to share’. These studies of people in different cultural, historical and geographical contexts have demonstrated that meaning can be constructed in many different ways – implying that drug use may be normalised in one sociocultural context, and admonished in another (White, 2004:12).

The present study focused on the **sociocultural meaning** that participants from a particular geographical and sociocultural community constructed around drug use, non-use and drug prevention. My research was embedded in the assumption that the meaning of drug use was contextualised in the culture and history of the particular cultural group and geographical community, resulting in numerous harmful associations and internalised stereotypes. These stereotypes prevail in a country in which social and economic transformation is happening at a slower pace than anticipated, thus threatening the ideals of national unity in post-apartheid South Africa (Alexander, 2007:92). The slow pace of transformation is particularly evident in the geographic community under study, in which the high rate of unemployment, under-resourced schools, poor recreational infrastructure are juxtaposed against large numbers of informal liquor outlets (Hayman, 2013), which serve as a source of income. It is against this background that drug use in the community has been socially constructed as a normalised activity which, seemingly, is tolerated, even by those who would previously have challenged its occurrence and its associated negative consequences. The strength of the social constructionist view is its contention that restricting and limiting meaning constructions of a particular phenomenon can be deconstructed and new meaning reconstructed.

The Barker (1987) defines **prevention** as a process aimed at minimising and eliminating the impact of conditions that may lead to social malfunctioning. Concurring with this definition, McWhirter et al. (2007) suggest that prevention is an anticipatory process that prepares and supports individuals and systems in the creation and reinforcement of healthy behaviours and lifestyles. **Drug prevention** has been described as the process aimed at delaying the onset of drug use (McWhirter et al.,
2007), and reducing its health and social consequences (World Health Organisation [WHO], 2002).

The reviewed literature does not use a uniform concept to refer to the prevention of drug use, arguably because prevention is targeted at different levels of use. Some literature employs the concept drug (substance) abuse prevention whilst others simply refer to drug prevention. The traditional Public Health Model proposed three categories of drug prevention in 1964, viz: primary prevention, aimed at preventing (new) onset of drug use; secondary prevention, aimed at identifying and treating those with a drug problem; and tertiary prevention, which focuses on avoiding a relapse and maintaining the health of those who have been treated (McNeece & DiNitto, 2005). In accordance with this definition, primary prevention focuses on larger numbers of people who have either no or very little experience of drug use (Ksir, Hart & Ray, 2008:415). The Institute of Medicine introduced a new categorisation of drug prevention, suggesting that universal prevention is for the general population; selective prevention for particularly defined populations at highest risk; and indicated prevention for people demonstrating early signs of drug related problems (National Institute on Drug Abuse [NIDA], 2003). Since the focus of the present study was on preventing and delaying the onset of drug use, it resides in the arena of primary prevention or universal prevention, as described above.

The concept identity assumed a central position in this study, as the study was located in a particular geographical community, inhabited by a specific ethnic group, with the focus on a specific age group. The many different contextually relevant concepts pertaining to identity will subsequently be presented from the basis of the social constructionist theoretical framework. The concept identity has consistently been described as an individual's definition of self, which enables him or her to be distinguished from another persistently (Côté, 2006; Korfmacher, 2006). In the context of this study, identity will encompass definition of self in the context of race, culture, ethnicity, community and developmental phase (specifically the adolescent phase).

Identity formation in this context is considered from a meaning-centred perspective, in which it is understood as ‘a social construction accomplished in situ’ (Shi & Babrow,
This description is congruent with the sentiments of Atwater (1996), who propose that people's cultural realities, including how they view themselves and the types of decisions they make, are constructed through social interactions. Besides being informed by the sociocultural context, identity formation has also been acknowledged as a developmental and internal process (Markstrom, 2010:1). The focus on identity is particularly relevant to the proposed study, since the primary unit of analysis in this study constituted adolescents, whose major developmental task is to construct a personal identity, according to classical theories on identity development (McLean, Breen & Fournier, 2010:166; Nguyen & Brown, 2010:4; Louw & Louw, 2007:309). This developmental process has been referred to as individuation, where the adolescent learns to establish an independent sense of self, whilst simultaneously sustaining close relationships with others. This implies that people are not passive beings, but rather that they have agency to shape social perception and influence on the self. This view has been termed the narrative approach to identity formation, which essentially entails making meaning of the past as a way of understanding the self with the passage of time (Giddens in McIntosh & McKeeganey, 2000).

In essence then, identity formation is the ability of an individual to uphold a narrative of his/her biography, and to challenge deleterious social constructions of his or her identity, that are incoherent with how he or she wishes to be viewed (Hendricks, 2005:1). The envisaged outcome of the present study was that the research participants would, during the process of data generation, become aware that "identity is something that is both found, in terms of what we have become, and made, in terms of how this can be reconstructed into what we are yet to become" (Burkitt, 2008:188). This view concurs with the sentiments of Swartz (2010:4), who argues that identity formation has become increasingly fluid, as South Africans try to adapt to a rapidly increasing multicultural and diverse society. His position that identity formation is 'partly 'assumed' (taken on) and partly 'ascribed' (assigned)' is the combination of a constructionist and evolutionary approaches.

The construct of race remains sensitive in the South African context, as it was an instrument used by the apartheid regime to distinguish between people on the basis of physical and biological characteristics, such as hair texture, eye colour and skin colour,
as recorded in the Population Registration Act of 1950. **Racism** refers to the value judgment of people on the basis of such racial classifications. Alexander (2007:94) argues that whilst these racial identities are incongruent with the ideals of a democratic South Africa, they are sadly perpetuated in the country’s Employment Equity Act (EEA), Act No. 55 of 1998. The terms ‘race’ and ‘designated groups’ only serve to accentuate the use of biological hierarchies and hence the reinforcement of unequal social relations, inequalities and racial prejudice (Alexander, 2007:94) in a post-apartheid South Africa that is increasingly characterised by differences in income and class, rather than race. Echoing this sentiment embedded in a social constructionist perspective, Machery and Faucher (2005:1208) classify the concept of race as a “pseudo-biological concept that has been used to justify and rationalise the unequal treatment of groups of people by others”.

My decision to use the concept ‘Coloured’ in the present study is seemingly in direct opposition to the suggestions by Alexander and other like-minded thinkers, cited above. Alexander (2007:102) in particular states that: “given the history of racial conflict and inequality, it is the duty of those who have the power to do so, to create conditions in which the need to identify in this way becomes unnecessary and undesirable”. In doing so, he argues, we would contribute to the realisation of the non-racial values enshrined in Section 1(b) of the South African Constitution. My decision to use the concept ‘Coloured’ ironically, served to achieve, in my view, exactly the same objective, albeit using a different strategy. The use of the concept in the data collection question had provocative intent – aiming to elicit the participants’ individual and shared constructions, precisely to explore whether, firstly, their construction resonated the widespread stereotypical associations with drug use; and secondly, to incite a deconstruction and ultimately a reconstruction of this harmful social perception, that ‘Coloured’ identity (in whichever way participants choose to describe it) is associated with drug use. The interplay between the potential harmful use of the concept ‘Coloured’ versus the emancipatory aim of the study is illustrated in this adapted view of Elliott (2005): The construction of discourses of ‘Coloured’ and the creation of ‘Coloured identities’ are part of the process that Foucault (1994:19) describes as the ‘constitution of subjects’, whereby the intersection of various types of power, knowledge and authority create new ways of conceiving and ‘thinking of’ types of person.
Nastasi and Schensul (2004:181-184) report that the concept culture has historically been used by anthropologists to refer to patterns of behaviour and similarities found in people from similar nationalities and ethnic groups. Le Baron and Pillay (2006:27) acknowledge that the term ‘culture’ (usually conflated with ethnicity, race or religion) is indeed difficult to define. According to these authors, the concept constitute more than merely differences in how people speak, dress and eat. Supporting this view, Bakker and Ruane (2009:245) illustrate the complexity of the concept culture by suggesting that it refers to more than ‘just membership of an ethnic group’; rather it comprises the meaning that people construct from experiences in their lives.

Le Baron and Pillay (2006), similarly, regard culture as a “flow of meanings and identities that consciously and unconsciously guide us” which constantly adapts to changing environments. They, therefore, loosely define culture as “the shared, often unspoken, understandings in a group that shape identities and the process of making meaning” (Le Baron & Pillay, 2006:26).

By way of elaboration on the complexity of this definition, the concept culture has also been applied in many different contexts, referring to people from different organisations, developmental levels, divergent sub-groups (e.g. culture of the addict), and occupational groups (e.g. teacher culture). Unger, Baezconde-Garbanati, Shakib, Palmer, Nezami & Mora (2004:1807) have simplified the definition to suggest that it includes “everything in human society that is socially rather than biologically transmitted among members of the society”. For the purpose of this study, culture is interpreted as acquired patterns of engagement, thinking, belief systems, values, ideologies, myths, ways of speaking and relating in a particular context.

**Ethnic identity**, on the other hand, has been described as the cultural domain of identity, which includes identification with the local cultural environment (Markstrom, 2010). These shared cultural components can include (but are not limited to) preferences in language use, religion and types of food (Unger et al., 2004:1807). In the context of this study, my social construction of the concept ‘Coloured’ constitutes reference to a specific ethnic group, whilst the concept culture will be privileged to encompass the socially constructed patterns of engagement, belief systems, rituals,
norms, values, language and other identified areas of commonality embraced by people in a specific and localised context (i.e. the Northern Areas of Port Elizabeth, inhabited by a predominantly ‘Coloured’ indigenous/ethnic group). In adopting this approach, I am also mindful of the caution by Sue and Sue (in Bakker & Ruane, 2009:243) to guard against incorrect assumptions of similarity between people from the same ethnic or cultural group, as their differences may be greater than between different ethnic or cultural groups.

Resnicow et al. (2000:272) explain that cultural sensitivity reflects the extent to which the design, presentation and evaluation of prevention and health promotion programmes are representative of the ‘ethnic/cultural (and linguistic) characteristics, experiences, norms, values, behavioural patterns and beliefs of a selected population’. Culturally sensitive programmes should furthermore also incorporate material that resonates with the historical, environmental and social forces in a particular cultural context. The US literature offers numerous examples of programmes that have been tailored to the cultural context of the target population (Pettigrew et al., 2011:117; Brody, Murry, Gerrard, Gibbons, Molgaard, McNair, Brown, Wills, Spoth, Luo, Chen & Neubaum-Carlan, 2004:901; Hecht et al., 2003:234; Molgaard & Spoth, 2001:19).

The present study was conducted in a diverse, increasingly multicultural South Africa, with participants in the research study experiencing the diversity first hand, due to the introduction of multicultural education in public schools (Swartz, 2010:7). The focus of the present study, hence, was all the more relevant, ultimately as a contribution to ‘social cohesion and nation-building, in a culturally diverse society’, where people would learn, to firstly develop an understanding and appreciation of their own culture, which ultimately enhances a sensitivity and respect for other cultures.

Anticipating that the participants would assign a biological construction to the concept race, I shared Grebe’s (cited in Institute for Justice and Reconciliation, (IJR) 2012:12) ambivalence about whether or not to use the concept of race. Grebe (IJR, 2012:12) suggests that, although the use of the concept is politically incorrect, students should ‘resist attempts at suppressing or delegitimising analyses employing race, even when these are based on a real fear of reinforcing stereotypes’. The reflection of surveillance
statistics according to racial categories by SACENDU and research findings by the National Research Council are cases in point. By the same token, Grebe (IJR, 2012:12) argues that we should work towards rebutting our own theories and replacing them with more erudite theories revealing real underlying social dynamics. The present study aimed to lay the foundation for the integration of culturally sensitive theories with ones that account for the interplay between individual perceptions and macro factors to inform tailored drug prevention interventions.

The adolescent sample group that was purposely selected for the present study was within the age range of 16-18 years, which necessitates a presentation of definitions of adolescence as well as youth. Adolescence connotes the complex transition between the states of childhood dependence and adult independence (McCauley & Salter in Fatusi & Hindin, 2010:2; Wood & Hine, 2009:4). Louw and Louw (2007) distinguish between early adolescence (12-14 years) and late adolescence (15-19 years). In contrast, the legal definition proposed for youth by the National Youth Commission (2000:7) includes young people between the ages of 14-35 years, whilst the Ministry for Welfare and Population Development (South Africa, 1997) has categorised youth to constitute persons within the age range of 16 to 30 years. Sathiparsad (2008:349) explains that the effects of apartheid and the political transition in South Africa have resulted in adolescents being exposed to vastly different life circumstances and experiences, subsequently informing the legislative definitions of youth by the post-apartheid government. The definition proposed by Louw and Louw (2007) will be adopted for the purpose of this study, as it presents the closest match to the delineation of the sampling criteria based on age.

The problem of drug use amongst adolescents needs to be considered against the developmental transitions that signify this life stage, one of which is to construct a personal identity (Louw & Louw, 2007:281). Societal changes add to the challenges for adolescents; Fatusi and Hindin (2010:1) aptly point out that today’s generation of young people have to navigate the transition to adulthood in a world that is “vastly different from previous generations – a world where AIDS, globalisation, increasing urbanization, electronic communication, migration, economic challenges, among other external forces, have radically transformed what it means to be young”. The cultural context in
which the adolescent is socialised also makes the transition to adulthood significant. My own social construction of the geographic and socio-cultural context of the adolescent participants in the present study was presented in the preceding sections of this chapter. The social construction that peer pressure constitutes a significant challenge in adolescence has been part of the dominant social discourse. Whilst it is acknowledged that a dominant influence in adolescent substance use is associated with peer substance use (Kim et al., 2002:565), the alternative construction I wish to propose in this study is that adolescents and their peer group be viewed as valuable assets worthy of investment (Pilkington, 2007:217) and capable of reciprocal positive influence on each other. This is in stark contrast to constantly denoting them as an ‘endangered and dangerous group – at risk from others, to themselves, and to the fabric of communities’ (Kim et al., 2002:566).

The final concept is practice guidelines, which are defined by Proctor and Staudt (2003:209) as: ‘systematically compiled and organised knowledge statements to help practitioners select and use the most effective and appropriate interventions for attaining desired outcomes’. Hofstee (2006) furthermore suggests that practice guidelines should specify the detail in terms of the ‘what, how, where and why’ of the proposed interventions. The latter definition will guide the formulation of the practice guidelines for culturally sensitive drug prevention interventions in this study.

1.10 OUTLINE OF THESIS

The research report has been laid out as follows:

Chapter One provides an overview of how the study was conceptualised, where it was located, the research questions and goals. The two conceptual frameworks underpinning the study are described, followed by a brief introduction to the research approach, design and methodology employed to execute the study. The chapter concludes with an explanation of the journey metaphor that guided the discussion of the participants’ (viz. travellers, observers, peer and practitioner navigators) narratives and, finally, the definitions of the key concepts that framed the study.
**Chapter Two** reviews the literature and theoretical perspectives on drug prevention, starting with an overview of how drug prevention is defined from the differing perspectives, the history of drug prevention theories and models, and the different conceptual frameworks explaining the reason for drug use and addiction. The two conceptual frameworks (and key concepts inherent to these frameworks) are subsequently foregrounded and specific drug prevention programmes, aligning with these frameworks, are reviewed in terms of their strengths, weaknesses and functional elements. The chapter further contains guidelines on the implementation of drug prevention interventions at each of the multisystemic levels (viz. family, school, peer, community and societal domains).

**Chapter Three** outlines the qualitative research approach, the narrative tradition of the inquiry research design and the research methods that were employed for the purposes of the study. The study was undertaken in two phases and is described accordingly. The chapter further contains a description of the four sample groups, the triangulation of data generation and data analysis. The chapter concludes with a reflection on how trustworthiness was achieved, as well as the ethical considerations that received attention throughout the study.

**Chapter Four** contains a presentation of the biographical narratives of the travellers, guided by the journey metaphor. The major themes that emanated from the analysis of the travellers' narratives are illuminated. This chapter does not contain a literature control, as it was important to present an uninterrupted presentation of the travellers' personal experiences on the drug use journey.

**Chapter Five** details the discussion of the research findings pertaining to the travellers and observers’ socio-cultural meaning construction around ‘Coloured’ identity, drug use and non-use. The discussion is supported by a literature review and direct quotations from the participants.

**Chapter Six** presents and discusses the findings of the peer and practitioner navigators’ socio-cultural meaning construction around ‘Coloured’, drug use, non-use
and drug prevention. The final section of this chapter deals with the navigators’ reflection on their own drug prevention interventions.

**Chapter Seven** begins with a synthesis of the findings from the empirical study among the four sample groups, as presented and discussed in the three preceding chapters, and the conclusions drawn from these findings. The synthesis is followed by a discussion of the participants’ recommendations for drug prevention, supported by a literature review, and culminating in conclusions drawn from these recommendations. The final section of the chapter is devoted to the presentation of the practice guidelines for culturally sensitive drug prevention interventions.

**Chapter Eight** summarises the methodology employed in the study, the conclusions drawn from the summary, the limitations of the study and the implications of the conclusions for future research, practice, further training of practitioners and policy in the field of drug prevention.

### 1.11 CHAPTER SUMMARY

The early onset of drug use amongst an increasingly younger population is a source of serious concern. Although drug use transcends racial, ethnic, class and gender boundaries, there is sufficient evidence to conclude that socioeconomic status, culture and societal variables are some of the most important determinants in adolescent drug use (Burnhams, Myers & Parry, 2009:2; United Nations Office on Drugs and Crime (UNODC) in Myers et al., 2008; Atkinson, cited in Myers et al. (2008:18), 2004; National Institute on Drug Abuse (NIDA), 2003; Hawkins, Catalano & Miller, 1992). These findings underscore the importance of prevention approaches that are context specific and responsive to the needs of the community to whom the drug prevention intervention is directed; hence the focus on cultural sensitivity in drug prevention interventions. This study sought to enhance an understanding of the sociocultural meaning constructions of drug use, non-use and drug prevention in a community stereotyped as naturally prone to drug use, in the belief that such an understanding would aid in the development of guidelines for culturally sensitive drug prevention interventions, which would substitute problem-saturated normative social descriptions (Pilkington, 2007:219;
London, 1999:23), with a reconstruction or restorying that would characterise positive adolescent development and, cultural and community resilience.

The next chapter (Chapter Two) contains an overview of the literature review and theoretical perspectives on drug prevention and cultural sensitivity.
CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL PERSPECTIVES ON DRUG PREVENTION

2.1 INTRODUCTION

Rothman and Thomas (1994:31-33) caution that researchers and practitioners should not reinvent the wheel. For this purpose, it is important to gather information on what has been done before (referred to, by the aforementioned authors, as ‘reviewing the state of the art’) to address the problem under investigation or to develop new knowledge products for practice. According to the authors, there are three steps involved in the gathering of information, namely (a) using existing information sources; (b) studying natural examples; and (c) identifying the functional elements of successful models. This Chapter contains a descriptive and critical review of the existing sources of information in the field of drug prevention, gathered by means of a literature review.

Henning et al. (2004:27) state that a literature review is undertaken in order to contextualise a study, provide a critical review of the current literature in the study area and, in the process, identify which gaps the relevant study aims to address. Drug prevention is a well-researched field, with a vast array of literature comprising predominantly quantitative studies and randomised control reviews of drug treatment and prevention programmes. Hence, the adoption of the unconventional approach to present a separate literature review chapter in this qualitative study was motivated by the desire to capture the progressive development in the field of drug prevention and to specifically illuminate the gaps in terms of incorporating cultural sensitivity in drug prevention interventions.

Chapter One contained a clarification of the key concepts related to this study, located in a social constructionist paradigm. Therefore, these concepts will not be revisited in Chapter Two. The presentation of this literature Chapter will take the following format: firstly, a descriptive review of the significance of drug prevention and a history of drug prevention approaches will be presented followed by a critical review of the theoretical explanations for drug use, and dependence. Thereafter, the theoretical frameworks for the present study, located in the conceptual framework of the study, i.e. the social constructionist framework combined with the risk and the protective/resilience framework will be introduced. This discussion will be followed by a detailed review of practice approaches to drug prevention interventions, targeted at each of the contextual systems.

2.2 WHAT IS MEANT BY PREVENTION, AND WHY IS THIS SO IMPORTANT?

The focus of the present study was to enhance understanding of the meaning that adolescents from the Northern Area communities of Port Elizabeth attached to the constructs ‘Coloured’, drug use, non-use and drug prevention, with a view to informing practice guidelines for culturally sensitive drug prevention interventions for the adolescents from these communities. Implicit in this focus was the claim that existing drug prevention programmes were probably failing to achieve significant changes in drug abuse amongst adolescents, given the current statistics, and also because they were incongruent with the meaning and social constructions these young people had of...
drug use in their communities, or because these prevention programmes failed to challenge and problematise the social constructions that normalise drug use and their associated deficit oriented consequences.

The epidemiological statistics cited in Chapter One served as rationale for why this study focused on prevention rather than the treatment of drug use. In addition, research findings that predate the 1990s suggest that primary prevention is significantly more successful than treatment. Similarly, these research findings were all echoed by practice observations from a variety of stakeholders in the field consulted during the conceptualisation stage of the present study (Stanley, 2012; Sharmar, 2012; Meintjies & Japhta, 2012), who all confirmed the need for drug prevention interventions that would ensure a reduction in the number of existing drug users and delay the number of new users. They were less certain about what was required to ensure the effective prevention of drug use and abuse, but offered clear descriptions of the interventions they had undertaken and the barriers encountered in the process.

The irregular evaluation and non-standardisation of evaluations of existing drug prevention programmes also complicate the process of deriving effective drug prevention guidelines. Given this contention, and the aim of the present study, it is important to understand the history of drug prevention programmes and be familiar with earlier successful and unsuccessful drug prevention interventions. Furthermore, it is crucial to understand the prerequisite conditions and variables required for successful prevention.

The definition and meaning of prevention have evolved over time. The goals of drug prevention programmes are generally to delay the onset of drug use (McWhirter et al., 2007), and to reduce its health and social consequences (World Health Organisation [WHO], 2002). At a micro level, prevention programmes are aimed at individuals at risk of substance use and, at a macro level, programmes are located at the level of international treaties, conventions and other structural interventions (Harker et al., 2008). Medina-Mora (2005:25) defines prevention as any activity aimed at averting drug abuse and reducing its health and social cost. McWhirter, McWhirter, McWhirter and McWhirter (2013), on the other hand, provide a broader and more comprehensive
definition by suggesting that prevention means stopping something before it happens, averting the impact of the existing problem and strengthening knowledge, attitudes, and behaviour that promote emotional and physical well-being. The categories of primary, secondary and tertiary prevention (informed by the traditional Public Health Model) were added in 1964, with primary prevention aimed at preventing (new) onset of drug use, secondary prevention aimed at identifying and treating those with a drug problem, and tertiary prevention focused on avoiding a relapse and maintaining the health of those who have been treated (McNeece & DiNitto, 2005).

An alternative classification for prevention was introduced by Brook, Whiteman, Gordon, Nomura and Brook (1986), consisting of the following three categories: (i) universal prevention, which is aimed at the general or a whole population group; (ii) selective prevention, which is aimed at a subgroup of a population that presents with some level of risk factors; (iii) and, lastly, indicated prevention, which is aimed at individuals and groups at high risk for demonstrating early signs of substance related problems (McNeece & DiNitto, 2005:237). The hierarchical positioning of these three categories of prevention is depicted in the continuum of care model, as illustrated in Figure 1 below. It is important to note that this newer classification of prevention approaches indicates the target of intervention (referring to the section of the community at which the prevention is geared).

![Continuum of care model](Image)

FIGURE 2.1: Continuum of care model  
[Source: Institute of Medicine (IOM) Prevention Classifications cited in McWhirter et al. (2013:289)]
The continuum of care model, depicted in Figure 2.1 above, illustrates the positioning of prevention as the starting point to the continuum, followed by treatment and eventually maintenance (or aftercare). The arrows pointing in both directions illustrate that all three phases of intervention constitute cyclical and interactive process.

Table 2.1 below illustrates that the scope of intervention is determined by the category of drug use.

<table>
<thead>
<tr>
<th>Classification of the categories of drug use</th>
<th>Proposed interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-use</td>
<td>Primary prevention</td>
</tr>
<tr>
<td>Drug use (once off use or experimentation)</td>
<td>Primary prevention/Early intervention</td>
</tr>
<tr>
<td>Misuse (Social and recreational use)</td>
<td>Early intervention</td>
</tr>
<tr>
<td>Abuse (Symptomatic or harmful use)</td>
<td>Treatment</td>
</tr>
<tr>
<td>Dependence (Addiction)</td>
<td>Treatment of dependency, relapse prevention and social integration</td>
</tr>
</tbody>
</table>

TABLE 2.1: Matching of level of drug use with proposed intervention
[Sources: Adapted from McNeece & Di Nitto, 2013; Myers et al., 2008; and Medina-Mora, 2005]

The present study proposed to provide the building blocks (guidelines) towards a primary prevention intervention, aimed at decreasing the prevalence of new users of drugs, delaying the onset of use, and maintaining such declines. Ksir et al. (2008:415) suggest that the focus in primary prevention is on larger numbers of people who have either no or very little experience with drug use. The automatic negative impact of primary prevention may therefore be that it is introducing larger numbers of children to information about drugs to which they otherwise may not have been exposed, hence enhancing the curiosity of children who are pro-drug use. As part of the conceptualisation of the study, I observed two primary prevention interventions presented by social workers and trained volunteers respectively to groups of adolescents. What became apparent, was that there was no prior screening or assessment of the participants in these programmes, enhancing the likelihood that the
participants included adolescents in an advanced stage of drug use or at an early phase of experimentation.

Naudé (2009:125) proposes several additional characteristics of primary prevention, which are as follows:

- It is targeted at a particular population, which is addressed in group format.
- Its presentation takes on a systematic approach, incorporating the interaction of all the subsystems in the ecological system.
- It is culturally sensitive and valid.
- It is concerned with social justice.
- It is collaborative, educational and empowering.

Each of the above characteristics of primary prevention will be revisited later in the Chapter, when existing drug prevention programmes are reviewed.

Drug prevention approaches in the United States and other parts of the world have evolved considerably over the last century, with each of these approaches being informed by the nature and extent of drug-related problems at the time (SAMHSA, 2011). The table below (Table 2.2) depicts the progressive history of drug prevention, the premise that informed the practice approach, and its critique or shortcomings.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Practice approach to drug prevention</th>
<th>Assumptions</th>
<th>Critique/Limitations of the approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1930s</td>
<td>Banning of drugs and an increase in taxes on marijuana (McNeece &amp; DiNitto, 2005)</td>
<td>People are unfamiliar with the potential risks of drug use and therefore need protection</td>
<td>People found other mechanisms to access the drugs</td>
</tr>
<tr>
<td>1960s</td>
<td>Informational sharing approaches, employing scare tactics</td>
<td>Inducing fear about social and health consequences would deter people from using drugs</td>
<td>Graphic, exaggerated portrayal of the consequences of drug use could not be authenticated by the adolescents’ own experiences and observations of drug-using friends. The focus was also on the agent (the drug), rather than on people’s motivation for using drugs (Rhodes &amp; Jason, 1988)</td>
</tr>
<tr>
<td>Early 1970s</td>
<td>Didactic approach providing accurate, factual information about the types of drugs and their effects</td>
<td>Providing authentic, accurate information about drugs and their consequences would result in adolescents making informed decisions to refrain from experimentation</td>
<td>Resulted in educated consumers of drugs, especially those who were already recreational drug users (SAMHSA, 2011:6)</td>
</tr>
<tr>
<td>Late 1970s</td>
<td>Affective education, incorporating aspects of value clarification, alternatives to drugs and personal and social skills (Ksir et al., 2008:418-419)</td>
<td>Presumed that an understanding of one’s motivation for drug use and enhancement of self-esteem would make people less susceptible to drug use. The focus was on altering emotional states without the assistance of drugs and also on enhancing a sense of intrinsic worth.</td>
<td>Failed to effect a reduction in drug abuse, as simply enhancing self-esteem was not sufficient to address problem behaviour (McWhirter et al., 2013). More emphasis needed to be placed on the acquisition of skills required to enhance personal and social competence (Ksir et al., 2008:420). Many schools stuck to ‘value free’ drug prevention programmes out of fear that they would be seen to be imposing moral values on learners (Ksir et al., 2008:419).</td>
</tr>
<tr>
<td>1970s</td>
<td>Social learning approach</td>
<td>Adolescents cannot resist drug offers, as they have</td>
<td>Despite the positive consequences of this</td>
</tr>
</tbody>
</table>
underdeveloped internal value systems and require life skills. The social learning approach was also referred to as psychological inoculation training, where the focus was on acquiring refusal skills and 'pressure resistance skills' (Ksir et al., 2008:420).

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Strategy Description</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early 1980s</td>
<td>Presentation of healthy alternatives to drug use</td>
<td>Creating natural highs through recreational activities (such as sky-diving or surfing) would reduce the attraction to the effects of drugs. This approach did not appear to reduce drug usage levels when presented in isolation. In addition, the healthy alternatives were not always viable to the community in which they were presented (McNeece &amp; DiNitto, 2005).</td>
</tr>
<tr>
<td>1980s</td>
<td>Amendment of legislation that affected drug use</td>
<td>Reducing the supply and consumption of drugs and limiting the harm that they cause. In 1986, the United States Government supported ‘drug free schools and communities’; school policies on drug use; locker searches; suspensions and the expulsion of learners with drug related offenses (Ksir et al., 2008:420). The effectiveness of this strategy was compromised by the cost of policy amendments and the absence of a systematic approach to effecting the changes.</td>
</tr>
<tr>
<td>Late 1980s</td>
<td>Behavioural strategies</td>
<td>Drug prevention focused on the enhancement of social competencies and prosocial coping by having older students tutor younger. Life skills education was adopted around the world, based on the empirical evidence on the effectiveness of the</td>
</tr>
<tr>
<td>Time Period</td>
<td>Approach Description</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1980s</td>
<td>Community involvement approach</td>
<td>If society acts as an advocacy group against drug use and encourages the development of partnerships between government agencies, NGOs and public entities, the onset of drug use would decrease significantly (McNeece &amp; DiNitto, 2005).</td>
</tr>
<tr>
<td>1990s</td>
<td>Comprehensive research-based, drug prevention models adopting a combination of affective, cognitive and behavioural dimensions.</td>
<td>Focusing on the development of life skills as well as prosocial attitudes was more likely to address the motivation for drug use, equipping the individual with resistance skills and providing healthy alternatives.</td>
</tr>
<tr>
<td>Late 1990s; early 2000s</td>
<td>Theory based drug prevention approaches, focusing on the risk/protective factor continuum</td>
<td>Reducing the risk and enhancing the protective factors would buffer an adolescent against drug use (Myers et al., 2008; Kim et al., 2002).</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Knowledge-only interventions</td>
<td>Dissemination of information about the effects of drugs, aimed at enhancing negative attitudes towards drugs.</td>
<td></td>
</tr>
<tr>
<td>Affective interventions only</td>
<td>Focusing on the development of self-esteem and/or self-awareness, assuming that psychological factors enhance vulnerability for drug use.</td>
<td></td>
</tr>
<tr>
<td>Peer-based interventions</td>
<td>Focusing on peer resistance and drug refusal skills and strengthening inter- and intrapersonal skills to resist negative influences.</td>
<td></td>
</tr>
<tr>
<td>Knowledge plus affective</td>
<td>Educational programmes about the dangers of drugs, combined with affective education to enhance decision-making skills and aid in value clarification.</td>
<td></td>
</tr>
</tbody>
</table>

2 This utilitarian comprehensive approach was research-based, culturally relevant, age appropriate, interactive, and family-based (Van Wormer & Davis, 2008:203), and also included the social and legislative aspects of prevention.
Interventions are aimed at providing and encouraging involvement in constructive alternative activities, which also promote competence in control and self-regulation.

TABLE 2.3: Categorisation of drug prevention programmes
[Source: constructed from information extracted from Tobler (1986 in Faggiano et al., 2008:255)]

The section that follows, provides an overview of the theoretical models that inform drug prevention.

2.3 TRACKING HISTORY OF PREVENTION APPROACHES AND THEIR THEORETICAL LENSES

There are a host of theoretical models that inform drug prevention interventions. Several of these models are in coherence with theories that inform drug addiction (dependence), whilst others are more closely affiliated with experimental drug use (refer to Table 1 above for a distinction between experimental and dependent drug use). Since the focus of the present study was to arrive at guidelines for primary prevention interventions (i.e. to avert and delay the onset of drug use), both groups of theories were consulted and reflected upon; the intention being to clearly illustrate the overlaps between the two groups of theories. Below, a brief overview of the theories of experimental drug use will be introduced, followed by the theories on drug addiction.

It transpired from the literature review that the theories relating to drug use evolved from the theorists’ world views, ontological assumptions and systematic research on the phenomenon. The US National Institute on Drug Abuse (NIDA) (1997) identified the following two broad categories of motivation for drug use:

- People are motivated by the positive effects of drugs. This implies that they use drugs to ‘feel better’, which suggests that prevention efforts should be focused on finding alternatives or substitutes that can yield the same positive effects.
• People are motivated to use drugs to avoid ‘feeling bad’ often as a means of self-treatment, which suggests that the focus should be on treating the underlying condition.

Whilst several sources report on theoretical explanations for drug use, the findings from three core studies were selected for the literature review in this Chapter, as these studies constitute comprehensive reviews of previous theories and drug prevention practice interventions. These reviews were undertaken by Petraitis, Flay and Miller (1995); Fraser (2004); and Castro-Sarinana (2001). A comparative analysis of the three reviews, which identifies the similarities and differences between their conclusions, will now follow.

Petraitis et al. (1995) conducted a review of fourteen multivariate theories of experimental drug use. The conclusion of their study was that the different theories could be organised by extracting their central constructs into three distinct types of influence, namely: a) social and interpersonal; b) attitudinal and cultural; and c) intrapersonal factors. In comparison, Castro-Sarinana (2001) has identified 50 factors associated with adolescent drug use, grouped into a three category explanatory framework. These categories are: a) the predisposing environment; b) the drug itself; and c) the individual. These two frameworks overlap with the multisystemic three category framework proposed by Fraser (2004), aimed at organising the etiological factors of drug use and, in the process, providing guidelines for the assessment of drug problems. The overlaps and distinctions between the three frameworks are discussed below, using the labels denoted by Fraser (2004) as the core structure.

• **Environmental factors:** According to Fraser (2004), these factors constitute a combination of community norms and laws that inform the availability of drugs, as well as the neighbourhood characteristics that may enhance a drug use culture. What Castro-Sarinana (2001) refers to as the predisposing environment, Petraitis et al. (1995) describe as the attitudinal and cultural factors that dictate public policy and social values regarding drug use. The description of Castro-Sarinana (2001) also makes reference to the drug itself – with its properties and availability contributing to how readily it was being used.
• **Interpersonal and social factors:** Fraser (2004) suggests that these risk factors transpire in family, school and peer context. Petraitis et al. (1995) concur, adding that they not only include the relational and influential power of these subsystems, but also belief systems, which determine the individual’s risk for drug use. According to the proposed framework by Castro-Sarinana (2001), the factors under this category are located in the predisposing environment.

• **Individual factors:** Fraser (2004) denotes these as the psychosocial and biological factors (or characteristics of the agent—as described by Castro-Sarinana, 2001) that predict the likelihood of an individual’s vulnerability to drug use. Petraitis et al. (1995) concur, including the individual’s skills as part of the intrapersonal factors.

The researchers cited above argue that their frameworks can be used to guide the assessment of the degree of risk for drug use, with the assumption that it will in turn guide the targets for drug prevention interventions. Petraitis et al. (1995), however, suggest that it is also important to determine the levels of influence of these risk factors, to ascertain whether they are proximal, distal or ultimate. The nature and immediacy of drug prevention interventions then in turn will be determined by the assessment of the type and level of influence of these risk factors, and also by the parallel identification of protective factors that enhance an individual’s resistance to drug use.

The focus of the discussion now moves to a broad overview of theoretical explanations for drug addiction or dependence. These theories provide an explanatory framework for why someone would progress from experimental drug use to harmful or addictive drug use. These take the form of a factual presentation in table format of the primary assumptions on which the theory was based, and its implications for drug prevention and treatment interventions, followed by a reflection on the advantages and disadvantages of the theoretical model.
<table>
<thead>
<tr>
<th>Model</th>
<th>Assumptions</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moral</td>
<td>The individual’s compromised moral values and integrity make him/her vulnerable to drug addiction. Addiction results from a depleted spiritual life and therefore preventive and treatment interventions require value clarification and training in morality.</td>
<td>It enhances personal accountability and adds a spiritual dimension to counselling. It also appeals to persons to make good choices in order to escape addiction.</td>
<td>It subjects people to moral judgments and enhances stigmatisation. This may serve as an aversion to seeking treatment.</td>
</tr>
<tr>
<td>Psychological (Cognitive behavioural; learning; Psychodynamic and Personality Theories)</td>
<td>The Psychological theories include a number of explanations for drug addiction: Firstly, vulnerability to drug addiction emanates from unmet childhood needs; secondly, specific personality characteristics (i.e. impulsive personality, low tolerance for stress, general sense of social alienation, and low commitment to societal norms), which enhance the users’ susceptibility to addiction. Thirdly, people are vulnerable to addictions when drugs are used for their pleasurable effects and to relieve stress. Drug use is hence a learnt behaviour, influenced by a variety of psychological factors, such as punishment, conditioning and reinforcement.</td>
<td>It reduces the guilt and shame that accompany drug use; it enhances chances of recovery, as underlying problems can be treated, a recurrence prevented, and drug use be replaced with constructive coping mechanisms. Preventive interventions would therefore include enhancing optimal development at intellectual, social and emotional levels; positive self-identity; promoting effective coping and problem-solving skills, as well as training in self-management.</td>
<td>Potential of categorising people and attributing blame to external factors, which may become a reinforced pattern. Model offers a rather narrow description of people and does not consider the multiple influences in people’s lives.</td>
</tr>
</tbody>
</table>

50
Disease or Medical model: People may have a genetic predisposition or inherent vulnerability to drug addiction [Genetic model, often classified under the disease model]. Addiction is a long-term condition that can be treated but not cured. Affected individuals should refrain from any form of drug use and those who are addicted need medical treatment for their addiction. Treatment seeking is more likely, as blame is removed. Goal of treatment is abstinence. Primary prevention efforts promote health care in the form of cultivating good nutrition, and promoting physical well-being (Rhodes & Jason, 1988). The externalisation reduces personal accountability; it justifies drug use behaviour and does not offer a variety of treatment or prevention options.

Biopsychosocial: Combination of biological, psychological and social factors interact to influence addiction. Holistic approach to treatment and prevention. Many different dimensions to treatment complicate the process.

Sociocultural: Societal norms, family, peer and cultural determinants of drug use behaviour. Advocates anti-drug use norms at societal level. Interactive systemic approach. Enhances negative stereotyping about certain cultures. Individuals may attribute blame to culture, rather than assume personal responsibility.

**TABLE 2.4: Theories of drug addiction**

*Table developed by the researcher with information extracted from the following sources: Hitzeroth and Kramer (2010:13-19); Ross and Deverell (2010); Mcneece and DiNitto (2005:26-38; 2013)*

The primary theories that guided the present study were introduced in Chapter One, namely: (a) the social constructionist theory (incorporating the sociocultural theories); and (b) the risk/protective resilience theory. These will be reviewed in the ensuing section of this Chapter.
2.4 PRIMARY CONCEPTUAL FRAMEWORKS THAT FRAMED THE STUDY

2.4.1 Social constructionist conceptual framework

The social constructionist framework proposes that people’s view of themselves and the world is embedded within historical and cultural stories, beliefs and practices (Etherington, 2006:46-47). The contextual background to the present study, presented in Chapter One, offered an overview of the fundamentalist approach (White, 2004), which projects ‘Coloured’ adolescents as helpless victims, enslaved by a historical cultural identity embedded in alcoholism. The reality is that young people and adults of all ethnic groups have been using drugs for thousands of years (Ksir et al., 2008). Long before the emergence of professional treatment, a variety of mood altering substances were enjoyed. Ksir et al. (2008) suggest that the question is not whether most adolescents will use drugs, but rather which one they will try. Herrick (2012:1050) further refutes the stereotype around drug use being an inherently ‘Coloured’ phenomenon, pointing out that heavy occasional drinking amongst the educated and affluent (across ethnic groups) has emerged as a normal social occurrence, warning that it is these individuals who are more likely to add to the significantly high number of motor vehicle accidents in South Africa. The increasing prevalence of risky drinking in this group also contests the notion that the most vulnerable are the riskiest.

Furthermore, drugs have been known for numerous positive purposes, amongst others, therapeutic effects (Ksir et al., 2008), the celebration of cultural rituals (Van Wormer & Davis, 2008), recreational benefits (McNeece & DiNitto, 2005); enhancing self-confidence, avoiding negative states (Potgieter et al., 2010); coping and avoiding peer rejections (Patrick, Patel, Caldwell, Gleeson, Smith & Wegner, 2010); a lucrative source of income; and in particular a context in which cultural identity can be constructed (London, 1999).

What is evident from the literature is that society’s views of drugs (including alcohol) have changed, and that the perception of drug use now depends on the circumstances of its use, the political climate, the type of people associated with it (Van Wormer &
Davis, 2008:77) and, from a practice-research perspective, the epistemological and ontological positions of the researcher and practitioner (Denzin & Lincoln, 2008). It is therefore evident that drug prevention practice approaches need to be informed by an understanding of the sociocultural meaning of drug use in the community, whilst simultaneously focusing on the interplay between the community’s social cultural context, the individual’s self-identity, and macro variables. In keeping with the aforementioned conclusion and the goal of the present study to enhance understanding of the socio-cultural meaning of drug use, non-use and drug prevention, the focus of the literature review now moves to socio-cultural theories.

2.4.1.1 Sociocultural theory

The father of the sociocultural theory, Vygotsky (1896-1934), constructed this theory in the context of developmental psychology, claiming that parents, caregivers, peers and the culture at large influence the development of skills in and transference of culture to children (Louw & Louw, 2007:29). Vygotsky argues that guidance and assistance by adults or peers enable children to respond in more competent ways than what they would have on their own. Papalia, Olds and Feldman (2001:44) refer to this process as ‘individuals internalising society’s ways of thinking and behaving and making those ways their own.’ Such transitory assistance (i.e. scaffolding) and guided assistance provided by a more skilled adult or peer facilitates the development of independent thinking. Expanding on Vygotsky’s hypothesis that one’s developmental life course can be shaped by significant others in one’s proximal environment, Ross and Deverell (2010:172) argue that the sociocultural theory includes the cultural views, beliefs and societal influences that inform the socialisation process (Ross & Deverell, 2010:172).

The sociocultural theory as applied to drug use proposes that the definitions of drugs, their effects, drug-related behaviour and the experience of drug use itself are socially constructed, implying that the meaning attached to drug use is dependent on the social context in which it occurs (Hitzeroth & Kramer, 2010; McNeece & DiNitto, 2005:31). The varying uses of drugs, discussed under Section 2.4.1, concur with the afore-mentioned view and the sentiment by Unger et al. (2004:1782) that the concept of drug ‘is a social construction that exists within a cultural context’. In some cultures, drugs are used for
medicinal purposes, whilst in others they are an integral part of recreational and cultural gatherings. Harper and Genovese, cited in McNece and DiNitto (2013:298), report that the history of alcohol use amongst African-Americans dates back to the 17th century, when it was provided to slaves to ensure compliance and prevent escapes. This practice mirrors the use of the ‘dop system’ implemented in the 19th century in South Africa by ‘White’ agricultural employers (London, 1999:1408). Moreover, government policies dictate in which context and to what extent drug use would be tolerated.

The unified approach (a variation of the sociocultural theory) proposed by Hunt and Barker (2001) suggests that the meaning and value of drugs are determined by the people with whom the drugs are associated, how they are used, and the interconnectedness between the different roleplayers involved with drugs (i.e. from production to distribution and, finally, consumption). As such, the unified theory argues against the demonising of drugs and questions the legislation aimed at achieving a drug-free society (Hunt & Barker, 2001).

Offering further variations of the sociocultural theory, McNece and DiNitto (2005) differentiate between supracultural, culture-specific and subcultural theories. The authors explain that supracultural theories refer to how a society is organised, its culture and the use of drugs, whilst culture-specific theories account for why drunkenness is condemned in certain cultures (such as the Italian culture) compared to the French’s tolerance for drunkenness (Hitzeroth & Kramer, 2010; Hunt & Barker, 2001). The focus of the present study was located in the subcultural theories, which dictate that whilst the broader environmental factors may explain the onset of drinking, the specific social variables relating to age, gender, ethnicity and sexual orientation, to name a few, will explain why people become harmfully involved with drugs (McNeece & DiNitto, 2005:33). Considering the varying cultural interpretations of drugs and drug usage, the focus of the literature review now shifts to the conceptualisation of cultural sensitivity, followed by a discussion of cultural risk factors, those that enhance drug use, and those that protect against drug use.
2.4.1.2 Revisiting definition of cultural sensitivity

Resnicow et al. (2000:272) contend that cultural sensitivity is ‘perhaps one of the most widely accepted principles of public health’. Furthermore, they argue that the principle of modifying interventions to achieve congruence with the social and cultural features of the targeted service recipients should be indisputable, on ethical and philosophical grounds. Having said that, the authors acknowledge that there are ‘key empirical questions regarding feasibility and effectiveness merit investigation’ (p. 281). The authors offer three arguments (cited in Section 1.1 of Chapter One) as motivation for tailoring drug prevention programmes to ensure their cultural sensitivity. They acknowledge that the concept cultural sensitivity has been used interchangeably with other related concepts, such as cultural competence, cultural relevance, cultural appropriateness, cultural tailoring, cultural targeting and ethnical sensitivity. The inconsistent use of the terminology, combined with a lack of empirical research on cultural sensitivity (Hecht & Krieger, 2006; Hecht et al., 2003; Resnicow et al., 2000:272) further supports the need for research in this field.

The concepts ethnic identity and cultural sensitivity were defined in Section 1.9 of Chapter One. To promote clarity, the other concepts relevant to the present study are defined below. Cultural competence refers to the ability of an individual to demonstrate cultural sensitivity (Resnicow et al., 2000:272). Engelbrecht’s (2006:258) definition of the concept cultural friendliness resonates with the definition of cultural competence. He defines cultural friendliness as a disposition or attribute that should form part of the practitioner’s identity, suggesting that cultural friendliness is a constant attitude that must be lived. In comparison, cultural sensitivity, he argues, is something that can be switched on and off, as it refers to a specific skills set, knowledge base and values that practitioners need to acquire and adopt, in order to illustrate awareness and respect for the audience’s language, semantics and cultural perceptions. It follows logically then that cultural tailoring would refer to the process of adapting existing drug prevention material to resonate with the cultural and social contexts of the target audience. Resnicow et al. (2000:273) suggest that culturally-based drug prevention interventions focus explicitly on ethnicity, cultural values and history to promote behavioural change.
Multicultural prevention programmes, on the other hand, have been equated with the concept cultural pluralism, implying that these programmes incorporate multiple perspectives of race and ethnicity.

The authors advise that cultural sensitivity constitutes two dimensions, i.e. surface structure and deep structure (Resnicow et al., 2000:269). Surface structure entails making the programme content, as well as the setting in which the prevention message is delivered, resonant with the social and behavioural characteristics of the target audience. Deep structure entails contextualising the message to enhance the impact of the programme. This requires developing an understanding of the target population’s sociocultural meaning constructions of a particular health behaviour. In the context of the present study, it entailed investigating the historical, familial, environmental, political and social factors embedded in the phenomenon of drug use, non-drug use and drug prevention in a historically marginalised community – illuminating the rationale for the selection of the risk/protective resilience theory located in an ecological framework.

2.4.1.3 Cultural sensitivity in drug prevention

2.4.1.3.1 Cultural factors which promote drug use

The concept culture was defined in Section 1.9 of Chapter One. It is imperative, though, to reflect on the following elements of culture, as proposed by Griswold, cited in SAMHSA (2011), to illuminate the current discussion. Griswold proposes that culture includes the following five elements:

- Norms – which reflect in an individual’s behavior
- Values – which underscore what is important to an individual
- Symbols – which refer to how an individual expresses him-/herself and can manifest in the form of art, stories, music, language and other forms
- Practices – which encompass the traditions or behavioural patterns that may not be connected to beliefs and values.
Whilst some elements of culture may be overt, most are covert or hidden, making it imperative for practitioners to engage in a thorough exploration of any individual or community targeted for intervention.

Culture has a reciprocal relationship with social factors in any given context. Marmot (2007:1159) emphasises that “behaviour and its social patterning are largely determined by social factors” – a view supported by several researchers who have aligned themselves with social constructionist theories (Pickett & Chiricos, 2012; Pycroft, 2010; Pilkington, 2007; Papalia et al., 2001). By implication, therefore, one needs to understand the meaning of behaviour as it manifests in a particular social-environmental-political context. Unger et al. (2004:1782) confirm that drug use and non-drug use are influenced by numerous complex factors that differ across cultural contexts, making it imperative for researchers to understand the influences that prevail within particular communities of interest. Therefore, the argument is that an appreciation of the influences that exist within specific cultural contexts will enable practitioners to tailor existing drug prevention programmes accordingly.

As mentioned in Chapter One, Resnicow et al. (2000:272) suggest that the rationale for tailoring drug prevention programmes to ensure that they are culturally sensitive is informed by three factors: i) variations in drug use prevalence rates across ethnic/racial groups; ii) variations in unique risk factors for drug use; and iii) variations in the predictors of drug use across groups. For the purposes of the present study, the first factor was attended to in Chapter One, with the presentation of statistics obtained from the two South African National Youth Risk Behaviour Surveys (2004 and 2010) and epidemiological trends, as cited in the SACENDU reports (Dada et al., 2012; Plüddemann, 2008). The unique history of the ‘Coloured’ ethnic group and its stereotypical association with drug use were furthermore discussed in Chapter One, and will be referred to again in Section 2.4.2.5 of Chapter Two. Adolescence as a unique risk group was defined under Section 1.9 of Chapter One, and will be revisited in Section 2.4.2.3 of this Chapter. Returning to Resnicow’s (2000:272) three-factor rationale for cultural sensitivity, the goal of the present study was to address factors ii and iii, as the findings reveal specific sociocultural meaning constructions that illuminate risk and protective factors pertaining to drug use and non-drug use.
The rationale for ensuring cultural sensitivity in drug prevention interventions has been illustrated in several international studies (Buckley, Sheenan & Shochetet, 2010; Ager, Parquet & Kritzinger, 2008; Sharland, 2006; Unger et al., 2004:1782-1806; Botvin et al., 2001; Resnicow et al., 2000; Hawkins et al., 1992; Ajzen, 1991). At a local level, Harker et al. (2008:20-44) concluded from an audit of drug prevention interventions in the Western Cape, South Africa (discussed under Section 1.1 of Chapter One) that whilst the participating practitioners agreed that their programmes were culturally sensitive, hardly anyone could concretise the components depicting cultural sensitivity.

In keeping with the rationale for the literature review, as illuminated under Section 2.1 of this Chapter, the ensuing review will report only on those research studies that share characteristics with the population that formed the focus of the present study.

Unger et al. (2004:1782-1806), who conducted research amongst African and Latino American adolescents, illuminate a number of cultural factors identified as influential in adolescent drug use in the United States. Whilst the authors acknowledge that some of these factors are fuelled by moral and political agendas, they mention several sources to illustrate the empirical evidence for the relevance of these culture specific factors, as cited below:

- The neighbourhoods occupied by immigrant families are characterised by overpopulation, high levels of poverty and crime, easy access to drugs, and low access to educational and occupational opportunities and recreational outlets.
- The acculturation processes that facilitate integration into the US culture coincide with a loss of 'protective cultural values and support systems from the culture of origin'.
- Adolescents experience a significant identity confusion, exacerbated by having to traverse two cultures.
- Direct and subtle marginalisation and discrimination experienced as a result of belonging to an ethnic minority group.
- Exposure to US media, which reinforce the stereotypical portrayal of adolescents having a drug use culture.
The description of the neighbourhood characteristics and experience of marginalisation appear to resonate with the community in which the present study was undertaken (Oppelt, 2012:15; Martin, 2011).

Whilst drug use is prevalent amongst different race, ethnic and socio-economic groups, the socially disadvantaged communities (generally from so-called minority groups) have consistently demonstrated the highest prevalence of especially illegal drug use amongst the youth (Brook et al., 2006; Elliot et al., 2006; Morojele & Brook, 2006; Botvin et al., 2001; Johnson et al., 1990). Ross and Deverell (2010:172) have identified exposure in childhood, peer and parental drug use and attitudes towards drug use as the significant determinants in the onset of drug use. Hitzeroth and Kramer (2010) concur, suggesting that the following sociocultural factors have the potential to enhance the progression from an experimental drug use journey to a journey of drug addiction: peer group pressure; social values and norms; social support structures; and parental role modelling. However, according to McNeese and DiNitto (2005), socio-cultural theorists contend that environmental factors account for the differences in drinking practices in different cultural groups. In socially disorganised communities, for example, the collective value of the community is not recognised, validated or capitalised upon, giving rise to more regular drug use in these communities (Plüddemann et al., 2008; Vera & Shin, 2006:85; Parry, Morojele, Saban, Alan & Flisher, 2004; Smokowski et al., 2000).

Concurring with this social construction of drug use and its effects, the President of the Congress of Traditional Leaders of South Africa assigned the cause of alcohol abuse to poverty and other social ills (Chauke, 2012). Peltzer et al. (2010:11), who conducted a review of illegal drug use and treatment in South Africa, arrived at similar conclusions; however, emphasising that ‘rapid changing social and economic climate, coupled with increased availability and promotion of drugs and the demand for them, have contributed to the increasing magnitude of the national drug abuse problem’. The authors have concluded that adolescents’ risk for drug use appears to escalate when they live in communities that are characterised by inferior housing, education and health care facilities. The early onset of drug use by adolescents and their preference for
illegal, more addictive drugs (such as Methamphetamine and Ecstasy) were further identified as significant risk indicators for adolescent drug prevention interventions.

A traditional custom identified in South Africa is ‘ukugez’ iballpen’, which refers to the custom among high schools learners to engage in excessive drinking as a symbolic form of ‘washing the pen’ after examinations. Chauke (2011:2) reports on a call from the South African Trade and Industry Minister, Elizabeth Thabethe, for the banning of this harmful tradition. Noganta’s (2012) research study draws attention to another harmful practice, namely the excessive consumption of traditional beer and other alcohol during traditional ‘Abakwetha’ (circumcision initiation rituals.) Parry et al. (2004a:369) label the South African drinking culture as one that is void of moderation. The authors claim that South Africans ‘drink to get drunk’ – a harmful trend that has taken on worrying proportions amongst adolescents, especially during school holidays.

This concludes the review of studies illuminating specific cultural influences in adolescent drug use, which would need to be considered when developing culturally sensitive drug prevention programmes. The literature review now focuses on the specific cultural factors found to protect adolescents against drug use.

### 2.4.1.3.2 Cultural factors that protect against drug use

The ensuing section comprises a brief review of only three studies, since the other relevant studies will be reviewed when the second theoretical framework, the Risk/Protective Resilience Theory, is presented later in this Chapter.

Research on ‘African-American’ youth revealed that, despite experiencing significant socio-economic deprivation and discrimination, their onset of alcohol use was much later than that of their ‘White’ peers (Kogan, 2005, as cited in McNece & DiNitto, 2013:301). The authors found that the protective factors that reduced their susceptibility to drug use included the following: positive family relationships; religiosity; and a positive life orientation. Abbey (2006, as cited in McNece and DiNitto (2013), who conducted research among 7500 African-American Grade 7-12 learners from the Detroit area, established a positive correlation between research participants’
susceptibility to drug use and low school commitment, combined with irregular church attendance. In contrast, the protective factors were good school grades, school commitment, participation in school activities, and church attendance.

Chauke (2012), who reported on South African adolescents’ harmful use of alcohol following examination periods, suggested that the remedy should be the creation of recreational activities and the improvement of economically disadvantaged areas. Other suggestions also include enhancing the attendance of religious services and promoting high educational aspirations and achievement, as these have been found to be inversely associated with the use of illegal drugs amongst adolescents (Grunbaum, Tortolero, Weller & Gingiss, 2000:146).

2.4.1.4 Drug prevention approaches informed by Sociocultural Theory

It seems evident from the above review of findings that sociocultural measures in respect of drug preventive interventions should focus on intervening in the relationship between individuals and the community; effecting primary prevention through social change; ensuring that the social context is as comfortable as possible; revisiting traditional customs (Rhodes & Jason, 1988); and effecting structural changes in communities.

A highly effective model to bring about change in people’s behaviour and subsequently interaction with others is the **Social Influencing Model**. This model, which was adopted from successful cigarette smoking prevention programmes (Ksir et al., 2008:421), is a combination of the Social Learning Theory (Bandura, as cited in Hill, 2008:453) and the Theory of Reasoned Action (TRA) (Azjen & Fishbein, as cited in Hill, 2008:453). It has been the underlying conceptual model for many drug prevention programmes targeting adolescents (Cuijpers, 2002; Tobler, Roona, Ochshorn, Marshall, Streke, & Stackpole, 2000:276). According to Botvin et al. (1994), the Social Influencing Model is found on the premise that:

- behaviour is learnt through social modeling and hence can be unlearnt;
• the adolescents’ propensity to drug use is influenced by their belief in their abilities to abstain from drug use, and a range of other psychological variables (these include their perception of drug use norms, the anticipated consequences of drug use, their own values about and attitudes towards drug use, and their intention to use);

• adolescents’ drug use is informed by interdependent and overlapping social influence (which include their peer group and immediate adult figures), which are in operation during everyday social interactions, and more specifically so during an offer-response drug engagement interaction.

Botvin et al. (1994:117) therefore conclude that the Social Influencing Model is designed to increase adolescents’ ability to resist social influences to smoke, drink or use drugs. This view is supported by Stokols (1996) and Gosin, Marsiglia and Hecht (2003:121), who contend that social influence can bring about changes in a person’s thinking patterns, attitudes and behaviour in relation to those of others. Social influence training can therefore be directed at cognitive, affective and behavioural levels, aiming to effect changes in people’s cognitive schemas and views; altering how they evaluate a particular phenomenon; and bring about an explicit change in behaviour. From the review of the literature, it may be concluded that drug prevention programmes located in the Social Influencing Model should include the following functional elements and strategies:

• Training in drug refusal skills
  o educating adolescents to identify and resist social pressure
  o preparing them to plan for high risk situations
  o enhancing the presence and influence of prosocial peers and adult mentors

• Increasing the role of positive parental and community role models

• Making a public commitment to non-drug use

• Countering drug advertising

• Reinforcing anti-drug use norms and challenging normative beliefs about drug use
• Using teen leaders, as they are the primary socialisation agents in adolescence (Ksir et al., 2008:421-422)
• Using the principles of operant and classical conditioning, reinforcement of desirable behaviour and punishment of undesirable ones to effect changes at behavioural level
• Using the principles from the Health Belief Model (HBM), Self-efficacy Theory, Theories of Reasoned Action (TRA), and Theories of Planned Behaviour (TPB) to effect changes at cognitive level and symbolic processes in mediating changes to personal behaviour (Stokols, 1996).

The Competence Enhancement Model is also reflected upon under the Socio-cultural Theory, as it incorporates the Social Learning Theory (Bandura in Hill, 2008:453) and the Problem Behaviour Theory (Jessor & Jessor in Hill, 2008:453). The latter theory postulates that people engage in and persist with behaviour, even though it may be regarded as problematic by others. The functional value that the behaviour serves for the individual makes detracting from it more difficult. Drug prevention programmes formulated on these theories hence focus on equipping adolescents with general competence skills, combined with specific drug resistance skills. Botvin et al. (2001) refers to the Personal and Social Skills Models, aimed at teaching ‘relatively general skills for coping with life that will have a broad application rather than a situation specific or problem specific application’. (Gosin et al., 2003:121). He reports on the effectiveness (albeit limited over time) of this approach in drug prevention. Hill (2008) comments that the Social Influence Model and the Competence Enhancement Model are in close synergy with social work intervention, which is premised on the person-in-environment interaction. Consistent with this approach, the two models look at how individual variables interact with social influences and the availability of drugs in the adolescent’s immediate environment, hence also explaining its incorporation in the theories relating to drug use. Bower, Carroll and Ashman (2012) emphasise the enhancement of social competence as a skill crucial for drug prevention. The authors cite drug prevention programmes such as Kool Kids (Carroll & Houghton in Bower et al., 2012) or Mindfields (Carroll, Ashman, Bower & Hemingway in Bower et al., 2012), which focus on equipping children with overt skills in problem-solving, planning, goal-setting and self-reflection.
In summary, drug prevention interventions embedded in a socio-cultural theory would incorporate elements from social influencing theories, resulting in interventions directed at cognitive, behavioural and affective changes in individuals and their engagement with their environment. Rhodes and Jason (1988) have suggested that effective socio-cultural methodologies would include group work interventions with adolescents, to promote skills transference, and utilising especially TADA groups to mobilise for bringing about more prosocial norms for teenagers. Furthermore, they propose that the focus should specifically be on high-risk individuals, including adolescents, who are in a difficult life transitional phase; learners with learning problems; and/or very gifted children in dysfunctional families (Rhodes & Jason, 1988).

The focus of the chapter now advances to a discussion of the Risk/Protective Resilience Conceptual Framework.

### 2.4.2 Risk/Protective Resilience Conceptual Framework

The Risk/Protective/Resilience Conceptual Framework is derived from Bronfenbrenner's Ecological Systems Theory, as cited in Swanson, Spencer, Harpalani, Dupree and Noll (2003:750). According to Bronfenbrenner (1994:39), the ecological environment is regarded as ‘a set of nested structures each inside the other like a set of Russian dolls’. The ecological system consists of five interlocking contextual subsystems (the micro-, meso-, exo-, macro-, and chronosystems), which are reciprocal and interactive in nature (refer to Figure 3 below).
The ecological model has subsequently proved useful in understanding the ‘impact of culture, politics, relationships, social interactions, and life experiences on attitudes, behaviour and competencies of children, adolescents, and their families’ (McWhirter et al., 2013:21) or, as stated by Swanson et al. (2003:751), addresses the intricate interaction between distal and proximal factors that have an influence on previously marginalised groups. At the heart of the ecological system is the individual with his/her distinctive personality traits and biological make-up. The other subsystems are summarised in tabular form below:
The **Microsystem** consists of the people in the individual’s immediate physical and social environments with whom there are the most frequent proximal engagements. These are the family, school and neighbourhood and, of course, peers, as the latter group gains prominence in the individual’s life. Each of the microsystems impacts on the individual’s life in different ways. It is evident from these descriptions that the more stable and consistent the micro systems of the individual, the greater the likelihood of positive developmental outcomes (Bronfenbrenner, 1994).

The **Mesosystem** comprises the relationships, interactions and processes between individuals and subsystems in the microsystem. Bronfenbrenner (1994:40) has simplified it by stating that a mesosystem is ‘a system of microsystems.’ According to McWhirter et al. (2013), an individual’s development is steady when there is stability and consistency in the mesosystems. In the context of the present study, an individual who has a positive attachment to school and lives in a cohesive neighbourhood with supportive family, is more likely to experience positive development of a prosocial nature.

The **Exosystem** consists of associations between the individual and other subsystems that have a more distal impact on the individual. Bronfenbrenner (1994:40) has identified three exosystems that are likely to have an indirect impact on children’s development, viz the parents’ place of employment; the family’s social network and the neighbourhood-community context. In the context of the present study, the neighbourhood-community context largely embodies a normative approach to drug use, where several informal drug outlets and taverns serve as the only source of income for many families, constituting the daily realities for many of the adolescent participants.

The **Macrosystem** has been described as the ‘societal blueprint for a particular culture or subculture’ (Bronfenbrenner, 1994:40). In essence, this would include the belief systems, race relations, societal structures, cultural values and resources at national and international levels (McWhirter et al., 2013:24) of a given society and influences what happens in the microsystem. In the context of the present study, it would require looking beyond the ethnic identity and cultural context of the group under investigation to explore the changes at societal level and how they have influenced the participants’ constructions around drug use and non-drug use (Swanson et al., 2003).

The final system is the **Chronosystem**, which constitutes the socio-historical changes or consistency in the different systems over time. Examples of the chronosystem for the travellers in the study would include the changes in South Africa’s socio-political landscape, which have resulted in the adolescent participants, all born after South Africa attained its democracy in 1994, being referred to as the ‘born frees. The desegregation of schools is one example of a direct socio-political change, which has enabled the peer navigator participants in this study to attend a previously ‘Whites only’ school.

| TABLE 2.5: Summary of subsystems constituting ecological model |
| [Source: Information extracted from Swanson et al. (2003); Bronfenbrenner (1994) and McWhirter et al. (2013)] |
McWhirter *et al.* (2007:19) highlight the following three assumptions, characteristic of the ecological model:

i) The environment and the individual are in continuous interaction, in a reciprocal relationship and have the potential to change each other.

ii) The individual is an active participant in his or her environment and can therefore also exert influence on the environment.

iii) The ecological model assumes bi-directionality; implying that changes in one ecological system would also trigger changes in one of the others, whether proximal or distal.

Kelly (in Van Schalkwyk & Hoelson, 2009:423) makes reference to the adaptive nature of the context from which individuals would draw skills and resources, in order to navigate challenges and demands in their environment. Herrick (2012:1047) has criticised the ecological systems theory as being too structuralist in nature, proposing the post-structural political ecological approach as an alternative. This approach allows for the exploration of issues of identity, meaning and construction of people’s (broader) social and economic context, in order to arrive at preventive interventions that also have implications for governance at the highest level. Swanson *et al.* (2003) propose yet another variant to the ecological model, which is Spencer’s (1995) phenomenological variant of the ecological systems theory (PVEST), which they suggest allows one to study the interaction of race, culture, socio-economic status and context of development with identity and other prominent developmental processes.

The Risk/Protective Resilience Conceptual Framework is an adaptation of Bronfenbrenner’s ecological systems theory that attends to the limitations highlighted above. The risk/protective approach is consistent with principles for evidence based practice for drug prevention (McNeece & DiNitto, 2013:236-239; Myers *et al.*, 2008; National Institute on Drug Abuse (NIDA), 2003; Kim *et al.*, 2002). As indicated in Chapter One, risk factors are defined as those characteristics at the ‘biological, psychological, family, community, cultural’ (Substance Abuse Mental Health Services Administration, (SAMHSA), 2011) and societal level (Elliott *et al.*, 2006) that enhance the likelihood of a person engaging in drug use and experiencing the subsequent
negative outcomes (McWhirter et al., 2007). Risk factors also have the potential to increase the maintenance or aggravation of vulnerability (McNeece & DiNitto, 2013:236) and furthermore point to the area where primary prevention is required (Medina-Mora, 2005). Protective factors, on the other hand, refer to those internalising and externalising factors (McNeece & DiNitto, 2013:236) associated with reduced potential for drug use or variables that interact or buffer the effects of risk factors (Liddle & Rowe, 2006), and hence point to the area where primary prevention should be undertaken (Medina-Mora, 2005).

Substance Abuse Mental Health Services Administration (SAMHSA, 2011:2) emphasises that risk and protective factors assume different characteristics, which are identified and described below:

- Some are fixed, like gender and ethnicity.
- Some are variable, like household income and peer association.
- Some are causal (like methamphetamine abuse, resulting in paranoid behavior).
- Some act as proxies (like neighbourhoods in which a normative drug use culture prevails).
- Some may indicate the presence of an underlying problem (yellow stained hands may indicate the use of dagga).

Effective drug prevention interventions focus on reducing the presence and effect of risk factors and increasing the presence and influence of protective factors (Harker et al., 2010). The conceptual orientation of the present thesis also contends that reality is socially constructed and, therefore, what may be regarded as a risk factor in a particular social context, may be regarded as a protective factor in a different social context.

The Substance Abuse Mental Health Services Administration (SAMHSA) Report of 2011 makes reference to four key features of risk and protective factors that practitioners should consider when designing and evaluating drug prevention interventions. These are:
- Risk and protective factors exist in multiple (interactive) systemic contexts of the individual, family, peer, school, community and societal level (as indicated in Figure 2 above). McNeece and DiNitto (2005) confirm that a risk and protective factor framework allows for a more theoretical exploration of issues that cut across age, race, social context and several other unique and overlapping domains of functioning (Medina-Mora, 2005; National Institute on Drug Abuse (NIDA), 2003:2). A logical conclusion, therefore, is that prevention interventions should be located in multiple contexts simultaneously.

- Risk and protective factors are interrelated and cumulative: risk factors can be positively correlated with one another, have autonomous effects as well as interactive or moderating effects on one another, or be negatively correlated with protective factors (Substance Abuse Mental Health Services Administration (SAMHSA), 2011; Loxley et al., 2003:9). Therefore, the relationship between the number and type of risk and protective factors determines the likelihood of a person’s vulnerability to drug use.

- A single risk factor can enhance risks and problems at multiple levels: normative drug use in a community, for example, can contribute to the normalisation of school drop-out and adolescent conduct problems. A prevention intervention targeting community drug use norms therefore has the potential to effect positive change in multiple areas.

- ‘Risk and protective factors are influential over time’ (Substance Abuse and Mental Health Services Administration (SAMHSA), 2011:5). Ineffective parenting can result in children having the freedom to experiment with drugs, which may culminate in addiction and subsequent limited educational and occupational advances.

Whilst adolescents’ display of risk factors does not guarantee their use of drugs, it does indeed enhance the likelihood of the onset of drug use. Equally true is the observation that many adolescents who present with multiple risk factors never succumb to drug use (McNeece & DiNitto, 2013:236; Elliott et al., 2006). This would explain why certain individuals with multiple risk factors who grow up in a socially toxic environment are able to resist drug use, whilst others in a similar position succumb (Garmezy, 1991).
This was the primary premise of the present study, which motivated the inclusion of both adolescent drug users as well as non-drug users in the sample. This also explains the inclusion of the concept ‘resilience’ in the conceptual framework of the study.

The concept resilience was defined and the motivation for its inclusion in the conceptual framework provided under Section 1.6 of Chapter One. Since the conceptualisation of resilience is linked to the ecological systems theory, the study distinguishes between resilience at individual, family and community levels; the latter will be discussed under the respective subheadings that follow in this chapter.

Since multiple risk and protective factors operate in mutually exclusive, reciprocal, but also autonomous ways, a key question is: how would one determine the primary focus of drug preventive interventions? Substance Abuse and Mental Health Services Administration (SAMHSA) (2011:4) suggests adopting a developmental focus to prevention as one such guideline. A developmental approach enables practitioners to match their interventions ‘to the developmental needs and competencies of their audience’. The literature review that follows, will elucidate the risk and protective factors that have been matched to the three different stages of childhood.

Unlike quantitative studies, that offer descriptive statistics translated into frequency counts of protective factors, qualitative researchers are guided by the meaning participants construct around these factors. Eriksson et al. (2010:478), who conducted a meta-review of 30 previous reviews on factors that protect youth from externalising and internalising problem behaviour, offer a guiding framework in the form of a few questions. The questions, which follow, served as a useful guide in the present study to determine how to prioritise preventive interventions in the Northern Areas communities of Port Elizabeth:

- Are some protective factors more important than others?
- Are there favourable groupings of protective factors?
- Are specific protective factors unique to particular genders?
• Which protective factors are more important at which ages, and what are the processes through which they become effective?
• Are there culture salient and context specific protective factors?
• Which protective factors mediate which risks?
• How do some factors serve as both protective and risk factors, and which conditions enable such effects?
• Which mechanisms and processes can elucidate why certain factors are protective factors?

The ensuing discussion will focus on risk and protective factors located at each of the five domains in the ecological systems framework, as revealed by the literature review. The reader is reminded of the reciprocal, interactive and cyclical nature of these risk and protective factors.

2.4.2.1 Individual Domain

Variability in individual responses to stressors and external factors is determined by a range of factors. Individual factors have been likened to dispositional traits, biological and psychological characteristics and abilities that develop and are shaped in the context of one’s social environment (Substance Abuse and Mental Health Services Administration (SAMHSA), 2011; Kaplan & Sadock, 2007). Research on risk factors located at the individual systems level has revealed the following findings: A genetic predisposition or prenatal exposure to alcohol use (Substance Abuse and Mental Health Services Administration (SAMHSA), 2011; Fraser, 2004:188); having favourable attitudes towards drug use (Atkinson, cited in Myers et al. (2008:18), 2004; National Institute on Drug Abuse (NIDA), 2003; United Nations Office on Drugs and Crime (UNODC), 2004; Peleg, Neumann, Friger, Peleg & Sperber, 2001:263); the perception that most adolescents use drugs (Pentz, 2003); a belief that the person is immune to the effects of drug use; inadequate life skills, lack of self-control, rejection of values, emotional and psychological problems (Myers et al., 2008:16; Atkinson, cited in Myers et al. (2008:18), 2004; United Nations Office on Drugs and Crime (UNODC), 2004; National Institute on Drug Abuse (NIDA), 2003; Hawkins, Catalano & Arthur, 2002);
poor decision-making skills; inadequate drug refusal skills (Potgieter et al., 2010; Pentz, 2003); excitement or sensation seeking; curiosity; and inadequate coping skills (Hayman, 2013:77; McNeece & DiNitto, 2013:236; Potgieter et al., 2010); antisocial behaviour, rebelliousness, poor impulse control; attention deficit (Fraser, 2004:188); moral development (McNeece & DiNitto, 2013:238); gender – as drug use is more prevalent amongst men (Peleg et al., 2001:263); ethnicity (Swanson et al. 2003; Kim et al. 2002); and low self-esteem (Scheier, Botvin & Baker, 1997) – these have all been identified as individual level risk factors, whilst self-concept and high social competence have been identified as both risk and protective factors (Bower et al., 2012).

Individual protective factors refer to those individual traits and abilities that enable adolescents to resist the impact of negative influences on their lives. The literature makes reference to the following abilities and character traits as characteristic of individual-level protective factors: a resilient temperament; social skills; religiosity; and a belief in moral order (McNeece & DiNitto, 2013:238; Substance Abuse and Mental Health Services Administration (SAMHSA), 2011; National Institute on Drug Abuse (NIDA), 2003); an easy temperament; a positive attitude, high intelligence; low childhood stress; social and problem-solving skills (Fraser, 2004:191); optimism about the future; high self-esteem (Potgieter et al., 2010); positive personal characteristics, social and emotional competence (Myers et al., 2008:16; Atkinson, cited in Myers et al. (2008:18), 2004; United Nations Office on Drugs and Crime (UNODC), 2004; National Institute on Drug Abuse (NIDA), 2003). McWhirter et al. (2013:282) contend that the most powerful protective factor is having an attitude that is intolerant of deviant behaviour.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) has identified a difficult temperament as an individual-level risk factor in infancy and early childhood, juxtaposed against the following protective factors in the early childhood stage: ‘self-regulation, secure attachment, mastery of communication and language skills, ability to make friends and get along with others’. Risk factors in middle childhood include: ‘poor impulse control, sensation-seeking, early persistent behaviour problems, attention deficit/hyperactivity disorder, anxiety, depression and antisocial behaviour’. Wegner, Flisher, Caldwell, Vergnani and Smith (2008:1086) propose that
adolescence is a life stage when risk behaviour frequently occurs, making it a crucial period in which to promote prosocial behaviour. Accordingly, Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) has identified the following individual-level risk factors in adolescence: ‘emotional problems in childhood, conduct disorder, favourable attitude toward drugs, rebelliousness, early drug use and antisocial behaviour’. The protective factors include: ‘positive physical development, academic achievement/intellectual development, high self-esteem, emotional self-regulation, good coping and problem-solving skills, engagement and connections (in school, with peers, in athletics, employment, religion, culture)’.

Several of the protective factors emanating from the literature review cohere with the key competencies identified in the positive youth development literature. The work of McWhirter et al. (2007) and Roth and Brooks-Gunn (2003:170) are cited below as illustration of the key competencies in adolescence that enhance the likelihood of prosocial development and reduce adolescents’ engagement in risk inducing behaviour.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical school competence</td>
<td>Competence in academic, social and vocational areas</td>
</tr>
<tr>
<td>• Basic academic skills (skills of writing, reading, arithmetic to survive);</td>
<td></td>
</tr>
<tr>
<td>• Academic survival skills (social behavioural skills, e.g. following instructions; attending to tasks; raising hands; work habits; peer relationships; coping skills);</td>
<td></td>
</tr>
<tr>
<td>• Self-efficacy expectations: latter also related to concept of self</td>
<td></td>
</tr>
<tr>
<td>Concept of self, self-esteem, self-efficacy:</td>
<td>Confidence or a positive self-identity</td>
</tr>
<tr>
<td>• Self-concept: perception/view you have about yourself/evaluative component;</td>
<td></td>
</tr>
<tr>
<td>• Self-esteem – how we feel about ourselves, given our self-concept;</td>
<td></td>
</tr>
<tr>
<td>• Self-efficacy: beliefs we have about how capable we believe we are in performing specific tasks</td>
<td></td>
</tr>
<tr>
<td>Connectedness:</td>
<td>Connections to community, family and peers</td>
</tr>
<tr>
<td>connection with others; sense of close belonging in relationships; communication with others; 'mattering’ – knowing that you are important to others, juxtaposed with social isolation.</td>
<td></td>
</tr>
<tr>
<td>Coping ability:</td>
<td>Character or positive values, integrity and moral commitment</td>
</tr>
<tr>
<td>Ability to deal with anxiety and stress; how they cope with these emotions determine their adjustment; coping skills influence individuals response to stress; some young people exposed to greater degrees of stress; greater difficulty in dealing with it.</td>
<td></td>
</tr>
<tr>
<td>Control:</td>
<td>Caring and compassion</td>
</tr>
<tr>
<td>Lack of control over decisions; over the future; over life</td>
<td></td>
</tr>
<tr>
<td>Decision-making skills</td>
<td></td>
</tr>
<tr>
<td>Delay of gratification</td>
<td></td>
</tr>
<tr>
<td>Purpose in life</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 2.6: Key competencies of positive youth development**
Prevention interventions that target individual-level risk and protective factors are frequently incorporated into school-based, family-focused or multi-focused drug prevention interventions and will accordingly be presented under the relevant sections in this Chapter.

2.4.2.2 Family Domain

Whilst peer influences are paramount in drug use decisions for adolescents, several studies confirm that parental influence does matter and that the family remains an important socialisation agent for children (Miller & Plant 2010; Louw & Louw, 2007). Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) has listed the following family-level risk factors that, if present during the child’s infancy and early childhood, would enhance his/her propensity for drug use later: ‘parental drug use, and cold and unresponsive mother behaviour’. In contrast, the family protective factors during early childhood include: ‘reliable support and discipline from caregivers, responsiveness, protection from harm and fear, opportunities to resolve conflict, and adequate socio-economic resources for the family’.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) has identified the following as family risk factors during middle childhood: ‘permissive parenting, parent-child conflict, low parental warmth, parental hostility, harsh discipline, child abuse/maltreatment, drug use amongst parents or siblings, parental favourable attitude towards alcohol and drug use, inadequate supervision and monitoring, low parental aspirations for child, lack of or inconsistent discipline’. The family protective factors prevalent during middle childhood include: ‘consistent discipline, language-based rather than physically-based discipline and extended family support’. Family-based risk factors associated with adolescence are as follows: ‘drug use amongst parents, lack of adult supervision, and poor attachment with parents’. The family protective factors include: ‘family provides predictive family structure with rules and monitoring, supportive relationships with family members, clear expectations for behaviour and rules’.
Additional literature reveals that the following family factors enhance an adolescent’s susceptibility to drug use: family violence and child abuse (Loxley et al., 2003:46); poor family management; lack of parental supervision; parents’ favourable attitudes toward the use of drugs; family history of drug use; family conflict; parental tolerance to antisocial behaviour; family disorganisation; social isolation of the family; inconsistent and ambiguous family rules; parental unrealistic expectations (McNeece & DiNitto, 2013:238; Myers et al., 2008:16; Atkinson, cited in Myers et al. (2008:18), National Institute on Drug Abuse (NIDA), 2003; Hawkins et al., 2002; United Nations Office on Drugs and Crime (UNODC), 2004); family communication; poor parent-child bonding (Hayman, 2013:78; Fraser, 2004:188); parenting style; low parent monitoring (Potgieter et al., 2010; Vera & Shin, 2006:82); deficient parental limit setting and poor problem-solving skills in the family; absence of a religious affiliation in the family; authoritarian and punitive parenting approaches; and reconstituted family structures, characterised by high levels of conflict (Hayman, 2013:83; McWhirter et al., 2013:179). Kumpfer, Alvarado & Whiteside (2003:11-13) emphasise that pathogenic family structures, characterised by high degrees of relationship discord, enhance an adolescent’s vulnerability to stress, and therefore susceptibility to yield to drug offers. Several South African studies have also concluded that adolescents who experience parental drug use are more prone to emulate such behaviour, as it is perceived as acceptable, as opposed to those whose parents hold anti-drug attitudes (Potgieter et al., 2006; Brook et al., 2006; Jessor, 1991). A study by Youngblade, Theokas, Schulenberg, Curry, Huang, and Novak (2007:S52) has confirmed that ‘mundane aspects of family life’, which include family members taking the time to talk to each other; parents showing interest in who their children’s friends are; and families having a meal together, impact positively across multiple areas of children’s lives.

As an illustration of the interaction between risk factors, Vera and Shin (2006:82) point out that a lack of adult supervision is often prevalent in low income families and communities, as parents cannot afford after-care or babysitting services. It is under these conditions that children start to watch age-inappropriate programmes that provide distorted messages about identity and sex and portray substances in a desirable fashion. Garbarino (1999) warns that these types of programmes often portray the world as an uncaring and dangerous place, which compromises children’s own sense of
confidence and trust in their environment. Borawski, Levers-Landis, Lovegreen and Trapl (2003) confirm that there is a strong link between adolescents’ risk-taking behaviour and three parent variables, i.e. parents’ monitoring, supervision of their adolescents, and the trust that they exhibit in their children. Furthermore, they categorise parental guidance into six clusters: a) no parental guidance; b) limit setting on the quantity and frequency of drug use; c) actively discouraging the use of substances; d) occasional mentioning of alcohol by parents; e) thorough discussion regarding consequences of drug use; f) parents’ favourable attitude towards drug use. The findings from the study by Borawski et al. (2003) have established that the adolescents in clusters c) and e) had the lowest prevalence of drug use and that both groups had few if any drug using peers and were more focused on future goals.

Some literature uses the terms family strengths, family resilience and family protective factors interchangeably. The distinction, though, between these concepts is that family strengths and protective factors can exist independent of family challenges, but serve as a shield during difficult times (McWhirter et al., 2013:132). My understanding of the difference is that family resilience is those strengths and family processes that evolve and develop as a direct result of the family navigating specific family challenges. The growing body of literature on family resilience has identified the following family-level protective factors: parental supervision; child’s attachment to parent; parent’s attachment to child; parent’s involvement in child’s activities; positive attachments between family members; a parenting style that projects warmth and consistency; an emotionally nurturing and supportive home environment (McNeece & DiNitto, 2013:237; Swahn, 2012:22; Myers et al., 2008:16; Atkinson, cited in Myers et al. (2008:18), 2004; National Institute on Drug Abuse (NIDA), 2003; Hawkins et al., 2002; Ledoux et al., 2002; United Nations Office on Drugs and Crime (UNODC), 2004); positive parent-child communication; a positive family environment, which includes a lack of physical crowding; a positive relationship with at least one caregiver (Fraser, 2004:190); and a democratic parenting style (Sharland, 2006:257).

Walsh’s (2003:3) definition of family resilience as: ‘The path a family follows as it adapts and prospers in the face of stress, both in the present and over time’, is regarded as a comprehensive description of the concept. Resilient families therefore respond
positively to these trying conditions in unique ways, depending on the context, developmental level, the interactive combination of risk and protective factors, and the family’s shared outlook. Emanating from this definition are the three core pillars of family resilience, which are summarised in the table below:

<table>
<thead>
<tr>
<th>Belief systems</th>
<th>Organisational processes</th>
<th>Communication processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families with a positive belief system view challenges as meaningful and hence try to derive meaning from these experiences; there is a strong foundation of trust in the family; challenges emanating from family life cycle transitions are normalised and contextualized; family crises are viewed as meaningful, manageable and comprehensible; they adopt a positive and optimistic approach to their future and accept that there are situations that cannot be changed; they have a strong sense of spirituality which is practiced in various forms; and their moral values translate into a commitment to help others.</td>
<td>Also referred to as family shock absorbers, and is characterized by flexibility, connectedness (i.e., offering mutual support to each other and relying on strong leadership in the family, offering and seeking forgiveness during times of conflict), and active mobilization of their social and economic resources. This includes mobilising support structures and balancing work and family strain effectively.</td>
<td>The communication processes in resilient families facilitate effective family functioning and is characterized by clear, open emotional expression, collaborative problem solving and informed by the goals of the family and focused on effecting success (McWhirter et al., 2013:132; Becvar &amp; Becvar, 2000).</td>
</tr>
</tbody>
</table>

**TABLE 2.7: Three core pillars of family resilience**

[Source: Walsh (2003:3)]

The next section provides an overview of four family-based programmes rated as effective family-based drug prevention programmes, following rigorous empirical evaluation. The selection of these four programmes was informed by the following factors:

- They were implemented in communities that shared several characteristics with the communities in which the present study was located.
They evidenced strong cultural sensitivity.

Their criteria for effectiveness related to a reduction in alcohol and drug use; as well as a reduction in risk factors and an increase in the protective factors against drug use.

These programmes are: i) The Strengthening Families Programme 10-14 (SFP 10-14); ii) Familia Adelante; iii) Preparing for the Drug Free Years Programme (PDFY), and, iv) The Strong African American Families Programme (SAAF). The reader’s attention is drawn to the fact that all four these programmes were developed for the United States context and therefore will need to be adapted for the South African, should they be deemed relevant. The decision to present US based programmes were informed by the absence of evaluated South African based programmes.

**Strengthening Families Programme for Parents and Youth 10-14 (SFP 10-14)**

The Strengthening Families Programme was originally developed by Kumpfer, DeMarsh and Child (1989), but then underwent a major revision, culminating in the Iowa Strengthening Family Programme (ISFP). This Programme was further revised to ensure that it was culturally appropriate. It resulted in the Strengthening Families Programme for Parents and Youth 10-14 (SFP 10-14) by Spoth and his colleagues and tested between the years 1999-2008. This Programme is deemed to be appropriate for ethnically diverse families of all educational and economical levels. It is commended by Molgaard and Spoth (2001); rated as exemplary by the US Department of Education; reported to be a model programme by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) and flagged in NIDA’s list of research based prevention programmes (Gorman, Conde & Huber, 2007:586). Harker Burnhams, Townsend, Dada and Pluddemann (2012:11), who have conducted a systematic review of effective multi-focused universal prevention programmes, remark that besides the effectiveness of the Programme in delaying the onset of adolescent substance use, its value is enhanced by the fact that it has been replicated. As this Programme is undergoing an adaptation for implementation in Cape Town in communities that mirror
the ones in which the present study was located, it will be discussed in more detail than the other family-focused programmes in this chapter.

The SFP 10-14 is a universal after-school programme focused on the enhancement of family relationships as one of the protective factors buffering against adolescent drug use. The specific objectives of the Programme are:

- to promote the development of skills in 7th Graders (10-14 year olds) to facilitate their resistance to drug use;
- to target the parenting practices that can effect a reduction in adolescents’ propensity for drug use;
- to build stronger, supportive and guiding family units.

The table below provides a synopsis of the SFP 10-14 Programme:

<table>
<thead>
<tr>
<th>Target audience</th>
<th>Adolescents ages between 10-14 years and their parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>8-13 families</td>
</tr>
<tr>
<td>Programme duration</td>
<td>Seven session curriculum x 2 hours at a time + 4 booster sessions after 3-12 months of programme completion</td>
</tr>
<tr>
<td></td>
<td>Seven consecutive weeks</td>
</tr>
</tbody>
</table>
| Presentation format | **First six sessions:** Parents and adolescents attend separate sessions running parallel for the first hour. Second hour – supervised family session  
**Seventh session:** Joint session where family units practise the skills together |
| Facilitators | Three facilitators: One for the parents’ sessions; two for the adolescents’ sessions |
| Venue requirements | Two venues required, with the family session taking place in the larger of the two venues |
| Programme content | Overlapping content for the parents and adolescents’ sessions: For example, when the parents learn about enforcing consequences for adolescents’ breaking rules, the adolescents’ session will focus on the importance of rules. In the joint family session that follows, the parents and youth will be presented with an experiential learning opportunity regarding problem solving in the event of rules being broken |
Methodologies employed
Include discussions, skills building activities, observational learning from viewing video tapes that illustrate the modelling of positive behaviour, and games to develop skills and enhance positive interactions. Families also design posters.

Reinforcement of skills
In the final family session, the presenters present a slide show of the pictures taken during the Programme. A certification ceremony is held during the last session, where a framed certificate with pictures of parents and adolescents is presented to each family. In the last session, parents and adolescents write two structured letters to each other.

Theoretical framework
The Programmes are developed on the premise of three theoretical models:

**Biopsychosocial Vulnerability Model:** This model purports that there are specific biopsychosocial risk variables (for example, family values and attitudes) that interact with specific stressors (for example, family stressors like financial stressors and family disagreements) which enhance the adolescents’ vulnerability to drug use.

**Family process model:** The family process model suggests that family risks and stressors are buffered by family coping skills (like conflict resolution, problem solving and family management skills; social and material support). Adolescents’ behavioural outcomes are therefore determined by the interaction between the risk and protective variables mentioned above and the rest of the meso and macro systemic influences, like community, peer and school related variables.

**The resiliency model:** The resilience framework adopts a focus on family protective processes, enhancing the resiliency characteristics in youth.

<table>
<thead>
<tr>
<th>TABLE 2.8: Summary of SFP 10-14 programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source:</strong> Molgaard, Kumpfer and Fleming (1997)</td>
</tr>
</tbody>
</table>

The focus of the adolescents’ sessions is on promoting prosocial goals for the future, coping with stressors and intense emotions, valuing parents and significant others, enhancing the adolescents’ desire to be held accountable, and acquiring skills to resist peer pressure. The parents’ sessions focus on their role as positive socialisation agents, especially during early childhood years; emphasising the developmental phases and parents’ different roles in each of these phases; the importance of offering nurturing support; the effective daily management of children; learning about limit setting and enforcing the agreed upon sanctions; and exchanging beliefs regarding substance use.
The family sessions provide an opportunity for the youth and parents to practise the skills they have acquired in the parallel sessions. These include family communication, listening to each other, crystallising family values and family strengths, acquiring the skill to employ family meetings to address family concerns and solve problems, and learning how to plan family fun events (Molgaard et al., 1997).

Several studies (including a longitudinal follow-up of the participating families and individuals over a six-year period) have confirmed the success of the SFP 10-14 in terms of the delayed onset of drug use, a decrease in alcohol and drug use, and improved positive engagements between parents and children (compare Spoth, Redmond & Shin, 2001). Faggiano et al., (2008:255) cite the findings from a systematic review of the SFP (10-14) as effective over the long term for the primary prevention of alcohol misuse. The findings further reveal that for ‘every nine individuals who receive the intervention, there will be one less student using alcohol, using alcohol with permission or having drunkenness episodes four years later’. Whilst the findings also suggest that the culturally focused skills training underpinning the SFP 10-14 is more effective than the Life Skills Training Programme (a school-based prevention programme, developed by Spoth et al. (2001)), Harker et al. (2012:11) recommend combining the two programmes. The table that follows, illustrates the strengths, weaknesses and functional elements of the SFP 10-14 Programme:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Functional Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interactive nature of the Programme, as parents and children learn alongside each other and have the opportunity to actively practise the skills in the joint family session. Enhances skills of both parents and their children and changing problem behaviours in the family. Provides opportunity for positive family engagement under supervision.</td>
<td>Broad age range of children (may have combination of children from Grades 4-8) No indication that the unique needs of the children and families would be assessed and Programme tailored accordingly. No reflection on which parents to include in blended families in the event of a shared custody</td>
<td>Adolescents’ sessions: Developing goals and dreams Appreciating parents Following rules Handling peer pressure Reaching out to others Parents’ sessions: Supporting goals and dreams Appreciating family members Using family meetings Understanding family values Building family communication</td>
</tr>
</tbody>
</table>
Booster sessions 3-12 months after the Programme to enhance retention of impact.

agreement.

No reference to how normative drug use in the community can be addressed.

No incorporation of how goals and dreams can be effected in strength limiting environments with limited resources.

Reaching goals
Putting it all together

**TABLE 2.9: Strengths, weaknesses and functional elements of SPF 10-14 Programme**

**Familia Adelante Programme**

The second family focused drug prevention programme to be considered is the Familia Adelante Programme (originally known as the Hispanic Family Intervention Programme) (Cervantes, Goldbach & Santos, 2011). This Programme was developed in the early 1990’s for Mexican American (Latino) families aimed at reducing multiple risk behaviour. It was developed around the assumption that Latino youth and their families were experiencing specific culturally based risk factors that required culturally specific interventions. Examples of these risk factors include racism, discrimination, acculturative stress, immigration and educational challenges. The developers furthermore argued that addressing multiple risk elements promoted the chances of positive outcomes at multiple levels and could potentially also be more cost effective. The premise of the Programme was therefore that if the cultural group was capacitated to deal with acculturative stress, it could result in a decrease in substance use and sexually risky behaviour, whilst at the same time promoting individual, peer and family protective factors (viz. improved peer and family communication).

The **goals of the programme** are as follows:

- Reducing multiple risk behaviour in families
- Equipping families to deal with acculturative stress by
Promoting individual, peer and family protective factors (enhancing peer and family communication)

The table below provides a synopsis of the Familia Adelante Programme:

| Target audience | Hispanic families (experiencing acculturative stress) (parents and children)
|                 | Children: 11-14 year olds, referred by their teachers or school counsellors – presenting with behavioural challenges and scholastic challenges – not as a result of language.
|                 | Parents’ inclusion in a group was subject to their children’s inclusion in a group.

| Number of participants | 8-10 participants per group
|------------------------|--------------------------
| Programme duration     | This is a 12-weeks after-school programme of 90-minute sessions at a time
| Presentation format    | Presented to parents and youth in concurrent but separate group sessions
| Facilitators           | 1 facilitator per group: Bilingual and bicultural facilitators
| Venue requirements     | Two venues
| Programme content      | It is presented as a psycho-education programme aimed at enhancing communication skills and psychosocial coping, raising awareness about substances and HIV; revisiting perception of harms; improving school behaviour; and social norms about sexual behaviour and substance use.
| Methodologies employed | Interactive methodologies
| Theoretical framework  | Theoretical framework of the stress-illness paradigm to arrive at the identification of risk domains.
|                        | The quantitative identification of stressors was also informed by qualitative studies on stress and coping, which culminated in the launch of the Familia Adelane, which contained a combination of risk and protective domains on which to train children and parents alike.

TABLE 2.10: Summary of Familia Adelante (FA) Programme
[Sources: Cervantes et al. (2011); Harker et al. (2012:30; 35)]

Harker Burnhams et al. (2012:30; 35) remark that the Familia Adelante Programme may be particularly relevant to the South African context, as it was implemented in a community mirroring the socio-economic circumstances of several previously marginalised communities (like the one in which the present study was conducted).
There is a programme for youth and parents that runs concurrently, but separately, with each group consisting of 8-10 participants.

The evaluation of the programme highlights a reduction in alcohol and marijuana usage amongst adolescent participants, as well as a reduction in the use of legal drugs by participating parents. The evaluation furthermore points to indirect alcohol and other drug outcomes pertaining to improved communication with peers and family; an enhanced sense of belonging and connection with the family; and HIV-related anxiety and social norms regarding sexual behaviour (Cervantes et al., 2011). Some of the critique emerging from the evaluation of the programme is the lack of a control group; and a high attrition rate in later follow-up sessions with the participants.

The strengths, weaknesses and functional elements of the ‘Preparing for the Drug-Free Years’ (PDFY) Programme are summarised in the table below:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Functional Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culturally specific</td>
<td>No separate focus on cultural resilience.</td>
<td>Stress from discrimination and racism.</td>
</tr>
<tr>
<td>Target racial and ethnic minority groups</td>
<td>Predetermined focus areas – no prior needs identification with the target audience.</td>
<td>Economic and work and school-related stress and strategies to deal with it.</td>
</tr>
<tr>
<td>Address multiple risk factors</td>
<td>Potential for deviancy training (in the absence of a highly skilled facilitator), as all children present with behavioural difficulties.</td>
<td>Family stress, parental stress.</td>
</tr>
<tr>
<td>Parents and youth involved – systemic benefits</td>
<td></td>
<td>Negative peer pressure and decision making, and strategies to promote making protective decisions.</td>
</tr>
<tr>
<td>Multiple longitudinal evaluations of the Programme</td>
<td></td>
<td>Parents’ session: Disciplining and how that differs from their home country where corporal punishment is allowed.</td>
</tr>
<tr>
<td>After School Programme</td>
<td></td>
<td>Promoting family communication.</td>
</tr>
<tr>
<td>Bilingual and bicultural staff</td>
<td></td>
<td>Gang prevention and substance abuse education.</td>
</tr>
</tbody>
</table>

TABLE 2.11: Strengths, weaknesses and functional elements of the Familia Adelante Programme
Preparing for the Drug-free Years (PDFY)

This Programme, which was developed by Kosterman, Hawkins and Spoth, is offered as an after-school programme to parents (of children 8-14 years). The Programme evolved from an awareness of the rapid onset of substance use amongst adolescents, highlighting the need for parents to be equipped with the necessary abilities to reduce such onset (Kosterman, Hawkins, Spoth, Haggerty & Zhu, 1997).

The goal and objectives of the PDFY are as follows:

- Promoting protective factors in the family, especially those that would buffer their children against the risk of the onset of substance use by:
  - Facilitating parent-child interaction
  - Enhancing parents’ skills in consistent and family management
  - Promoting positive reinforcement for prosocial behavior
  - Promoting a positive family environment, characterised by reduced family conflict
  - Equipping parents and children with skills to resist peer pressure and engagement in harm-inducing behaviour.

The table below provides a synopsis of the PDFY Programme:

<table>
<thead>
<tr>
<th>Target audience</th>
<th>Parents with children 8-14 years from rural schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>Maximum 10</td>
</tr>
<tr>
<td>Programme duration</td>
<td>Five consecutive session programme x 2 hours per week</td>
</tr>
<tr>
<td></td>
<td>Children attend</td>
</tr>
<tr>
<td>Presentation format</td>
<td>Parents attend all five sessions; children attend one session</td>
</tr>
<tr>
<td>Venue requirements</td>
<td>One venue</td>
</tr>
<tr>
<td>Programme content</td>
<td>Drug education; family norms regarding drug use</td>
</tr>
<tr>
<td>Methodologies employed</td>
<td>Interactive, multi-media, skills training, families complete homework assignments</td>
</tr>
</tbody>
</table>
Theoretical framework

The PDFY Programme is founded on the Social Development Model, which proposes that healthy adolescent development is subject to positive attachment to the adolescents’ socialisation agents, i.e. family, school and peers. Positive bonding to these socialisation agents will therefore reduce the propensity for anti-social behaviour. Bonding with the family has three facets, i.e. the family should provide opportunities for positive engagement; the child’s degree of skill with which he/she engages in the family; and, thirdly, the family’s reinforcement of positive behaviour (family expectations and norms) and punishment of the inverse.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Functional Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Founded on a strong research base</td>
<td>- Not sufficient attention devoted to the children’s view on family strengths and how these can be promoted</td>
<td>- Theoretical base – Social Development Model</td>
</tr>
<tr>
<td>- Robust research design</td>
<td></td>
<td></td>
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<tr>
<td>- Large percentages of families have been families of colour</td>
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<tr>
<td>- Children’s restricted participation in the actual</td>
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<tr>
<td>- Emphasise positive engagements with child’s socialisation agents, i.e. family, peers and school</td>
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</tbody>
</table>
- Culturally sensitive
- Inclusive of single parent families
- Opportunity for parents to immerse in skills training
- Reciprocal learning opportunity from fellow parents in the programme
- Opportunity to receive feedback from peers in a safe environment

programme may result in reduced ownership of the process

- Parents equipped with parenting skills to ensure family presents child with opportunities for positive engagement
- Parents reward positive behaviour and punish disapproved ones appropriately
- Parents and children trained in negative peer and risk inducing resistance skills
- Managing family conflict

TABLE 2.13: Strengths, weaknesses and functional elements of preparing for Drug-free Years (PDFY)

The Strong African American Families Programme (SAAF)

The Strong African American Families Programme (SAAF) is an after-school programme developed by Brody et al. (2004) and consisting of a parent, youth and family syllabus. The primary focus of the Programme is to develop pathways to competence and adjustment for rural African-American children and adolescents living in single and married parent families.

The objectives of the programme are as follows

- to reduce the onset of alcohol use
- to equip the youth with adaptive strategies to deal with racism, and
- to reduce harmful sexual behaviour amongst youth.

The table below offers a summary of the SAAF programme:

| Target audience | Families with children, up to age 11 years  
| Families from poor socio-economic environments  |
| Number of participants | Not more than 10 in a group  |
| Programme duration | Seven consecutive weekly meetings x 2 hours per session  |
| Presentation format | Separate sessions for parents, family and youth sessions,  |
Facilitators | Youth sessions presented by youth leaders
---|---
Venue requirements | Held at community facilities.
Methodologies employed | Interactive methodologies including role-playing
| Videotapes
| Youth sessions presented by youth leaders

TABLE 2.14: Summary of the SAAF Programme
[Sources: Harker Burnhams et al. (2012); Brody et al. (2004)]

Brody et al. (2004:903), commenting on the efficacy of the Strong African American Families Programme, have reported that children who received adaptive racial socialisation with overt messages about race relations, cope more effectively with episodes of discrimination; were more likely to excel academically; had a more positive view of themselves; and were less inclined to internalise negative messages about race. A randomised control longitudinal review by Brody (2010, as cited in Harker Burnhams et al. 2012:40), revealed that youth in the control group drank twice as often as those in the SAAF group during the previous month, at last assessment follow-up. It was furthermore found that ‘youth in the SAAF group were less likely to initiate alcohol use at 29-month follow up’.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Functional elements</th>
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</thead>
<tbody>
<tr>
<td>Multi-systemic interventions – i.e. parents, youth and families; Interactive methodologies used (i.e. roleplaying; guided discussions amongst parents following video screenings; Multifocused – i.e. alcohol prevention and promoting responsible sexual behaviour; Timing of presentation coincides with onset of peer influences – so parents of pre-adolescent children; Robust research design – 29 month follow-up; After-school programme</td>
<td>Focused only on legal drug alcohol. Predetermined curriculum, so there is no opportunity to explore the needs of the participants.</td>
<td>Parents’ sessions: Responsible, regulated parenting; adaptive racial socialisation strategies; clear parental communication regarding sex; and norms about alcohol use. Youth sessions: Skills development programme, focusing on negative peer influences and alcohol resistance; adaptive strategies to deal with racism; abiding by household rules. Family curriculum: Enhancing</td>
</tr>
</tbody>
</table>
The similarities between the four programmes discussed above all included an informational focus, a parent training focus, and an emphasis on family interaction. Ksir et al. (2008:426-427) confirm that these three elements usually form part of preventive interventions with parents. According to the authors, support groups for parents usually constitute the fourth element in parent training programmes; however, these were not evident in any of the three programmes described above. One possible explanation may be that support groups appear more appropriate at secondary prevention level or selective and indicated prevention targets, whilst the three programmes described above all resort under universal preventive programmes. Two additional collective elements, which are evident in the four reviewed prevention programmes, are the incorporation of lifeskills training for adolescents, as well as interactive sessions between parents and children to ensure there is a co-construction of learning and skills.

Myers et al. (2008:19-20) propose a number of guidelines that should be followed when constructing family-based drug prevention programmes. These guidelines were drawn from the systematic reviews of a number of family-based prevention studies, which confirmed the value of parent training programmes, and family skills training programmes, in effecting positive changes in children’s behaviour (Petrie et al., Foxcroft, Ireland, Lister-Sharp, Lowe and Breen, 2003 cited in Myers et al., 2008:19; and Komro & Toomey in Myers et al., 2008:19-20), and strengthening family bonds. Guidelines drawn from additional sources are also included in the table below:

<table>
<thead>
<tr>
<th>Guidelines to be followed when constructing family-based drug prevention interventions</th>
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<tbody>
<tr>
<td>The guidelines for family skills training include the following:</td>
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<tr>
<td>• Interventions should be informed by theory and emanate from research findings (United Nations Office on Drugs and Crime (UNODC) in Myers et al., 2008:20).</td>
</tr>
<tr>
<td>• Programmes should be informed by the needs and the degree of risk assessment of the target population (UNODC in Myers, 2008:20).</td>
</tr>
</tbody>
</table>
The programmes should be child friendly, implying that they must be age- and developmentally appropriate to include all children (Loxley et al., in Myers et al., 2008:20).

The family skills training programmes that have proven to be effective should be selected and adapted to the cultural context and socio-economic needs of the target population.

Family-based programmes should adopt a family resilience approach (in other words, strengthen the family’s organisational processes, communication patterns and positive belief systems (Walsh, 2003:3).

Focus on enhancing positive family relationships, increasing family supervision and monitoring (Myers et al., 2008:20; Kerr, Stattin & Burk, 2000).

Prevention workers should refrain from once-off family-based interventions and instead ensure that family skills programmes are long enough to have a lasting impact.

As with all evidence-based interventions, it is recommended that family-based programmes be subjected to a systematic monitoring and evaluation (United Nations Office on Drugs and Crime (UNODC) in Myers et al., 2008:20).

Build in a follow-up booster session between 3-12 months after the initial intervention to reinforce the programme’s benefit (Molgaard et al., 1997).

Include family activities that will culminate in visible outcomes (like a family collage) that can be constructed in the session and taken home with the family as a reinforcement of the learnings (Molgaard et al., 1997).

TABLE 2.16: Guidelines for constructing family-based drug prevention programmes

2.4.2.3 Peer Domain

Section 1.9 in Chapter One contains an overview of how the concept youth is defined, making specific reference to the broad age range (14-35 years) provided for in the South African definition. Despite the individual differences in temperament, attitude, emotional regulation and intelligence between adolescents, Eriksson et al. (2010:115) highlight the normative changes that adolescents experience during this developmental stage. The table below provides a brief synopsis of these normative changes:

<table>
<thead>
<tr>
<th>Cognitive development:</th>
<th>Moral development:</th>
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<tbody>
<tr>
<td>In terms of developmental theories, adolescents’ cognitive development is at the formal operational stage (Piaget, 1950), implying that they should be capable of engaging in abstract thought, understanding and applying ethical or moral principles, have reflective thought, and have levels of empathic understanding and a sense of</td>
<td>At a moral reasoning level, they are expected to advance from the pre-conventional stage two to the conventional stage three of morality. During the pre-conventional stage, adolescents obey superiors primarily for the benefits of having their own needs met. During the conventional stage, adolescents’ moral choices and social conformity</td>
</tr>
</tbody>
</table>
what is best for society (Thompson, Rudolph & Henderson, 2004:12 & 17).

are determined largely by their need for acceptance and approval from significant people in their lives, such as peers and family (Le Roux, Pretorius & Smit, 2004: xiv-xv).

**Psycho-social:**
Borsari and Carey (2001) allude to adolescents’ need for peer acceptance, embedded in a need for belonging and the knowledge that they add value to the lives of others.

**Psycho-sexual:**
Adolescence marks the identity vs role confusion stage, according to Erickson. At a psycho-sexual level, this refers to adolescents’ sexual identity and relationships, where the primary focus is on gaining the interest of the opposite [and/or same] sex, with the view to sexual pleasure and procreation (Thompson & Henderson, 2011:158).

**TABLE 2.17: Summary of adolescent development stages**

The value of the peer group in terms of each of these dimensions of development is indispensable and will be revisited later in this section.

Apart from the developmental changes, Fatusi and Hindin (2010:1) refer to the changes adolescents in the 21st century have to deal with, which is vastly different to what it meant to be young a mere decade ago. Echoing this reality, Ashwell (2009:19) points out that these changes and problems prevail at ecological, economic, social and political levels. Diamond, cited in Lamb-Du Plessis (2012:77), refers to five major causes of the collapse of past societies, stating that although these crises are nothing new, they have never before occurred at such a global scale. The author describes the five causes as follows: environmental damage, climate change, loss of relationships with friendly neighbours, rise of hostile neighbours, and political and social factors.

For South African youth, who make up more than 40% of the country’s population (Statistics South Africa, 2012), the political and social changes impact on how they view the role of education and prospects for their own future. Altman (2012) reports that youth constitute the largest portion of the population and have the highest rate of unemployment. Findings from the South African Community Capability Studies, undertaken by the Centre for Democratising Information (Altman, 2012) have confirmed that an alarming 30.8% of ‘Coloured’ youth reported education as useless and less
interesting, as opposed to 17% for ‘African’ youth and 0% for both ‘White’ and ‘Indian’ youth. Altman (2012) hypothesises that this attitude may be informed by the high unemployment rate amongst the ‘Coloured’ ethnic group and the perceived limited opportunities, with employment equity guiding recruitment in the South African labour market.

As alluded to earlier, the adolescent population that the present study focused on has become known as the born-frees, having been born after the demise of apartheid in South Africa. It is, however, evident that they continue to navigate the legacies of apartheid (Altman, 2012; Peltzer et al., 2010). Offering a brief glimpse of the complexity of the social environment in which South African youth find themselves, Soudien (2007:9), summarises as follows:

*the mix of ingredients that have come to characterise young lives in South Africa … life and family histories disrupted by either the loss or absence of appropriate role models in their families and their immediate social circles … the combustive chemistry of race, class, religion, language and gender … [and] the re-articulation of all of these in the melee of globalisation.*

The findings from the Reconciliation Barometer (an annual survey published for more than ten years) reveal a growing disconnect and rising cynicism between the ‘born-free’ generation and the country’s past. It appears that the ‘born-free’ generation’s biggest discontent with the current government is the lack of employment opportunities, resulting in a rising educated unemployed youth population (Institute for Justice and Reconciliation (IJR), 2012).

Lamb-Du Plessis (2012:78) cautions that although the ‘emerging South African youth are more materialistic, more techno-literate, better educated and better connected than the previous generation’, it is crucial to view the youth as a valuable social asset and investment, rather than a challenge. This is a call echoed in the National Youth Development Policy (National Youth Commission, 1997). Lamb-Du Plessis (2012:78) cites several other South African literature sources that reflect the same sentiment. However, in order to harness the youth as an investment requires an understanding of
the challenges the current youth have to navigate, as well as the specific strengths they demonstrate. The challenges have been described above.

A significant strength that adolescents present, is their versatility and general competence in using modern technology. Lamb-Du Plessis (2012) observes that technology, ranging from cellphones, email, e-chat rooms, internet, electronic arcade games and community radio, has become a powerful medium of communication and entertainment. These media may all be optimised when designing peer-led interventions with adolescents aimed at igniting a positive peer influencing effect.

The peer group becomes the primary source of socialisation during the adolescent period (Kliwer & Murrelle, 2007; Kim et al., 2002:568; Oetting, 1992), especially with regard to the learning of social norms. It is, therefore, not surprising that peer substance use has been confirmed as the dominant influence in adolescent substance use (Brook et al., 2006; Kim et al., 2002), hence making peer-led intervention a logical drug prevention approach for reducing the onset of adolescent drug use (Loxley et al., 2003:127). Unfortunately, this developmental life stage has been construed very negatively by adults, who describe it as a time of turbulence, and emotional and identity confusion, where parental authority and guidance is challenged and the influence of adolescent peers is paramount. Offering a different perspective, Kerr et al. (2010) propose that competence in adolescence is characterised by a decrease in parental monitoring and an increase in adolescents’ autonomy.

The peer risk factors for adolescent drug use identified in the literature include the following: peers who have a favourable attitude towards drug use; peers who use drugs; peers who are generally risk-prone; peers who have an affiliation to a gang; peers who subject others to peer pressure (McNeece & DiNitto, 2013:237; Brook et al., 2006; Karcher, Brown & Elliott, 2004; Loxley et al., 2003:127-129), and alienation by prosocial peers (National Institute on Drug Abuse (NIDA), 2003). Falkowski (2003) and National Institute on Drug Abuse (NIDA) (2003) have revealed that negative peer association, which is one of the most immediate risks to drug involvement and subsequent expanded antisocial actions, occurs mostly when supervising adult figures
or nurturing parent-child relationships are absent. Kerr et al. (2010:39), on the other hand, found that the monitoring of adolescents is enhanced by youth rather than parent-driven initiatives.

Apart from peer monitoring, the peer protective factors that emanated from the literature review include: prosocial peer association (Hayman, 2013; Potgieter et al., 2010); avoidance of peers who are prone to drug use (Loxley et al., 2003:128); friends who uphold non-drug use norms; and the presence of mentors (Substance Abuse and Mental Health Services Administratin (SAMHSA), 2011). A study by Buckley et al. (2010) has revealed that adolescents offer protective behaviour to those peers with whom they share close friendships. Contrary to the earlier findings that negative peer association enhances susceptibility to drug use, Smokowski et al. (2000:438) have found that resilient adolescents refuse to be enticed by the apparent exhilaration of the risk-taking behaviour of their peers, but instead learn from the consequences of these behaviour in others. Azjen and Fishbein (cited in Hill, 2008:453), however, have found that adolescents benefit from observational learning only if they consider themselves susceptible to the harmful consequences of drug use. This finding resonates with the principles of the Theory of Reasoned Action (Hill, 2008).

Several post-modernist thinkers have acknowledged the opportunity for growth and maturation during the adolescent life stage (Jones, 2009; Louw & Louw, 2007:310). What is often construed as problematic behaviour, in fact becomes powerful mechanisms through which adolescents assert their agency, i.e. enabling them to experience a sense of power, recreation, acceptance, protection (Pilkington, 2007) or a sense of purpose in their community. Ungar (2006:7) refers to this process as adolescents’ search for health; implying that they need to generate substitutes for this harm-producing behaviour rather than focus on suppressing it. Louw and Louw (2007:313) suggest that adolescents who master this developmental transition period, and emerge with a secure ethnic identity, demonstrate ‘higher self-esteem, optimism, a sense of mastery over the environment and more positive attitudes towards their own ethnicity’.

Practitioners who embrace this positive perspective are more inclined to view the adolescent peer group as a valuable asset worthy of investment, instead of constantly
regarding them as an ‘endangered and dangerous group – at risk from others, to themselves, and to the fabric of communities’ (Kim et al., 2002:566). Giving credence to this contention, Karcher et al. (2004:193) postulate that peer interaction has many ‘positive, growth-promoting qualities’, which can be enlisted to promote positive youth development. Whilst adult practitioners can fulfil an important role in organising these peer-based interactions through formal programmes, they also need to guard against the potential of deviancy training or harm-inducing peer socialisation (Karcher et al., 2004:193).

Borsari and Carey (2001) argue that whilst peer pressure is closely associated with adolescent drug use, a precise definition of the concept evades. What is known is that peer pressure is not one-dimensional, nor is it uni-dimensional. Instead, it is a systemic interactive process through which adolescents shape each other’s behaviour, and hence is more appropriately referred to as peer influence. In keeping with the conceptual framework of this study, I also prefer the concept peer influence to peer pressure, as the former suggests a sharing of power and meaning being construction in the process of adolescents’ peer interaction.

Constructive peer influence is subject to two reciprocal processes, i.e. the formation and preservation of good relationships with prosocial peers, as well as the mastery of effective relational skills (Karcher et al., 2004:196). The literature suggests that peer influence, which can be direct and indirect, occurs through four mechanisms, each of which should be carefully considered when designing effective interventions. (McWhirter et al., 2013:179; Karcher et al., 2004:194-195; Griffin, Botvin, Nichols & Doyle, 2003:3). These modes of peer influence may operate simultaneously or independently, and occur mostly in peer clusters (which is a designated section of the peer group that has become the primary source of influence on the adolescents’ values, attitudes and beliefs of its members) (McWhirter et al., 2013:283). Furthermore, the same complex set of dynamic influences is apparent in formal groups and structured activities; therefore, effective interventions must be designed, with an awareness of all four modes of influence, taking into consideration both direct and indirect peer influence. Other post-modernist thinkers suggest that adolescents purposefully and voluntarily associate with the peer group whose group norms they aspire towards and
whose behaviour they wish to emulate (Pilkington, 2007; Brook et al., 2006), suggesting that practitioners need to explore the value that adolescents derive from particular peer associations.

Drug prevention programmes that target peer relations and peer influence on others have also mostly been incorporated into school-based prevention programmes, and will therefore be discussed under that section of the chapter. Karcher et al. (2004:202) emphasise that some peer interventions, like peer mentoring and peer mediation, are programmes that can be presented in isolation, whilst others are incorporated in larger intervention programmes. Catalano et al. (2002) conducted a review of 25 empirically supported positive youth development programmes, from which only five appeared to have significant peer-helping-peer intervention components that offered potential for the development of prosocial interpersonal relationships amongst peers.

The table below contains a brief summary of each of these peer components, with specific reference to its potential benefit for drug prevention interventions:

| Peer counselling without direct adult guidance | Peer counselling is premised on the principle that youth may be more empathic towards each other. However, peer counselling has not received a lot of research attention, which suggests that it is a practice that needs to be carefully trained and supervised by professionals (Karcher et al., 2004:202). Peer counselling has been recommended as ‘particularly useful for youth of colour’ (Gibbs in Karcher et al. (2004:202). However, working with youth from different races requires additional training to ensure that peer counsellors understand the differences in how speech is used and the relevance of self-disclosure. Harker et al. (2008:11), referring to the custom of organisations to use volunteers in recovery from addiction as peer counsellors or in drug awareness campaigns, emphasise the recommendation of Alcoholics Anonymous (AA Guidelines), which suggests that a period of 3-5 years of “uninterrupted sobriety” must elapse before an ex-addict is utilised in this role. |
| Peer counselling with direct adult guidance | Karcher et al. (2004:203) refer to pair counselling with direct adult guidance as a useful peer intervention strategy, since the adolescents doing the counselling are both in need of assistance and the process is guided by an adult counsellor. The youth therefore depart from the premise that they both have problems, but also resources and strengths to address these for themselves and each other. Pair counselling may be particularly relevant where two adolescents in a dating relationship use drugs as part of their social |
outlet. The adult counsellor can use pair counselling to help the adolescents identify the
behaviour that enhances motivation for drug use in each other. Pair counselling
increases perspective taking and negotiation skills (Catalano et al., 2002).

<table>
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<tr>
<th>Peers as mediators, tutors and mentors</th>
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</table>
| Peer mentors are frequently older than their mentees, since few adolescents are likely to view their age peers as their mentors. The TADA drug awareness and prevention programme has been incorporated as a peer mentoring programme in certain schools in the Northern Areas communities, albeit with limited success (Stanley, 2012). The value of TADA as a peer-led drug prevention approach needs to be evaluated, and an adolescent perspective on the suitability of the name TADA explored. Oliver et al. (2006:2) emphasise that when young people are involved in decision-making about issues that affect them, it enhances their sense of control, meaning and connectedness. Research has further revealed that youth programmes that focus on youth helping each other, ‘contribute to academic and social outcomes and enhance self-concept and community values’ (Oliver et al., 2006:5).

The Mentor Foundation was established in 1994 in collaboration with the World Health Organisation, with the aim of working globally to prevent substance abuse. Since its inception, it has supported prevention programmes in more than 80 countries (Mentor, 2005), and is delivered through schools, youth clubs and other social settings. One of the mentor programmes is to encourage pairing an adult mentor with an adolescent who could benefit from adult guidance and support (Mentor, 2005). The Mentor Foundation Website contains a list of brief prevention interventions that have proven to be effective and are primarily based on the principle of providing children with a secure base of caring, acceptance and belonging, which in turn reduces their attraction to anti-social associations. Another important principle is to remove adolescents from peer clusters that may have harmful influences, and/or offer treatment to the whole peer cluster, aimed at modifying risk-inducing norms and attitudes. The principles of the mentor programme can be particularly useful in the Northern Areas communities, where single-parent families and blended families appear to be the dominant family structures.

Peer tutors and mediators may be of a similar age and school grade, and tutoring is primarily aimed at equipping peers with new skills or information about particular school subjects (Karcher et al., 2004:204). McWhirter et al. (2013:282) report that ‘cross-aged, same age and classwide peer tutoring and cooperative learning are successful peer-mediated interventions across academic subject areas and grade-levels’, primarily because they benefit both the tutor and the tutee at social and academic levels. Cooperative learning offers a peer support system, as opposed to fostering competition amongst individuals, and may be particularly useful in socio-economically marginalised communities (like the one in which the present study was conducted), where many
parents cannot afford to employ academic adult tutors.

Peer support networks enhance cohesion amongst adolescents with similar struggles and can foster positive interdependence. Peer support networks are particularly prevalent in health clubs, sports clubs, and in youth sport and recreational engagements (Loxley et al., 2003:128). Sporting clubs provide a sense of belonging and an avenue through which social behaviour and interpersonal skills can be modelled and observed. However, when the adolescents' involvement in these social outlets are juxtaposed against deviancy training and accessibility to drugs, it detracts from the value of this peer intervention. There appears to be a huge need for altering the cultural norms that associate sport with alcohol and drug use. To this extent, the current South African Minister of Health, Dr Aaron Motsaledi, is driving a campaign to effect a ban on all advertisements relating to alcohol.

<table>
<thead>
<tr>
<th>TABLE 2.18: Summary of peer intervention components</th>
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<tr>
<td><em>(Table developed by the researcher)</em></td>
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</table>

The discussion on peer interventions clearly illustrates the value of the adolescents’ peer group as facilitators of positive change and growth. They can assume this role as mentors, tutors, mediators and teachers where, depending on their role, they would model prosocial skills, support each other and facilitate interpersonal ‘*understanding across age, gender, cultural and peer group*’ (Karcher et al., 2004:209). Below follows a list of guidelines that practitioners should follow when they construct peer-based drug prevention interventions:

<table>
<thead>
<tr>
<th>Guidelines to be followed when constructing peer-based drug prevention interventions</th>
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<tbody>
<tr>
<td>Enhance the effectiveness of peer interventions by ensuring they are:</td>
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<tr>
<td>• voluntary and structured (avoid boredom);</td>
</tr>
<tr>
<td>• intrinsically motivating (provide sufficient challenges and opportunities to retain the youth's interest and commitment);</td>
</tr>
<tr>
<td>• engaging: Activities that allow the youth to use their volition; employing incentives;</td>
</tr>
<tr>
<td>• interactive and diversified: Interactions among youth from diverse cultural and ethnic backgrounds and both genders;</td>
</tr>
<tr>
<td>• promoting prosocial engagements with peers (in other words, ensuring that the needs of others and norms of society (i.e. of schools, family and justice system) are considered;</td>
</tr>
<tr>
<td>• providing opportunity for perspective taking and identity development (facilitate resolution of conflicts by considering each other's' unique perspective — preventing cross-cultural and</td>
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</tbody>
</table>
cross-gender misunderstanding; understand between group and within group differences which will also enable youth to revisit their own internalised stereotypes).

- allowing practitioners to reduce the risk of deviancy training that accompany peer interventions by screening, training and actively supervising peer mentors; include a balanced number of high and low risk youth in peer or group interventions; activities to be structured by adults to support conventional norms and to reinforce prosocial behaviours);
- closely supervised and evaluated to ensure sufficient support for the peer leaders.

TABLE 2.19: Guidelines for constructing effective peer interventions in drug prevention

(Table developed by the researcher with information extracted from the following sources: McWhirter et al. (2013:300); Karcher et al. (2004); Loxley et al. (2003:127)]

2.4.2.4 School Domain

Greenberg, Weissberg, O’Brien, Zins, Fredericks, Resnik and Elias (2003:467) state that 21st century schools are required to provide more than academic tuition to learners, given the range of psycho-, socio-emotional and economic challenges children and youth are experiencing these days. The irony is that these additional demands are placed on schools at a time when they are serving an increasingly diverse learner population (in terms of culture, language and abilities), albeit with diminished resources and serious infrastructure challenges.

A review of the literature has revealed that the following school-based risk factors enhance children’s susceptibility to drug use: school failure; low commitment to school; associating with drug using peers (Substance Abuse and Mental Health Services Administration (SAMHSA), 2011); low school achievement (Wong, Slotboom & Bijleveld, 2010:277); and expulsion from school (Bower et al., 2012:10). Findings from South African studies show the following risk factors: school disengagement (Kliewer & Murrelle, 2007); crowded and non-conducive school environments; interruptions in the school-year due to teachers’ industrial action; stress caused by certain school subjects; unrealistic demands and expectations; an excessively competitive culture; on-going violence; receiving drug offers (and pressure to use drugs) at school (Gernetzky, 2012); lax, ambiguous or inconsistent rules; teachers and learners being pro-drug use; lack of connectedness to the school; availability of alcohol and drugs on the school premises.
(Myers et al., 2008:16; National Institute on Drug Abuse (NIDA) (2003:19) suggests that a significant contributing factor to school failure is a child’s inability to read by the third or fourth grade. This is a particularly relevant risk factor in the South African context. Modisaotsile’s (2012) policy brief entitled: ‘The Failing standard of basic education in South Africa’, outlines the crisis in South Africa’s education, basing her argument on the following evidence: the fact that only 50% of learners who enrol in Grade 1 ultimately complete Grade 12; the fact that the majority of Grade 12 learners who pass Matric do not obtain university admission; and the findings from the Annual National Assessments (ANA) regarding the low levels of literacy and numeracy among Grades Three and Six learners.,

School-based protective factors include the presence of mentors; educational support for learning difficulties; an experience of school connectedness as a result of engaging in school activities; clear expectations for behaviour; physical and psychological safety (Substance Abuse and Mental Health Services Administration (SAMHSA), 2011:7); learners feeling cared for and supported by teachers; high expectations of learners; having clear standards and rules for appropriate behaviour; inclusion in school activities (Myers et al., 2008:16) and the association between high levels of parental warmth and high levels of academic resilience (Smokowski et al., 2000:427).

The school-based risk and protective factors emanating from the literature review underscore the importance of schools as an important environment for drug prevention interventions. Further evidence offered in the literature for locating drug prevention interventions at schools are as follows: it can reach the greatest number of young people simultaneously (McWhirter et al., 2007); children spend most of their waking hours there (Gomez & Ang, 2007:98); schools have become popular locations to supply drugs from (Reddy et al., 2008:16); schools have a powerful potential as a protective structure (Maseko, Ladikos, Prinsloo, Nesar, Van der Merwe & Ovens, 2003:150); schools serve as socialisation agents for prosocial behaviour; the availability of educators allow for the cost effective delivery of prevention programmes (Wegner et al., 2008:1085); and they reduce stigma and offer support to learners in an environment that is familiar and accessible to them (Crockett, 2012:56). Reddy et al. (2010:16) report that South Africa has approximately 5670 secondary schools that offer education to just
over three million learners (Reddy et al., 2010:16). Whilst schools remain the preferred location from which to distribute health-promoting behaviours, the difference in the education system between public and private schools, however, results in the discrepant delivery of health education, questioning the quality of health information that learners from socially marginalised schools are receiving. Apart from the poor infrastructure and lack of resources, a significant challenge in the public schools in South Africa remains the high teacher:learner ratio of 1:32 (cited in Modisaotsile, 2012:2), which makes it difficult for teachers to effectively convey subject learning material.

Notwithstanding the structural and resource limitations highlighted above, the Department of Education has (as an extension of the National Drug Master Plan, 2006-2011), developed a Policy Framework on the Management of Drug Abuse in all Public Schools and Further Education and Training Institutions (South Africa, 2002a, 2002:5) (refer to Table 2.20 below). The policy framework encapsulates recommendations made in the National Drug Master Plan and has been distributed to schools throughout South Africa. The guidelines in the policy framework are underpinned by principles enshrined in the Constitution and take into consideration the legal and other requirements pertaining to drug abuse. It further focuses on prevention and early intervention, based on a restorative justice approach.

- Developing safe and supportive school environments that value human dignity and celebrate innocence;
- Educating the entire school community regarding drugs and the abuse thereof;
- Developing a range of responses for managing drug related incidents within the school, taking into account confidentiality, the nature of the incident, the circumstances of the learners involved, and the needs and safety of the school community;
- Building capacity by giving educators, particularly those working with drug related incidents, access to professional development opportunities, provided by Provincial Departments of Education, other government departments and private providers;
- Regular monitoring and evaluation of policies and procedures for managing drug-related incidents in schools.

**TABLE 2.20: Guidelines for Prevention and Management of Drug Abuse in all Public Schools and Further Education and Training Institutions**
**[Source: South Africa, 2002a:5]**
Drug abuse issues have been incorporated as part of the compulsory Life Orientation learning area in the school curriculum for Grades 2-12 (Department of Education, 2002 and 2003). The onus, therefore, rests on the Department of Education to ensure that Life Orientation programmes provide learners with relevant knowledge on drug abuse so that they can make appropriate choices when confronted with drugs (South Africa, 2002b).

Foxcroft et al., cited in Myers et al. (2008:19), propose the following examples of strategies for school-based drug prevention programmes: Education (information sharing); encouraging healthy alternatives; focus on developing resiliency amongst youth; psychosocial approaches (building self-esteem); early identification of problems, and appropriate referral. Examples of such programmes include teacher training; school drug policies; early identification and referral; youth leadership activities; peer leader and helper groups; after-school programmes; community recreation and drop-in centres; peer resistance; life-skills or social skills training.

Bonell, Sorhaindo, Allen, Strange, Wiggins, Fletcher, Oakley, Bond, Flay, Patton and Rhodes (2010), on the other hand propose that teachers should promote learners’ sense of belonging to school by helping them improve their self-regard, improving relationships with fellow learners, as well as between learners and teachers. These findings resonate with one of the conclusions drawn from a study by Van Heerden (2008), who investigated the reasons for barriers to learning at a school in the Northern Areas of Port Elizabeth. The findings revealed that learners longed for a reduction in negative stereotyping by their teachers, which they thought would be brought about if teachers developed an appreciation for learners’ living conditions by conducting home visits. Recommendations from the teachers, on the other hand, included that the school should organise educational tours in order to help learners broaden their horizons and, in the process, develop an improved sense of hope for their futures.

Jacobs (2008) investigated the reasons for and consequences relating to adolescent drug abuse in one school in the Northern Areas of Port Elizabeth (involving 150 learners, 5 parents, 10 teachers, 2 social workers, and 1 auxiliary social worker, 2 priests, 1 adult running a drug rehabilitation centre and 1 ex-addict involved in drug
The findings from her study culminated in proposed strategies on how school management could reduce drug-related problems among learners. Recommendations included: training teachers in how to detect symptoms of drug use; revising school disciplinary measures, excluding the expulsion of learners as a sanction, as this only aggravates the problem of unemployment, poverty and violence; schools to focus on extra-curricula and co-curricula activities; life-skills programmes aimed at equipping learners with skills in problem-solving and decision-making; deploying social workers to schools to offer parents training and attend to learners’ difficulties around self-concept and yielding to peer pressure; and, finally, social workers to assist with training adolescent peer helpers.

Tobler et al. (2000), who conducted a meta-analysis of 207 school-based drug prevention programmes, found that those programmes presented by mental health practitioners and peers delivered more optimistic outcomes than the ones presented by teachers, concluding that teachers would require substantial training and continuous support to enhance the effectiveness of these programmes.

Wegner et al. (2008:1056) echo this conclusion, as well as the need for effective interventions aimed at reducing risk behaviours amongst South African adolescents. Responding to these identified needs, the authors developed and pilot tested HealthWise a school-based programme presented by teachers, aimed at reducing sexual and substance risk behaviour. HealthWise was developed on the grounds of the successful implementation of three independent programmes in the United States. These included: i) A life skills programme, focusing on skills such as anger management coupled with drug education; ii) Time wise – a programme aimed at enabling adolescents to use their leisure time productively; and iii) an integrated approach to reduce sexually risky behaviour. These different programmes were adapted to the South African context to ensure their cultural relevance.

The goal of the HealthWise Programme was to:

- Reduce the prevalence of risk behavior by enhancing the presence of protective factors such as positive behaviours and attitudes.
Table 2.21 below provides an overview of the HealthWise Programme:

<table>
<thead>
<tr>
<th>Target audience</th>
<th>Grade 8 learners (14-16 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>Programme infused in the Life Orientation curriculum, so presented to entire class groups (between 45-60 in a group)</td>
</tr>
<tr>
<td>Programme duration</td>
<td>18 lessons (12 in Grade 8 and six in Grade 9)</td>
</tr>
<tr>
<td>Presentation format</td>
<td>Presented during school time, during life orientation periods</td>
</tr>
<tr>
<td>Venue requirements</td>
<td>1 venue per facilitator; but needs to be large enough for comfortable seating</td>
</tr>
<tr>
<td>Facilitators</td>
<td>Life orientation teachers who were trained in presenting the programme</td>
</tr>
<tr>
<td>Programme content</td>
<td>Life skills education, combined with a focus on the productive use of leisure time and reducing sexually risky behaviour</td>
</tr>
<tr>
<td>Methodologies employed</td>
<td>Experiential methods: role-plays, discussion groups, practical demonstration by educators, youth development practitioner incorporated for demonstration of benefits of constructive use of leisure time.</td>
</tr>
<tr>
<td>Theoretical framework</td>
<td>Positive youth development perspective</td>
</tr>
</tbody>
</table>

**TABLE 2.21: Summary of HealthWise Programme**

[Source: Wegner et al. (2008:1094)]

The evaluation of the HealthWise programme is summarised in the table below, under the headings strengths, weaknesses and functional elements of the Programme.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Functional elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address multiple risk factors</td>
<td>Learners’ specific needs not assessed</td>
<td>Life skills education: Self-awareness, managing anxiety, managing anger, managing free time (x 4 sessions in Grade 8 and 2 sessions in Grade 9); decision-making, managing risk, avoiding risky sexual behaviour, myths and realities of drug abuse, community connections, negotiating relationships,</td>
</tr>
<tr>
<td>Employ experiential techniques</td>
<td>Experiential learning methods (role play/dramas) were time-consuming and therefore large class groups resulted in programme taking longer to complete</td>
<td></td>
</tr>
<tr>
<td>Studied school context and potential adolescent issues prior to implementation of the programme</td>
<td>Resulted in challenges between programme fidelity and adaptation (viz balancing the</td>
<td></td>
</tr>
<tr>
<td>Strong theoretical base, embedded in life skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme components proved effective in USA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Trained educators who were supported during regular facilitators meetings | original programme content with adapting it to the needs and pace of the learners) | drug education: facts vs myths, association between drug misuse and sexual health, conflict resolutions

TABLE 2.22: Strengths, weaknesses and functional elements of HealthWise Programme

The specific recommendations emanating from the process evaluation of the HealthWise programme were considered in the formulation of the practice guidelines for culturally sensitive drug prevention interventions and as such were integrated in Chapter Seven of this thesis.

Ke Moja, meaning ‘No thanks, I’m Fine without Drugs’, is the South African government’s national drug prevention approach, developed by the African Youth Development Fund (AYDF). This Programme was developed in response to an initiative undertaken by the United Nations Office of Drugs and Crime (UNODC) and the South Africa National Department of Social Development (DSD) and was launched in June 2003. The programme is a universal drug prevention programme directed at children, youth in and out of school, and tertiary students, with the following aims:

- Reducing the incidence of drug abuse amongst youth.
- Promoting a culture of learning and reducing unemployment.
- Enhancing youth’s ability to resist drug abuse.
- Increasing knowledge about drug abuse and related effects.
- Developing the ability to deal with peer pressure and exercise decision-making skills regarding drugs and alcohol.
- Engaging young people’s active participation in the prevention of drugs.
- Increasing the youth’s sense of responsibility (African Youth Development Fund, 2007).

An overview of the programme clearly illustrates that it has informational and affective components and employs youth facilitators and methodologies that are age and culturally appropriate. The literature review and consultation with professionals from the
Department of Social Development did not deliver any documented evidence of an evaluation of the process of implementation of Ke Moja, nor on the evaluation of the Programme. ³

Loxley et al. (2003:128-129) reported on Project KNOW as an effective school-based drug prevention programme, which incorporated the following functional elements: i) training in assertive refusal of drug offers; ii) role play and critical analysis of media advertisements; iii) peer-led social influencing interventions that include the five steps in the decision-making process as a critical skill. These five steps include: identifying/defining the situation; exploring a range of alternatives; evaluating the alternatives; and deciding on and implementing the decision.

The literature review illustrates the many common elements contained in school-based prevention programmes. The table below constitutes guidelines for developing school-based drug prevention interventions, as derived from the literature review:

<table>
<thead>
<tr>
<th>Guidelines for school-based drug abuse prevention programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- They should be research based and grounded in theory on risk and protective factors for drug use (Komro &amp; Toomey, cited in Myers et al. (2008:18)).</td>
</tr>
<tr>
<td>- They should provide developmentally appropriate information about drugs.</td>
</tr>
<tr>
<td>- They should enhance the development of social resistance skills training (this include: ‘self-control, emotional awareness; communication; social problem-solving; academic support; and social competence’) (Atkinson, cited in Myers et al. (2008:18), cited in Myers et al., 2008:18);</td>
</tr>
<tr>
<td>- They should include normative education: A critical focus is on their commitment not to use, and intention not to use; focus on their view of how prevalent drug use is; how acceptable it is; expectations and reactions of friends re drug use (Cuijpers, 2002:1019). Significant emphasis should be devoted to the awareness that not all adolescents engage in drug use (Komro &amp; Toomey in Myers et al., 2008:18).</td>
</tr>
<tr>
<td>- They should be presented within a broader context of skills training and comprehensive health education.</td>
</tr>
<tr>
<td>- They should employ interactive and experiential learning methods (Dusenbury &amp; Falco, cited in McNeece and DiNitto (2005:208) rather than didactic approaches. Interactive modality</td>
</tr>
</tbody>
</table>

³ It was apparent from the consultation with the community stakeholders and research participants that the Ke Moja Programme needs to be promoted more vigorously and rolled out to more schools in the Northern Areas.
The focus now shifts to the community and societal domains in the risk/protective resilience conceptual framework.

### 2.4.2.5 Community Domain

The saying, ‘it takes a village to raise a child,’ highlights the important influence that neighbourhoods/communities have on child and youth development. Elliott et al. (2006:1) assert that the ‘neighbourhood is seen as an important context that shapes family and peer activities and individual developmental outcomes’. Whilst agreeing with this view, Swisher and Whitlock (2004:216-217) argue that it is important to understand how the neighbourhood influences child and youth development. In the context of the present study, the concepts neighbourhood and community will be used interchangeably. However, the literature makes a clear distinction between them. A neighbourhood is defined as a geographically demarcated space, characterised by specific landmarks, physical boundaries and, most importantly, social interactions between residents (Swisher & Whitlock, 2004:223). The concept community is however more complex to define. For the purposes of this study, the concept underpins the

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**TABLE 2.23: Guidelines for school-based drug prevention programmes**

- They should make provision for critical feedback; practising drug refusal skills; provide contact and communication opportunities (Johnson et al., 1990:447).
- They should be presented by both peer leaders and adult (teacher) facilitators (Cuijpers, 2002:1019).
- They should provide teacher training and support.
- They should cover prevention issues adequately and provide sufficient follow up in the form of booster sessions and should preferably be of a long term nature.
- They should be culturally sensitive (Creswell, 2013:305).
- They should incorporate community interventions (i.e., family interventions; media campaigns; community mobilising committees) in order to enhance school-based interventions (Cuijpers, 2002:1020).
- They should contain booster sessions, be long term, and employ an evaluation method (Dusenbury & Falco, cited in McNeece & DiNitto, 2005:208).
- There should be administrative support offered to the implementation of the programme.
commonality of a shared experience of living in the same neighbourhood (Howarth, 2001), which in terms of the social constructionist view, gives rise to a co-constructed experience.

Since the history and context of a neighbourhood play a significant role in how it influences child and youth development, the following paragraph is devoted to contextualising the community where the present study was undertaken.

The study was located in the Northern Areas of Port Elizabeth. Section 1.1 in Chapter One briefly outlines how the onset of the Group Areas Act of 1950 and forced removals of communities from established neighbourhoods like Salisbury Park, South End, Fairview and Central resulted in the historical development of the Northern Areas. Du Preez (cited in conference publication: Healing through heritage and memorialisation, 2013:15) clarifies that the Northern Areas incorporated areas like Kleinskool, Veeplaas and Missionvale, which were already laid out in 1879. Du Preez (2013:15) asserts that the Northern Areas became characterised as a space occupied by ‘people, indigenous and other, who were forcefully placed and removed periodically’. Du Preez (2013:15) emphasises that, despite a long history of slavery, genocide, pass-laws and forced removals, the residents from the Northern Areas refused to surrender control to their colonialist and apartheid oppressors. Instead, they rallied together in showing passive and active forms of resistance. The 1990 Uprisings in the Northern Areas were one such form of resistance. The Uprisings started on 06 August 1990, as a community protest against rent increases, and turned violent when the Police dispersed the crowds with teargas. This culminated in six days of violence and looting of local shops and businesses, which claimed more than 50 lives, left hundreds injured and resulted in the demolition of businesses and schools (Barry, 2013:17-19). From my observations in practice, it would appear that these uprisings gave rise to reduced cohesion and deep-seated feelings of mistrust amongst community members, especially since many of the shop owners (resident in the higher income neighbourhoods of the Northern Areas) lost their livelihoods when their businesses, located in the lower income neighbourhoods of the Northern Areas, were looted and torched during the Uprisings.
Alluding to some of the negative stereotypes and social problems (referred to in Chapter One) associated with residents of the Northern Areas, Barry (2013:21) explains that the geographical community is ‘often referred to as a coloured area when not being referred to as a gangsters’ playground’ (p. 21). Various previous studies about the Northern Areas communities report on serious consequences resulting from the following risk factors prevalent in the lower income section of the community: unemployment, family dysfunction, normative drug use culture, low value attached to education, poor self-concept, and a general sense of hopelessness (refer to Hayman, 2013; Jacobs, 2008; Van Heerden, 2008).

Coleman (cited in Swisher and Whitlock, 2004:223) suggests that social relationships between residents in a neighbourhood offer three types of resources, i.e. a) the belief that the offers of support and resources to others will be reciprocal; b) access to information; and c) the effective endorsing of norms. This forms the basis on which residents in a neighbourhood construct a shared history and identity (Swisher & Whitlock, 2004:217). The figure depicted by Swisher and Whitlock (2004:216-217) illustrates how neighbourhoods influence youth development.

![Figure 2.3: How neighbourhoods influence youth development](Source: Swisher and Whitlock (2004:221)]
The text box on the far left includes the socioeconomic and demographic characteristics of the neighbourhood, which delineate the rough boundaries of prospects and challenges within the neighbourhood. The two text boxes in the middle, i.e. neighbourhood social capital and neighbourhood quality, refer to the quality of specific relationships and direct links in the neighbourhood from which the adolescent derives immediate and specific meaning. The text box on the far right encompasses the outcome of positive youth development, which can emanate from the presence of all the afore-mentioned characteristics and processes. The arrows suggest a linear direction of influence, which is the general ‘direction of causality’ (Swisher & Whitlock, 2004:220). The authors reiterate, however, that there is a dynamic interplay between the different neighbourhood aspects that shape youth development.

With these different contextual factors in mind, the discussion now proceeds to the risk and protective factors associated with communities that emanated from the literature review. The risk factors were identified as follows: community disorganisation, absence of community bonding, lack of cultural/community pride, community being pro-drug use, easy access to drugs in the community, inadequate youth and recreational services, non-adherence to laws that prohibits the sale of alcohol to children under the age of 18 years, unlicensed drug outlets, taverns, and the prevalence of gangs in the community [Atkinson, cited in Myers et al. (2008:18), National Institute on Drug Abuse (NIDA), United Nations Office on Drugs and Crime (UNODC) as cited in Myers et al., 2008:16; Hawkins et al. 2002]. These risk factors cohere with findings from local studies in the Northern Areas (Hayman, 2013; Jacobs, 2008; Van Heerden, 2008). Peltzer et al. (2010) assert that communities characterised by high drug availability contribute to the decline in social cohesion in families as well as communities. These conditions, they argue, ‘resulted from decades of apartheid policies that have created an environment in which temporary escape from the harsh reality of everyday life is often sought through the consumption of psychoactive substances’ (p.7). Elliott et al. (2006:2-3) and Santrock (1999), agreeing with the afore-mentioned authors, claim that high unemployment, poverty and a sense of being alienated from the middle class contribute to a sense of being ostracised and inferior, hence igniting a myriad risk factors. Challenging this internalised marginality, Martin (2011) attributes responsibility to
community members themselves, claiming that their own passivity contributes to a feeling of exclusion.

This way of thinking resonates with how community protective factors and community resilience have been conceptualised. Santrock (1999) refers to the quality of schools, organised community activities and the involvement of community mentors that can serve as community protective factors, especially when parental and family support becomes insufficient. Descriptions of community-based protective factors identified from the literature search includes: ‘caring and supportive, high expectations of youth, opportunities for youth participation in community structures’ (Myers et al., 2008:16). Community-based protective factors identified in two local studies include the following: spiritual resources in the community; and constructive community outlets and support from neighbours (Hayman, 2013; Potgieter et al., 2010). Additional community-based protective factors include positive relationships with prosocial community mentors (Balsano, Phelps, Theokas, Lerner & Lerner, 2009, Edwards, Mumford, Shillingford & Serra-Roldan, 2007) (combined with involvement in positive extramural activities) and broader community collaboration (Lerner, Dowling & Anderson, 2003).

Ahmed, Seedat, Van Niekerk and Bulbulia (2004) describes a resilient community as one that takes goal directed action to enhance the personal and communal abilities of its members so that they can deal with and influence the social and economic process of change in the community. The authors furthermore assert that a community has the capacity to mediate adversity, by drawing on ‘a range of material, social, psychological and cultural resources in situations of adversity’ (Ahmed et al., 2004:388). The integrative approach to fostering community resilience proposed by Berkes and Ross (2013:5) suggests that this process, seated in ‘the complex adaptive system and ecological understanding can incorporate the identification of explicit social strengths and connections to place, activated by agency and self-organizing’. Davidson (2013:24), however, criticised this description, claiming that Berkes and Ross (2013) underestimate the impact that power relations have on communities. They propose complexity theory as an alternative view, since it ‘allows for unexpected shifts in nodes of influence’ (Davidson, 2013:24). This argument by Davidson alludes to the role that societal forces play in the prevalence of risk behaviours in specific environments.
Since community and societal processes are so closely intertwined, the ensuing section will reflect on the literature review on societal risk and protective factors, followed by an integrated discussion on drug prevention at community and societal levels.

2.4.2.6 Societal Domain

Medina-Mora (2005) comments that broad environmental and societal risk factors, such as inequity, poverty, neighbourhood chaos, lack of health and social services, and accessibility to substances in the community, are significant factors that increase vulnerability to drug use and drug related harm. However, drug use, abuse and dependence do not discriminate on the basis of socio-economic status and hence the prevalence rates in these higher income neighbourhoods may be as high for different types of drugs (SACENDU Stats). Similarly, Herrick (2012:1050) alludes to the increasing prevalence of ‘heavy episodic drinking amongst the educated and wealthy’, which poses a bigger threat to the already compromised road safety in South Africa, since this category generally have access to motor vehicles. However, the negative consequences still appear to be greater in lower income neighbourhoods, since it exacerbates their daily problems.

Myers et al. (2008:16) identify the following societal-based risk factors for drug use: impoverishment, unemployment and underemployment, discrimination, pro-drug use messages in the media and limited enforcement of policies regulating access to the supply of alcohol and drugs. The findings from Hayman’s (2013) study, located in a low income neighbourhood in the Northern Areas, have identified access to social support grants as a protective factor, but its application as a risk factor. In contrast, findings by Nziyane (2010:291) illuminate how social support grants can be used as a poverty alleviation strategy in other low-income communities.

The societal protective factors against drug use include: media literacy around the dangers of drugs, decreased access to drugs, stricter law enforcement (both at municipal, regional and national levels; price regulations to reduce access to tobacco and other drugs, and legislation to restrict alcohol sales to under 18 year olds (Myers et al., 2008:16). Medina-Mora (2005), citing the World Health Organisation, emphasises
the role that society has to play in reducing vulnerability by supplying community resources, promoting comprehensive community engagements, and integrating social minorities. Herrick (2012) echoes this need, pointing out the need to address the prevailing class, racial and geographical stereotyping that characterises alcohol use.

It became evident from the literature review that a comprehensive community-based drug prevention strategy, intersecting societal processes, is a vital approach to enhance the effectiveness of prevention strategies at micro and meso levels. The multisystemic model illustrates how the preventive interventions can grow in intensity and density (Loxley et al., 2003:9) ranging from proximal micro systems to distal macro systems and structural interventions. In the context of this study, the focus of community-based drug prevention interventions is on bringing about a change in the structural aspects of the community that can promote positive adolescent development, health-promoting behaviours and social interactions.

These views have been supported by various scholars, some of whose work dates back to the early 1900's (Aguirre-Molina & Gorman, 1996:338; Chambliss, 1994; Dryfoos, 1993; Florin & Chavis, 1990; Florin & Wandersman, 1990). They have concluded that comprehensive community-based approaches appear to be the most feasible way of reducing the risk of substance use, as single focused interventions (targeting the individual's behaviour) have not yielded the desirable effects. McNeece and DiNitto (2005:217) furthermore endorse that the development and empirical testing of prevention theories have resulted in the knowledge that interactive and comprehensive programmes are more effective than single focused prevention interventions. Despite this growing awareness of the value of comprehensive community based-drug prevention approaches, Aguirre-Molina and Gorman (1996:352) asserted in 1996 that true comprehensive programmes that enhance community capacity for change and address risk factors at all systemic levels, viz. from environmental to individual levels, are by far the exception. Applying this learning to the present study would imply that the proposed prevention guidelines would need to provide practical recommendations to facilitate the implementation of such an approach, taking into account the individual, his/her peers, family, school, community and both voluntary and formal organisations involved in the context under discussion.
Ager et al. (2008:304) echo the value of community-based programmes in drug prevention, as opposed to school-based programmes. Their argument is conceptualised around the peak period of risk for drug use by children, being immediately after school (Snyder & Sickmund, 1999, cited in Ager et al., 2008:307). However, as illustrated in the earlier sections of this literature review, schools as social institutions have been experienced as a risk environment in themselves.

The enhanced involvement of parents, family and religious leaders and the neighbourhood at large is endorsed in favour of community based prevention programmes (Levinthal, 1999 cited in Ager et al., 2008:307), enhancement of community ownership (Orlandi, 1997 cited in Ager et al., 2008:308). Community-based prevention programmes furthermore have the potential to challenge the normalisation of drug use and instead 'produce more antidrug norms and prosocial behaviours' (Ager et al., 2008:307; Hawkins et al., 1992:88). This resonates with the stipulations of the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008) (South Africa, 2008b) and the NDMP (2012-2016) (South Africa, 2012a), which suggest that substance prevention programmes should address the values, perceptions, expectations and beliefs that the community associates with substance abuse.

Community-based drug prevention underpins a focus on sport involvement, implying that not only will sport serve as a distraction from drug use; it will also contribute towards a goal-driven future focus. Various scholars have emphasised the focus on sport and recreational activities as key ingredients for positive youth development (Bower et al., 2012; Gomez & Ang, 2007; Hamilton & Hamilton, 2004). These findings concur with a 2011 survey undertaken in the Western Cape, in which 49.9% of the more than 20 000 participants (Grades 8-10 learners) expressed the need for sports; 41.1% for recreation programmes; and 41.8% for arts programmes (Alcohol and Drug Research Unit (ADRU, 2012)).

Fagan, Hawkins and Catalano (2011:168) have suggested that community-based approaches have the advantage that they transcend the limitations that are imbedded in single domain focused prevention programmes. They particularly allow for ownership by
community members who form part of the process from the situational analysis (Weyers, 2011:156-7); hence ensuring that the relevant programme resonate with the needs, resources and norms of the specific community (Hawkins et al., 2002). This needs-driven approach is likely to be more effective than replicating a generic prevention programme across a variety of communities (Fagan et al., 2011). A second advantage of community mobilisation is the collaboration amongst the different stakeholders and sharing of resources, ultimately enhancing its cost effectiveness and reducing the replication of services (Fagan et al., 2011:168).

The authors caution that such tailor-made needs-driven approaches make it difficult to generate the specific components that underpin this approach, as each one will be unique to the targeted community. However, there are common elements that underpin community-based interventions, such as altering larger structural issues at community level that enable and/or facilitate drug use (i.e. exploring job creation interventions to reduce the unemployment rate in a community or starting a recreational centre for children in the targeted community through collaborative effects between stakeholders), since the focus is on the reduction of drug use in a given community. A second common element (referred to earlier in this chapter) is altering community norms and policies so that the hooka pipe and dagga smoking are acknowledged as drugs so that their use can be constructed as harmful and a disapproving attitude towards their use may develop. So, depending on the particular identified needs, a combination of these elements may be incorporated in a community-based drug prevention programme, as was the case for the present study.

Fagan et al. (2011:168-170) conducted a comprehensive review of community-based prevention programmes focused on adolescents in the United States. They singled out the nine programmes that contributed to a reduction in alcohol (and other drug) use or the accessibility of alcohol in their respective communities, and derived several guidelines for community-based drug prevention interventions, which are integrated in the table below.
Guidelines for community-based drug prevention programmes

- The effectiveness of community-based drug prevention interventions are enhanced if they are chosen and adapted by local community partnerships and community coalitions (Myers et al., 2008:20; Fagan et al., 2011:168-170).
- The implementation of universal school-based drug prevention programmes implemented concurrent with the community intervention enhances the effectiveness of the prevention interventions.
- Strategies aimed at environmental level, such as the amendments in community norms and policies, are effective only when implemented concurrent to other community-based approaches (Fagan et al., 2011:168-170). These include the training of the owners of local drug outlets about the principles or harm reduction and the legislative aspects regarding drug sales to under-age youth (Myers et al., 2008:21).
- Draw on local media to enhance the awareness of drug use communities, focusing on actual prevalence rates; decreasing stigma; and strengthening attitudes and norms supportive of sobriety (National Institute on Drug Abuse (NIDA), 2003; Treno & Lee, 2002, cited in Myers et al., 2008:20).
- Enhance prosocial bonding in the community by strengthening the implementation of recreational activities, and involvement in religious and spiritual groups (National Institute on Drug Abuse (NIDA), 2003).
- Actively address structural challenges such as inequalities, poverty and neighbourhood disorganisation, and enhancing social capital (Medina-Mora, 2005).
- Enforcing the laws pertaining to both legal and illegal drug supplies through regulating medical prescriptions, legislation to reduce access to drugs; the arrest and prosecution of drug suppliers and drug dealers and community interventions to reduce the accessibility of drugs in the community.
- Adopt a strategic prevention framework, characterised by five steps: 'i) assessing the needs, resources and readiness of the community to address problems; ii) mobilise and build community capacity to address the need; iii) develop a comprehensive strategic plan informed by the needs assessment and existing capacities; iv) implement evidence-based prevention programmes; v) monitor, evaluate, sustain and improve or replace those interventions that fail' (Rand Health, 2007:3).

<table>
<thead>
<tr>
<th>TABLE 2.24: Guidelines for community-based drug prevention interventions</th>
</tr>
</thead>
</table>

2.4.2.7 Chapter summary

The chapter attempted to provide an overview of what is known in the field of drug prevention, beginning with how prevention is defined, the history of drug prevention
approaches, the theories of drug use and addiction, followed by the key concepts in the conceptual frameworks, viz. the Social Constructionist and the Risk, Protective/Resilience frameworks. As this study was located in a specific community, the Northern Areas in Port Elizabeth, a residential neighbourhood associated with a particular ethnic group (predominantly ‘Coloured’ communities), the literature review offered a brief history of the neighbourhood and the ethnic group. The literature review illustrates the successful application of specific drug prevention programmes, underpinned by cultural sensitivity, illuminating the gap that the present study aimed to address.
CHAPTER THREE

DESCRIPTION AND APPLICATION OF RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter presents to the reader the research methodology that underpinned the design and application of this study. The two preceding chapters introduced the context of the study, specifically reflecting on what I knew about drug prevention and the cultural community in which the study was located, prior to embarking on the research journey. This is followed by an introduction to social research in general, followed by an overview of the constructivist research paradigm or world-view. The journey proceeds to a discussion of the qualitative research approach, as the selected approach for this study, followed by an overview of the narrative tradition of inquiry, deemed to be the most appropriate research design or blueprint for this study. The remainder of the methodology chapter describes the iterative, collaborative approach that was undertaken with the research participants from four different sample groups and community stakeholders in order to meet the outcomes of the study. The chapter further describes the tasks undertaken in the two phases of the research process, with phase one involving the empirical study among the four participant groups and phase two the development of the practice guidelines. The latter part of the chapter provides insight into the criteria and methods used to enhance the trustworthiness of the research process and the research findings. The final section of the chapter is a reflection on the ethical issues that were considered and addressed in the study.

3.2 ACKNOWLEDGING A SOCIAL SELF AND LOCATING PURPOSE OF PRESENT RESEARCH JOURNEY

Neuman (2006:14-15) asserts that a starting point in the qualitative research process is for the researcher to ‘acknowledge a social self’. For the purpose of this study, self-assessment and reflection about my position in society and the community in which the study was located, was required. I reflected on a relative degree of bias on my part, as I had grown up and attended school in the low income section of the Northern Areas
community, where drug use amongst the adult population was a normal phenomenon. Witnessing and experiencing the many social problems emanating from a combination of poverty and drug use, inspired my career path in social work and later clinical psychology, where I embarked on extensive work with adolescents and families from this community. I remained curious about ways in which prevention interventions could reduce the onset of drug use (or health inhibiting behaviours) and promote the early onset of health promoting behaviours. These questions prompted my earlier choice of a topic for my Master’s research study, which explored the knowledge, attitudes and behaviours of teachers with regard to HIV/AIDS as precursor to their role as HIV/AIDS educators, assuming that teachers' constructions filter through in their prevention interventions.

This reflective process, guided by the three questions proposed by Gillham (2005:9), enhanced my awareness of the pre-judgments with which I was entering the research process and helped me to guard against role confusion (of researcher vs therapist). In the process, the trustworthiness of the data was also enhanced, as will be discussed later in this chapter. The three questions were:

- **What do I expect to find?**
- **What would I prefer to find?**
- **What would I hope not to find?**

The rapid increase in drug use amongst the adolescent population left me wondering how adolescents living in the Northern Areas communities perceived their cultural and community identity and whether any of these views filtered through in the socio-cultural meaning that they constructed around drug use, non-use and drug prevention. My assumption was that an understanding of these processes would contribute to making informed recommendations for drug prevention guidelines that are culturally sensitive and contextually relevant.

The three **primary research questions** that emanated from the stance formulated above, were as follows:
• What are the social constructions of the construct ‘Coloured’ articulated by adolescents and social service practitioners living and working in the Northern Areas of Port Elizabeth?

• What is the socio-cultural meaning of drug use, non-use and drug prevention for adolescents from the Northern Areas of Port Elizabeth?

• How do the social constructions of social service practitioners of drug use and non-use influence the drug abuse prevention services that they render to adolescents from the Northern Areas communities?

The following sub-questions were subsequently formulated for the purpose of this study:

• How are drug use, non-use, and drug prevention constructed by adolescents from the Northern Area communities who are volunteers of Teenagers Against Drug Abuse (TADA)?

• What are the social constructions of drug use, non-use, and drug abuse prevention of non-drug using adolescents from the Northern Areas?

• What are the social constructions of drug use, non-use and drug abuse prevention of adolescents from the Northern Areas communities who have reduced their use of drugs?

• How is meaning about drug use, non-use and drug prevention constructed by social service practitioners who render drug abuse prevention programmes to adolescents from the Northern Areas communities?

The overall goal of this study was to enhance understanding of the socio-cultural meaning attributed to cultural and community identity; drug use; non-use; and drug prevention in the Northern Areas community, with the view of developing guidelines for drug prevention interventions that are culturally sensitive and contextually relevant.
The following objective was formulated in order to achieve the goal of the study:

- To explore narratives regarding the constructs of ‘Coloured’, drug use, non-use and drug prevention programmes among three distinct groups of adolescents (drug users, non-users and TADA peer mentors) from the Northern Areas communities.

This objective enabled me to arrive at constructs/conceptualisations that needed to be included in drug prevention programmes.

- To explore social service practitioners’ constructions of drug use, non-use and drug abuse prevention in relation to adolescents from the Northern Areas communities, and how such constructions informed the drug prevention services rendered to adolescents from these communities.

This objective helped me understand the social cultural meanings that influence the current content and methods of presentation of drug prevention programmes.

- To review the data collected from the adolescents’ narratives and the social work and social auxiliary work practitioners’ reflections on their drug prevention programmes against the existing theory on models for drug prevention.

This objective allowed me to draw parallels between what is proposed by theory and supported by research with regard to cultural sensitivity in drug prevention and the socio-cultural meaning construction of adolescents from the Northern Areas communities as far as drug use, non-use and drug prevention are concerned.

- To synthesise the above information with a view to developing practice guidelines for culturally sensitive drug prevention interventions relevant and responsive to the specific social constructions of adolescents from the Northern Areas communities.
This objective facilitated the development of practice guidelines that resonated with the narratives of the participants, the literature and research evidence on cultural sensitivity in drug prevention.

The first three objectives constituted the first phase of the research, and the final objective the second phase of the research process. The ensuing section of the chapter describes social research as the vehicle utilised to address the abovementioned goals and objectives.

3.3 SOCIAL RESEARCH AS VEHICLE FOR MEETING PURPOSE OF STUDY

Social workers and health practitioners at large are increasingly expected to operate in an evidence-based culture to ensure that they know whether or not their interventions are effective (Howard, McMillen & Pollio, 2003:235). The devastating consequences of drug abuse, especially its potential to stunt the emotional and psychological development of the user (Buckley et al., 2010), underscore the importance of enhancing the effectiveness of drug prevention interventions. Social workers have, up to the last decade, relied primarily on ordinary knowledge (Babbie, Mouton, Payze, Vorster, Boshoff & Prozesky, 2011:16), in the form of guidance from their colleagues, supervisors, in-service training, theoretical reviews and practice experience, to inform their interventions. The value of scientific knowledge or evidence in informing practice decision-making has since been recognised, and has not only enhanced practice effectiveness, but also increased the credibility of the social work profession and the ethical conduct of practitioners (Alston & Bowles, 2009). Guidelines on evidence-based or evidence-informed practice underscore the importance of prevention approaches that are context specific and responsive to the needs of the community in which the programme is presented; hence the focus on cultural sensitivity in drug prevention interventions.

Scientific knowledge as the product of social research has been defined by Alston and Bowles (2009:6) as the systematic collection of information and methodical inquiry aimed at arriving at common themes that can be used to inform action. Monette et al. (2011:4) add to the definition of social research that it is a methodical evaluation of
empirical data that relates to the social and psychological forces prevalent in a situation. McDermott, in Alston and Bowles (2009:6), echoes this view, listing three criteria that make social work research unique. A brief description of these criteria and their relevance to the present study is as follows: a) Firstly, the theorisation regarding the sample is located in a social, political and economic context; b) Secondly, the research is located in the ambit of applied research, aimed at bringing about a constructive change in the area of drug prevention; and c) Thirdly, the research facilitated the participation of a variety of community stakeholders. This included the adolescent sample from the Northern Areas and the providers of drug prevention services, all of whom would benefit from the collaborative end-product.

Babbie et al. (2011:14; 543) echo the argument that whilst scientific research is an epistemic imperative (i.e. the search for truthful or authentic knowledge), it cannot really be divorced from the moral and political agenda of the context in which the research is conducted – a view firmly endorsed by the manner in which the present study was conceptualised. In embracing this holistic approach to research, I incorporated the transformative dimension of research, where the primary aim was to search for useful, practical knowledge that would serve an emancipatory and empowering role in the cultural community in which the study was located. This approach to social research was congruent with the research paradigm used to provide a paradigmatic lens to the study, as will become evident from the discussion below.

3.4 DESCRIPTION OF PARADIGMATIC LENS THAT SERVED AS FRAMEWORK FOR STUDY

People's paradigms are their fundamental views about how the world works or their interpretive framework that depicts their assumptions about the problem under investigation (Denzin & Lincoln, 2003), and how they acquire knowledge about the world (Monette et al., 2011:38). Concurring with this view, Terre Blanche and Durrheim (1999:6) define a paradigm as the methodological commitments or “all-encompassing systems of interrelated practice and thinking that define for researchers the nature of their enquiry along three dimensions”, which are the ontology, epistemology and methodology. According to Guba and Lincoln (1994:108) cited in Denzin and Lincoln,
ontological assumptions attempt to answer the question: ‘What is the form and nature of reality and therefore what is there that can be known about it?’ Epistemology asks the question: ‘What is the nature of the relationship between the researcher and those being researched?’. Lastly, methodology asks: ‘How can the researcher go about finding out what he or she believes can be known?’

The paradigm employed for this study is located in social constructivism. This world view proposes that knowledge and truth does not exist independently of its observers (Denzin & Lincoln, 2008a), but are created in social interaction with others (Terre Blanche & Durrheim, 1999), and informed by the social, historical and cultural norms prevalent to our social context (Creswell, 2007:20-21). These views resonate with my ontological assumption. Growing up in the Northern Areas community, and particularly through working in the field of chemical addictions and youth development, I had the privilege of observing the power of contextual influences in how people define themselves and the decisions they make around the use and non-use of drugs. Congruent with the subjective approach of this paradigm, I had to recognise how my own background shaped my interest in the study, and in particular how I interpreted the research findings. Importantly, I had to be cognisant of the fact that the research findings would be my interpretations of the participants’ reports of their world and experiences.

Congruent with the constructivist paradigm, the focus of the study was enhancing understanding of the socio-cultural meaning that adolescents attach to drug use, non-use and drug prevention. The relevance of this paradigm to the present study is the conceptualisation that the adolescents’ decisions regarding drug use, non-use and response to prevention interventions are shaped by their socio-cultural context. This conceptualisation appears congruent with the sentiments of Atwater (1996), who proposes that people’s cultural realities, including how they view themselves and the types of decisions they make, are constructed through social interactions. This does not suggest that people are passive beings; on the contrary, the strength of this world-view is that it recognises the agency of people as active participants in this process of social construction. In line with the constructivist paradigm adopted for the study, it was envisaged that the research participants would come to appreciate that they had the
power to deconstruct historically disempowering narratives, and instead reconstruct new narratives with the potential of positive outcomes for adolescent or youth development. In order to achieve the outcome of the study, I needed to be close to the participants’ contexts in which their social cultural meaning relating to cultural identity, drug use, non-use and drug prevention was constructed.

Babbie et al. (2011:8) use the clause ‘epistemic interest of science’, explaining that the word ‘epistemic’ is derived from the Greek word episteme, meaning ‘authentic or truthful knowledge’. Whilst the ontological assumptions are based on the researcher’s belief in reality without any scientific proof, the epistemological assumptions reflect how we come to know, from a theoretical and from an empirical stance, what we believe there is to know. As such, epistemological assumptions centre on issues such as objectivity, subjectivity, causality and generalisability. Creswell (2007:247) furthers this explanation by emphasising that the epistemology of a researcher addresses the relationship between the researcher and that which is being studied. As such, contrary to practice from a positivist paradigm, the pattern of meaning is inductively developed in research located in a constructivist paradigm, which was also the case in this study. In line with my epistemological assumptions, I approached the research participants as the experts and subsequently invited them to engage in a collaborative relationship in which we could co-construct reality. The process, rather than the product of knowledge construction, was therefore an important emphasis (Guba & Lincoln, 1994 cited in Denzin & Lincoln, 2000), in line with the constructivist paradigm, which proposes that research is a political activity derived from social relationships, and influenced by power relations (Marshall & Rossman, 1999:95).

What is evident from the literature is that society’s view of drugs (licit and illicit) has changed and that the perception of drug use now depends on the circumstances of use, the political climate, the type of people associated with it (Van Wormer & Davis, 2008:77) and, most importantly, the epistemological and ontological positions of the researcher and practitioner (Denzin & Lincoln, 2008). Alcohol and other drug treatment and prevention approaches have been informed by these different paradigmatic stances, and numerous theoretical frameworks exist to guide the drug treatment and prevention arena. The present study was underpinned by two important conceptual
frameworks, viz. the social constructionist theories and the ecological risk/protective resilience frameworks (discussed in detail in the preceding chapter).

Terre Blanche and Durrheim (1999:6) suggest that the methodology involves how we practically go about to find out what we believe there is to know. Babbie et al. (2011:647) describe the research methodology as the methods and techniques that are employed during the implementation process of the research plan or design. Methodology is informed by the researcher’s ontological assumptions and hence requires decisions about which research design would best address the research question; what type of data to collect from whom, where and how; how to analyse the research findings, and, lastly, how to report on the findings in written form. In order to answer the research question and accompanying goals and objectives of the study, I adopted a qualitative research approach.

3.5 MOTIVATION FOR THE QUALITATIVE RESEARCH APPROACH

At the heart of qualitative research is the belief in multiple realities, as opposed to quantitative research, which argues for the existence of a single objective reality (Nicholls, 2009a:526). Researchers adopting the quantitative (positivist) approach depart with a research hypothesis, which they set out to confirm or reject by applying objective measures (such as questionnaires) to test the said hypothesis (De Vos, Strydom, Fouche & Delport, 2005). They apply accurate measurement as a method of data collection to quantify the variables under investigation, and use results derived in this manner as the firm basis for their understanding of human social behaviour (Monette et al., 2011:39). Quantitative researchers ordinarily draw samples that are representative of the communities they wish to investigate, so that they can generalise their quantified, objectively measured results (Sapsford & Jupp, 2006).

Qualitative researchers instead focus on gaining an in-depth insider's and complex understanding (or thick description) of situations as they are constructed by the research participants (Mack, Woodsong, Macqueen, Guest & Namey, 2005). Babbie et al. (2011:271) assert that qualitative research enhances an insider's perspective or the emic perspective of the views of social actors themselves, rather than the researcher’s
etic view. The research question often concentrates only on a specific aspect of human experience and aims to uncover the silences in narratives (Henning, Van Rensburg & Smit, 2004; Weis & Fine, 2000; Woods, 1999). Qualitative research, therefore, is inductive in nature, as it moves from the analysis of specific observations to arrive at general ideas and theories, whilst quantitative data analysis is more deductive in nature (Babbie et al., 2011; Nastasi & Schensul, 2004:182).

Qualitative research is described as multi-method in focus and employs an interpretivist-constructivist approach to its research participants (Denzin & Lincoln, 2008a). The present study explored the narratives of adolescents and social service practitioners around the use and non-use of drugs in a community and cultural context dominated by a narrative of drug abuse and dependence (Plüddemann et al., 2008a). The study was therefore suitably located in a qualitative research approach. Judging from the formulated research questions and the subjective constructivist paradigm of the study (Flick, Von Kardoff & Steinke, 2004), it is evident that the findings of the study would not be generalisable to the larger population of adolescents from the Northern Areas communities – a key critique leveled by quantitative researchers (Nastasi & Schensul, 2004:178). This critique is, however, rebutted by Nicholls (2009b:592) and Denzin and Lincoln (2008b), who argue that good qualitative studies instead contribute to the building of theory (which they derive from the in-depth, iterative inquiry), which can be generalisable to others.

The qualitative approach also allowed easier access to the service providers’ reflections on adolescents’ responses to drug prevention programmes. There is a silence in the literature on how drug non-use has been perceived and constructed by adolescents from high-risk urban ‘Coloured’ communities that are subject to the same socio-economic hardships and limited resources as adolescents who use drugs. The expectation was, therefore, that the narratives of these adolescents would elicit rich, thick descriptions that would form the basis of a deconstructed cultural identity, i.e. one that could form the building blocks to drug prevention programmes that are culturally appropriate and contextually relevant.
The strength of this study was the compatibility between the research approach and the guiding conceptual frameworks. Researchers such as Henning et al. (2004), Patton (2002) confirm that congruence between a research approach and the theoretical framework of a study accentuates the strength of a study.

Gillham (2005:26-28) cautions the qualitative researcher that this research approach is a costly one in terms of time and energy. The researcher can attest to this on the basis of the time devoted to the recruitment of participants; meeting with the gatekeepers; and subsequent meetings with the parents and adolescents to explain the research and to secure access and a commitment to participation. All the individual interviews with the sample of travellers were conducted at the participants' homes or at geographical locations in their neighbourhood, adding to the financial and time cost involved with the study. The next section accounts for the research design that served as the blueprint to the study.

3.6 RESEARCH DESIGN AND METHODS

De Vaus (2001:8-9) describes a research design as the structure or the plan that is required to guide the research process and that ensures that the research findings that are generated, respond to the initial research question as unequivocally as possible. This description accords with the views offered by Creswell (2007:249), Babbie et al. (2011:647), which describe the research design as the strategic framework of the entire research process, from the point of formulating the research problem right up to the delivery of the product of the research inquiry.

Yin (in De Vaus, 2001:9) emphasises that research design focuses on the logic of addressing the research problem and not the logistics; hence decisions about the sampling and which method of data collection to employ are all secondary to the question: 'What evidence do I need to collect?' Terre Blanche and Durrheim (1999:32) accordingly reiterate that the research design must be coherent with the specific research purpose. To this extent, qualitative researchers adopt research designs that are more flexible, as these are more suited to the inductive approach to research – a principle that has been criticised by quantitative researchers and experimentalists as
non-scientific as, according to them, any modification to the design opens the study to bias and compromises trustworthiness (Henning et al., 2004). This critique is, however, refuted when qualitative researchers ensure that there is a logical fit between their research paradigm, research purpose and techniques, i.e. achieve design coherence, as described by Terre Blanche and Durrheim (1999:35). Furthermore, congruent with the suggestion that one anticipates which types of information one will be collecting, De Vaus (2001:13) suggests that a good research design will allow the researcher to consider alternative plausible hypotheses before the time, which in turn will result in the researcher collecting evidence to evaluate the relevance of these alternative explanations as well. Paying adequate attention to ensuring design coherence will also enhance the validity of the findings which, according to Mouton and Marais (in Terre Blanche & Durrheim, 1999:33), is ultimately the aim of a research design.

In line with the considerations raised above about the logical fit between the research paradigm, purpose, context and techniques, the narrative tradition of inquiry was considered the most suitable research design to achieve the goal of the study. Bruner (1986), cited in Bleakley (2005:536,), suggests that there is a distinct difference between scientific and narrative ways of knowing. According to the author, science focuses on the establishment of truth, whilst narrative is concerned with the meaning inherent in an experience. Narrative (derived from the Latin word narrare) implies ‘to know’, whilst story-telling resembles the structuring of an experience, which could otherwise have come across as a series of chaotic events. Ollerenshaw and Creswell (2002:332) endorse that the unique aspect of narrative in comparison to other genres of research is ‘the chronology of narrative research with an emphasis on sequence’. According to Franzoni (1998), cited in Grbich (2007:125), the Russian formalists distinguish between the story (the actual action or event which occurs) and the plot (the orderly arrangement of the story for presentation to the reader), while the French structuralists accentuate the distinction between these two concepts by referring to the story as the historie versus the discours (the actual textual narration) (Grbich, 2007:125).

The view of what constitutes a narrative and how it should be treated has changed significantly over time. Some authors have used the term narrative analysis, narratives, stories, life histories, autobiographical research and biographical research (Ky Lai,
2010; Hardy, Gregory & Ramjeet, 2009; Bleakley, 2005) to refer to different variations of narrative research. Smith (2003:328) describes a narrative as a basic and universal mode of expression, that can be a written, oral or filmed account of events told to others or to oneself. Schwandt, cited in Denzin and Lincoln (2000) specifies that narratives can either reflect a personal experience about a specific event or a more detailed reconstruction of a life. These narratives emerge from different sources of data, ranging from photographs, interviews, archival material, ballads, letters, observations of naturally occurring everyday interactions, and conversations (Vincent, 2011). Narratives can furthermore emerge spontaneously in conversation during which people ‘recount experiences or tell stories to inform, instruct, entertain, impress, empower, exonerate, or cathart, among other things’ (Smith, 2003:327). Apart from spontaneous incidents of storytelling, narratives can also be elicited during interviews or can result from explicit requests to people to share their stories (Vincent, 2011). In the context of this study, participants were invited to share their stories. The travellers were invited to provide detailed accounts of their lives (which they all provided in spoken form), and I reconstructed these in written form, thus constituting biographical narratives (Roberts, 2003:176). Phoenix (2008:66) defines this as the ‘big story’ approach. In contrast, the ‘small story approach’ (Phoenix, 2008:66) was adopted with the observers, practitioner and peer navigators, as they were invited to share narratives about specific events and episodes relating to the socio-cultural constructions of ‘Coloured’, drug use, non-use and drug prevention that emerged from their daily social interactions. Phoenix (2008:66) cites Bruner’s (2002) reference to canonical narratives (normative cultural expectations), as opposed to personal narratives and how canonical narratives contribute to restrictive narratives, as will be illustrated in Chapters Four, Five and Six of this thesis.

The different classifications of narratives illustrate the varied ways in which narrative data can be elicited and employed. Some researchers focus on the content of the story – ‘the ‘what’ or internal structure of a narrative’ (Bal, 1997, cited in Bruce, 2005:536), whilst others focus on how the story is told. Researchers that are focused on the latter, pay close attention to the contradictions, ambiguities, hesitations, emotions and silences in stories (Hendry, 2010). Riessman (2008:81) explains the distinction further by suggesting that some researchers focus on the story as a whole, whilst others listen
to how the story was constructed, paying close attention to the details of speech. Notwithstanding these differences in approaches, a narrative tradition of inquiry allows researchers to access narrators’ world-views, their values and ultimately their meaning making systems (Riessman, 2008:154). This discussion is pursued further in Section 3.7 of this chapter.

A narrative inquiry hence allows for a more complete story of the studied phenomenon, contextualised in culture and social context, and over a span of time. In contrast, a phenomenological design offers an understanding of a particular phenomenon at certain points, but ‘frequently omit the important intervening stages’ (Webster & Mertova, 2007:4), illustrating the applicability of a narrative inquiry for the purposes of this study. Whilst I did not use an ethnographic design, which typically situates an individual’s stories within the context of his/her culture and culture sharing group (Creswell, 2007), I employed principles of ethnography during the data generation process by observing the social service professionals in their natural training environments in order to enhance my understanding of their social constructions of drugs and the potential influence of these constructions on their drug prevention interventions. A specific focus during the observations was on how adolescents used language and conversation to give expression to the meaning of drug use and non-use in their world (Hendry, 2010).

Gilbert (2002:225) asserts that the researcher’s ‘participation in research influences the narrative of the research participant, resulting in the researcher becoming a collaborator in the new and evolving story. This view is echoed by Andrews, Squire and Tamboukou (2008:17), who state that ‘as narrative researchers we are a part of the data we collect and our presence is imprinted upon all that we do’. Adopting a narrative tradition of inquiry as research design hence requires researchers to be aware that how they approach their first contact with the research participants, how they set the scene for the story being told, the type of language that they use, the phrasing of the data collection questions and how they dress during their interactions with research participants are all forms of communication about their ontological and epistemological stances. Section 3.7 illustrates how this awareness influenced the methodological choices exercised in the study.
The thinking and planning processes that inform social work intervention are seldom documented in a practice manual and can hence be accessed more effectively by enquiring about it in a narrative inquiry. Social workers also have underlying assumptions about what methods would be useful or harmful, based on the feedback they receive from different target audiences, and their own comfort or discomfort and expertise levels in a given area. Webster and Mertova (2007) suggest that narrative as a research method is much more honest and closer to reality than most empirical methods. Since the focus of the present study was also on how the participating practitioners and peer navigators’ socio-cultural constructions of ‘Coloured’, drug use and non-use influenced their drug prevention interventions, the chosen research design was considered to be most relevant to elicit honest reflections in this regard.

The research methodology depicts the methods and techniques that are employed in a study, is informed by the goals and objectives of a study, and needs to be coherent with the research design. The ensuing sections detail the methodological choices pertaining to sampling, methods of data generation and data analysis made for the purpose of this study.

3.6.1 Research population, sample and sampling method

Monette et al. (2011:136) define a population as all the possible cases or people who may be of interest to the researcher, with a key characteristic being that they share defining features or indicators of importance to the study. Babbie et al. (2011:173) concur, defining a population as ‘the theoretically specified aggregation of study elements’. This implies that the communal defining features or elements need to be specified so that the population can be delineated accordingly.

The identified population for the purpose of this study was delineated on the basis of two key variables, i.e. geographic location and ethnic orientation. Considering the formulation of the research problem described in Chapter One, the research population constituted the adolescent ‘Coloured’ ethnic group of the Northern Areas of Port Elizabeth, situated in the Eastern Cape Province of South Africa. The ‘Coloured’
population (Population Registration Act, 1950) constitutes at least 8.9% of the approximately 47 million South Africans countrywide, and at least 7% of the population in the Eastern Cape (Statistics South Africa, 2011). Section 2.4.2.5 in Chapter Two provides an overview of the Northern Areas in Port Elizabeth, in terms of how the community emerged, as well as specific defining features about the geographical area and its residents.

Given the proposed outcome of the study, i.e. the development of practice guidelines for culturally sensitive drug prevention interventions, I was also interested in the drug prevention services available, and therefore the second segment of the population constituted the social workers and social auxiliary workers from both public and non-governmental organisations that rendered drug prevention services to adolescents from the Northern Areas.

Since the adolescent peer group has been recognised as facilitators of change and development (Karcher et al., 2004:204), the third segment of the population constituted peer mentors, trained as members of TADA by either SANCA or the Department of Social Development, who rendered their drug prevention interventions in a school context to adolescents residing in the Northern Areas of Port Elizabeth.

Given the delineation of the research question, and the timeframe attached to a research project, it is impossible to gather data from everyone in the identified population. Sampling allows researchers to choose a group of people that will be representative of the larger population. Keeping in mind the importance of design coherence (Terre Blanche & Durrheim, 1999:35), the sampling in this study was done in accordance with the qualitative research approach. Alston and Bowles (2009:66) emphasise that quantitative researchers employ probability sampling so that they can claim statistical representativeness. Nicholls (2009b:590) points out that sampling in qualitative research is based on qualities instead of quantity, and argues that because every person is so different, no degree of sampling based on quantities can ever represent the study population. Sampling in qualitative research is therefore aimed at identifying a selected group of people/cases from the study population that can offer a rich, thick description of the phenomenon under study (Holloway & Wheeler, 2010).
Since the intended outcome of the study was to develop practice guidelines for culturally sensitive drug prevention interventions among adolescents from the Northern Areas communities of Nelson Mandela Bay, it became evident that the sample had to include both adolescent travellers and observers, as they could offer very different perspectives on the same phenomenon. The inclusion of both groups of adolescent participants was essential for the purpose of staying true to the philosophical paradigm of the study (i.e. the constructivist paradigm, which claims that reality can be co-constructed) and for the purpose of the triangulation of the different data sources.

A non-probability, purposive sampling technique was regarded as the most appropriate sampling technique to identify potential adolescent research participants for each of the two adolescent sample groups. Purposive sampling techniques have been designed to test or explore particular theoretical interests (Given, 2008; De Vos et al., 2005), and therefore categorise participants according to predetermined criteria (Mack et al. 2005:5), informed by the research question and linked to the purpose of the study.

Extreme case sampling was required for the sample of travelers, as I needed participants that had been on the drug use journey for any duration of time or intensity, ranging from simply taking off on the journey (i.e. experimentation) to travelling in the fast lane (i.e. dependence), with the additional requirement that the adolescents should have experienced self-initiated sobriety or received an intervention for recovery (Given, 2008). This would enable the travellers to narrate on the meaning that drug use, non-use and drug prevention held for them. There was no delineation on the type of drugs or the time periods of sobriety, since the focus was on the adolescent’s own narration of recovery. This is in keeping with the sociological accounts of the process of recovery from dependent drug use (McIntosh & McKeeganey, 2000).

The suggestion by Patton (2002) that sampling for additional informants should proceed until no new information or new insights emerge in the data generation interviews, was followed. Purposive sample sizes are often determined on the basis of theoretical saturation (the point in data collection when new data no longer bring additional insights to the research questions). Purposive sampling is therefore most successful when data review and analysis are done in conjunction with data collection.
The following three universal sampling criteria were formulated for the two different sample groups of adolescents (drug users/travellers and non-users/observers):

- They had to be in late adolescence (between 16-18 years of age) (since it is argued that views on drug use change from pre-adolescence to adolescence) (Myers et al., 2008; National Institute on Drug Abuse (NIDA), 2003).
- They had to be learners, as the initial intention was to develop guidelines for school-based drug prevention interventions. However, this decision was revised when it transpired that a large number of travellers had dropped out of school or had been expelled from school as a result of drug-related behavioural difficulties (Grunbaum et al., 2000:145).
- They had to reside in the Northern Areas of Port Elizabeth, as this was coherent with the formulation of the research problem.

A unique sampling criterion for the sample group of travellers was that they needed to have experience of any form of drug use for any duration of time or intensity, ranging from experimentation to dependence, and should have experienced self-initiated sobriety or received an intervention for recovery. In order to meet the outcome of the study, an embedded criterion for all adolescent participants was that they would be able to reflect on ‘Coloured’ ethnicity.

Drug prevention programmes are most frequently presented at either youth camps or in schools, primarily by social workers or social auxiliary workers. I decided to sample practitioners from a non-government organisation (a specialist organisation whose vision is to combat and prevent drug abuse) as well as practitioners from the Government Department responsible for the implementation of the national drug prevention programme, Ke Moje. The purposive sampling criteria for the inclusion of the sample of practitioners were that:

- they had to be registered with the South African Council for Social Service Professions (SACSSP) as either social workers or social auxiliary workers;
they should have presented more than three adolescent drug prevention programmes in the Northern Areas in the preceding three years. This would ensure that they had adequate and recent experiences on which to reflect, which would enhance the quality (thick descriptions) of their contribution to the outcome of the study.

A **snowball sampling technique** was also employed for the recruitment of both practitioner and peer mentors, as the participants were requested to approach colleagues who met the sampling criteria.

The ideal was to draw a sample of peer mentors from a population of TADA members operating in a school in the Northern Areas of Port Elizabeth. A non-probability purposive sampling method was employed, with the four sampling criteria stipulating that:

- the TADA members should have been trained by either SANCA or the Department of Social Development;
- the supervising social work agency should offer regular and continuous training and supervision to the TADA members;
- the TADA group should have been operating for at least a year in their school;
- the teacher appointed as the TADA supervisor at the school should be actively involved in promoting and supporting the services rendered by TADA members.

As indicated earlier, the sample size in qualitative research is dependent on the depth and breadth of the elicited data, and is determined by the indication that the data is repeating itself or that data saturation has been achieved (De Vos et al., 2005:335).

### 3.6.2 Gaining access to study area and cooperation from settings

Flick *et al.* (2004:195) propose that researchers use the term access, not entry, since they need to negotiate boundaries with community stakeholders. However, once access is granted, the researcher can achieve collaboration with the research community. De
Laine (2000:40-42) concurs regarding the challenges associated with gaining access to communities, specifying that access is associated with key components of establishing rapport, familiarity, engendering trust, and assuring the community of the professional and research ethics aspects of anonymity and confidentiality, having a genuine interest and not being disparaging.

Creswell (2007:243) defines a gatekeeper as the individual that facilitates the researcher's access to the research community. In this study, the sample of non-drug users was recruited with the assistance of three different gatekeepers, i.e. a social worker at an NGO, life orientation teachers at four different schools, and a Christian youth leader at a church in the Northern Areas.

I arranged separate meetings with each of the respective groups of gatekeepers, during which the following information was shared: the purpose and envisaged outcome of the study; the purposive sampling criteria that would inform their identification of suitable participants; the role and procedure of obtaining informed consent and assent; the ethical principles of ensuring anonymity and confidentiality (and the limits to confidentiality, as four other people would access the data, i.e. the scribe, the independent coder, the language editor and the research supervisor); the measures taken to enhance privacy and confidentiality (i.e. the signing of the confidentiality agreement by each of the said roleplayers); and the proposed method of data collection (which at the time was meant to be individual interviews). The gatekeepers were supplied with copies of each of the documents (refer to Appendices A-E), with the undertaking that they would contact me on the successful recruitment of participants and I would set up the logistical arrangements for the data generation process.

I accompanied the NGO drug prevention team (a social worker and social auxiliary worker) to a Christian youth camp, with the dual purpose of using the platform to recruit potential research participants and to be a participant observer of an existing drug prevention programme. This afforded me the opportunity to study a natural example of drug prevention (Rothman & Thomas, 1994). The camp was attended by a total of 62 youth members, comprising adolescents from the Northern Areas between the ages of 16-18 years, to whom I extended an invitation to submit their names should they wish to
participate in the study. The fact that only nine of the 62 youth members volunteered to participate could be interpreted in numerous ways; one being that they were excluded by the sample criteria, hence confirming the importance of the study and debunking the myth that adolescents involved in Christian groups abstain from drug use. Only two youth members were ultimately included in the sample, primarily due to the fact that many parents refused to grant consent for their children’s participation in the study. It transpired (during telephonic conversations with the parents) that their resistance emanated from their desire to protect their children, amidst a rapid increase in drug-related gang violence in the Northern Areas community at that time. The recruitment of research participants also coincided with the brutal murder of a witness in the neighbourhood in a gang-related court case (Wilson, 2012:1), heightening the anxiety levels of community members.

Following a suggestion by Hallowell, Lawton, and Gregory (2005) on how to deal with the parents of child research participants, and the caution by Mack et al. (2005:6) that researchers should be sensitive to the social and cultural context of prospective participants and guard against coercion, I empathised with the parents’ fears for their children’s safety, adding that whilst the research was not intended to elicit any information about drug-related gang activities, I respected their decision. Only one mother subsequently granted permission, following the daughter’s insistence that she could make a valuable contribution to the outcome of the study. The mother’s permission was, however, granted on condition that the research interview would not be recorded and that her daughter’s anonymity would be protected throughout the research process. Because of the mother’s concern (and the probability that she represented the voice of many parents in the neighbourhood in which the study was located), I decided (in consultation with my research supervisor) to change the method of data collection to written narratives for the sample of observers, which would be group administered in a school context. Alston and Bowles (2009:67) concur that data collection methods in qualitative research are more flexible and can be developed and adapted. However, the primary reason for changing the method of data collection in this study was what Schostak and Schostak (2008:169) have termed a fear of a forbidden discourse. In describing their research in economically disadvantaged communities in the United Kingdom (which bear a strong resemblance to the community in which the
present study was located), these authors, both advocates of radical research, suggest that it is precisely by encouraging these forbidden discourses by people on the inside that change can be effected in disempowered communities.

The second gatekeeper, the Christian youth leader, was informed that the method of data collection had been altered so that he could inform the proposed research participants accordingly. Three non-drug using adolescents were recruited by this gatekeeper.

It became apparent that the life orientation teacher gatekeeper would have to be the primary recruiter of research participants, as up to that point only five research participants had been recruited. I therefore needed to instill enthusiasm and reduce the resistance among both gatekeepers and parents, to ensure that they would allow me into their space and that they would share the expectation that the research would serve the best interest of the community (De Laine, 2000). In accordance with the useful suggestion offered by De Vos et al. (2005:399), namely that the researcher should identify the key informants in a setting, as these can help one access the community of interest, I decided to contact some of the life orientation teachers whom I knew, in person, instead of relying only on the subject coordinator, who by that time had already confirmed that she had presented my request at the previous subject meeting. I subsequently engaged with three life orientation teachers at three schools, in the process managing to recruit 25 adolescents who met the sampling criteria and who were interested in participating in the study. Once their interest had been confirmed and the signed consent forms by their parents had been received, an appointment time was established to visit the respective schools for the group administration of the data collection.

The adolescent drug users were recruited with the assistance of seven different gatekeepers. The initial pool of two gatekeepers (i.e. social workers from the Department of Social Development and an NGO) was widened after initial recruitment efforts secured only one research participant. The additional five gatekeepers included professional and lay practitioners with whom I had established cooperative relationships in practice and whose dedication in practice endorsed their vested interest in the study.
area. Fawcett, in Rothman and Thomas (1994:29) highlights that one of the benefits of collaborating with key informants is that they adopt a sense of ownership in the research process. The five additional gatekeepers included a social worker in private practice who specialised in the field of addiction counseling; the Chairperson of a community support group, Families Against Drugs (FAD); a lay counselor at a voluntary self-help organisation, Alcoholics Anonymous (AA); a life orientation teacher at a school in the identified community; and, lastly, a church minister who was also an AA coordinator and a support for youth in his congregation. Individual consultations were arranged with each of the gatekeepers, during which they were familiarised with the research protocol and procedure, as described earlier in this section.

This consultation process (with the lay counselor and the life orientation teacher), however, presented me with a significant ethical dilemma of the potential blurring between my dual role of researcher and therapist. Four such consultation sessions coincided with parents seeking assistance from the gatekeepers to gain access to drug treatment for their adolescents. De Laine (2000:135) cautions that in scenarios of this nature, the researcher needs to be conscious of the power differentials (in this case I had the information and skills power to elicit pertinent information, to screen and effect a speedy referral), as well as guard against assuming a counselor role. Responding to the request of the gatekeepers on the basis of moral and professional considerations (Alston & Bowles, 2009), I aborted the researcher role in favour of the social worker’s broker role (Potgieter, 1998), and in the process enhanced the gatekeepers’ awareness of referral processes and resources. The adolescents in question were subsequently excluded as potential research participants. Whilst I agree with Nash in Hallowell et al. (2005:59) that a researcher needs to maintain a balance between being a researcher and his/her responsibility as an empathic human being, I needed to remind both gatekeepers timeously and continuously of the distinction between the researcher and counselor role. Six participants were recruited by the lay counselor and life orientation teacher collectively.

The consultation process with the FAD support group took the form of the attendance of a FAD support group meeting, at which I was granted an opportunity to explain the purpose of the study to the more than 20 parents/support group members present. It
was important to join through a process of mimesis (Schostak, 2006:145), to be coherent with the tone of the meeting, and to demonstrate an authentic interest (De Laine, 2000:41). One of the support group members enquired about approaches to drug prevention, which allowed me to demonstrate experience and competence in the field (Sapsford & Jupp, 2006) and an opportunity to win their trust in the study (De Laine, 2000:42). The request by several parents that I include their children (over 18 year olds) in the research study, confirmed the parents’ need to understand the meaning constructions giving rise to adolescent drug use. I addressed their request by explaining the rationale for the age delineation of the sample.

The fact that I originated from the same cultural and geographical community under investigation, allowed me to ‘take for granted one’s social placement in a socially constructed reality and knowing one can contribute without concern that their identity is under risk of threat in the early phase of fieldwork’ (De Laine, 2000:42). The participant recruitment process afforded me the opportunity to explore the FAD’s current approaches to drug prevention, which elicited an invitation to review an upcoming drug prevention programme. This opened the door to the research going beyond the research agenda, hence making it transformative (De Laine, 2000:56-57). Two participants were recruited from the consultation with the FAD.

The consultation with the final gatekeeper, the church minister, who was also the AA coordinator in his community, culminated in an invitation for me to address a Christian youth gathering at his church. I accepted, and at the meeting explained the purpose of the study and requested volunteers to meet with me after the gathering if they were interested in participating in the study. One participant was recruited in this manner.

Following the preliminary recruitment of adolescent drug users by the gatekeepers, I arranged individual interviews with each of the adolescent drug users and their parents/guardians during which the purpose and process of the study were explained. The eager commitment from the majority of the parents and/or guardians suggested that they were hopeful that there would be gains for their children in the form of sustained recovery from their addiction. These assumptions were clarified with the parents, who generally responded in the affirmative. It was therefore necessary to
delineate the roles once again and to reassure the parents and the adolescents of the researcher’s professional and ethical duty to link the research participant to the necessary intervention resources, and that my role was that of a researcher. It appeared to bring relief to most of the research participants to learn about the two distinct roles of researcher and therapist, and they clearly felt more comfortable knowing that they would not be assessed, but rather consulted in their capacity as experts (Grbich, 2007:132) who could make a valuable contribution to service delivery.

In order to gain access to and cooperation from the sample of drug prevention practitioners, I submitted letters to the manager/director of the relevant NGO and the government department. The manager from the NGO responded within a week of receiving the invitation, and the focus group interview was set up. Access to the drug prevention practitioners at the government department was granted after three months of the request serving at the different levels of local, regional and provincial management. After receiving permission from the organisation’s management, and obtaining the list of drug prevention practitioners, I made contact with one practitioner in each organisation, requesting that he/she gather the names of colleagues interested in participating in the research study (thereby employing snowball sampling methods), to ensure that participation in the research would be voluntary and not in response to an instruction from the organisation’s management. The four practitioner navigators that volunteered their participation in the study constituted the entire drug prevention team from the NGO, who had only six social service practitioners in their employ at the time. The five practitioners from the government department constituted a small number of practitioners from the total population, with explanations of a high workload and pressing deadlines offered as reasons for non-participation.

I was mindful that access could be compromised by organisations/existing management structures, who might perceive the study as a direct evaluation of their programmes or that the proposed outcome would replace their services or that the researcher would be embarking into territory which they had claimed as their own. These concerns were also addressed during the initial meetings with the relevant managers and directors, during which the purpose of the study and the research protocol were explained. After access was granted, I met with the potential research participants to address their questions.
about the research and provide them with the opportunity to read the letter of introduction and sign the consent form. A total of nine practitioners were recruited in this manner.

The recruitment of the peer mentor/navigator sample (TADA members) was the least complicated, as the coordinator from the NGO, responsible for the training of the TADA members made direct contact with the supervising teacher at school. The latter took responsibility for forwarding the consent forms to the parents upon receiving confirmation of the learners’ interest in participating in the study. A date for the focus meeting group was established upon receiving confirmation from the teacher that the consent forms from the parents and the learners had been returned.

3.7 METHOD AND PROCESS OF DATA GENERATION

De Vos et al. (2005:402) emphasises that once access has been granted, it is important for the researcher to focus on understanding the priority issues for the population. In this regard, I wished to explore the concerns of the four sample groups of participants, but also desired to learn informally about the concerns of community members who were already actively involved in different forms of drug prevention ventures in the research community. The meetings with these three different stakeholders (i.e. the AA coordinator, management of FAD and the management of the South African Police Services (SAPS), Bethelsdorp Youth Development Forum) overlapped with the previous step in the research process (i.e. gaining access to the research community and studying natural examples). The information obtained from these stakeholders was not part of the formal data collection process, but instead was used to conceptualise the study (refer to Chapter One).

As described earlier in Section 3.6, the qualitative research approach embedded in a narrative tradition of inquiry was employed to understand the concerns and views of the four sample groups. I was particularly aware of the caution offered by Riessman (1993:8) that I would be listening to the participants’ interpretation of their experiences, rather than having direct entry to their experiences. In return, my reflections, prompts and questions to their interpretations would bring about a co-construction, implying that
I became an intricate, subjective part of the narration at each of the five levels of representation in the narrative research process, as listed below:

- Attending to the experience
- Telling about the experience
- Transcribing the experience
- Analysing the experience
- Reading the experience.

Riessman (1993:15) asserts that the meaning construction at each of these levels is flexible and contextual, which will become evident in this section as I discuss how I attended to the participants’ experience whilst they were telling me about the experience. A narrative inquiry allows for a more complete story of the studied phenomenon, contextualised in culture and social context, and over a span of time.

A pilot study was conducted upon approval of the research proposal by the Research Ethics Committee – Human (REC-H) at the University (refer to Appendix A). Pilot studies were conducted with the observers and travellers to assess the following: the viability of the research design; whether the method of data generation was user-friendly and non-intimidating; and whether the data generation methods elicited answers to the research questions (De Vos et al., 2005:210-215). The outcome of the pilot studies revealed that the life-grid served as a useful visual tool, which aided the travellers in structuring their spoken narratives. It was apparent, however, that the travellers needed to be presented with a choice to either narrate their stories in oral or written format. The written narrative option appeared to be less appealing to the travelers, as they were interviewed individually, hence enhancing an acute awareness of my presence in the room whilst they were writing. The pilot study with the observers revealed that group administration was preferred to individually administered written narratives. The pilot studies alerted me to the range of interviewing skills that would be required, and furthermore allowed me to estimate the cost and anticipated duration of the data generation process. The learnings derived from the pilot studies were discussed in supervision and subsequently implemented during the empirical study.
Different methods were employed to actualise the narrative tradition of inquiry for the four sample groups which enhanced the triangulation of the data. The table below illustrates the objectives that informed the different data collection strategies with each of the four sample groups of research participants. According to Creswell (2007), the utilisation of different data collection strategies adds value to qualitative studies, particularly narrative studies. Included in the table are the informal methods of information gathering, referred to earlier in this chapter and reiterated at the outset of Section 3.7.

<table>
<thead>
<tr>
<th>Sample groups and objectives</th>
<th>Data collection strategy</th>
<th>Relevant community stakeholders</th>
<th>Information gathering strategy</th>
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<tbody>
<tr>
<td>Adolescent Observers:</td>
<td>29 semi-structured written narratives generated during group administration sessions.</td>
<td>Three separate consultations with the coordinator of the AA.</td>
<td>Individual consultations.</td>
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<tr>
<td>Objective:</td>
<td></td>
<td>A second round of group administration where 19 of the 29 participants expanded the written narratives.</td>
<td>FAD support group meeting.</td>
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<td>Participant observer at a support group meeting attended by 35 group members.</td>
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<tr>
<td>Adolescent travellers:</td>
<td>29 semi-structured written narratives generated during group administration sessions.</td>
<td>Two separate consultations with the coordinator of the AA.</td>
<td>Individual consultation.</td>
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<tr>
<td>Objective: Same as observers</td>
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<tr>
<td>Practitioner navigators:</td>
<td>Semi-structured focus group interview with four drug prevention practitioners of an NGO.</td>
<td>Meeting with the SAPS, Bethelsdorp Youth Development Forum.</td>
<td>Meeting with three youth forum members (i.e., coordinator, chairperson and secretary).</td>
</tr>
<tr>
<td>Objective:</td>
<td>Semi-structured focus group interview with five drug prevention practitioners at the</td>
<td>25 community members, members from voluntary self-help organizations (adult).</td>
<td>CANRAD conference – parallel session re drug abuse.</td>
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<td>government department.</td>
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Formal methods of data generation

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<th>Informal methods of information gathering</th>
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<tr>
<td>Relevant community stakeholders</td>
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<td>Information gathering strategy</td>
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prevention services rendered to adolescents from these communities.

| Peer navigators: **Objective:** To explore the peer navigators’ constructions of drug use, non-use and drug prevention to adolescents from the Northern Areas communities and how that informs their drug prevention services rendered at school. | Semi-structured focus group interview with ten peer navigators. |

### TABLE 3.1: Description of methods of data generation

#### Data generation with observers

The initial plan was to conduct in-depth interviews with adolescent observers, as the wish was to elicit depth and richness of detail (Monette et al., 2011:245) that could help me meet the objective highlighted in the table above. Meeting this objective would help me to arrive at constructs/conceptualisations that would form the basis of the guidelines for culturally sensitive drug prevention interventions (refer to Chapter Seven). However, I had to amend the method of data collection to that of semi-structured written narratives (for the reasons described in Section 3.6.2) and in the process forfeited the benefit of further probing and clarification questions afforded by face-to-face interviews (Mack et al., 2005). The advantages of the substitute method, i.e. written narratives, however, were located in its anonymity – an important requirement for adolescents (Louw & Louw, 2007); its non-intrusive nature; and, lastly, its time and cost-effectiveness. The decision to use an interview guide for the semi-structured interview lent structure and direction to the data generation process, and served as reassurance to the parents about the type of information that would be generated from the interview. Locating the data collection at school served as a further safety measure and convenience arrangement.
The following **three questions** served as probes to the written narratives:

1. **What does the word ‘Coloured’ mean to you?**
2. **What do you think is the reason for the alcohol and drug abuse amongst adolescents from your community?**
3. **How can alcohol and drug abuse be prevented amongst adolescents from your community?**

A few observers requested clarification on what I meant by the word ‘Coloured’, to which I responded that the written narrative offered them the opportunity to reflect on what the word meant to **them**. After the preliminary analysis, it was apparent that the majority of the participants perpetuated the predominantly problem saturated narrative (Morgan, 2000:26) relating to drug abuse amongst ‘Coloured’ adolescents; albeit using the second person voice. Furthermore, their narratives represented what Hennink (2007) refer to as interpretative repertoires, i.e. a coherent system of meanings that has developed over time and is used to evaluate actions or events from a cultural context rather than an individual perspective.

In keeping with the social constructivist paradigm of the study, consideration of design coherence, and the goal to develop drug prevention guidelines, I decided, in consultation with my research supervisor, to provide the research participants with an opportunity to construct a different version of their social world (Burr, 1996). Realising that this narrative data did not represent facts about the adolescents, but rather their perceptions and interpretation of their world (Lieblich, Tuval-Mashiach & Zilber, 1998:49), I decided to advance the co-construction of an alternative story (Bruce, 2007).

I also wanted the participants to find their own voice and construct their narratives in the first person voice, given the empowerment potential of the research design and the goal of the study. I subsequently arranged for a second round of data generation with the respective gatekeepers, and in this co-construction process (Cortazzi, 1993) provided the following explanation when I met with the participants in their respective group settings:
“When I analysed the essays you wrote for me the first time, I learnt so much about how you view drug use and prevention amongst adolescents in the Northern Areas. It made me realise that I do not know enough about how you have managed to stay away from drug use and also what you enjoy about your cultural identity and your neighbourhood. I would therefore appreciate it if you can answer the two additional questions on the original sheets that you wrote your first essays on.”

The two questions were as follows:

Question 4: What do you appreciate about ‘Coloured’ identity and residing in the Northern Areas?
Question 5: What has enabled you to not become involved in alcohol and drug use?

The questions were purposefully constructed (Young & Fitzgerald, 2006) to challenge the dominant, internalised, culturally stigmatised and marginalising story of drug abuse amongst the ‘Coloured’ community. My assumption was that prompting an alternative narrative would provide them with the opportunity to uncover implicit stories of resistance and resilience, which may otherwise have remained silent (Etherington, 2006; White & Epston, 1990). This view has been endorsed by Clandinin and Connely (2000), who describe narrating from the first person’s voice as a liberating act, allowing one to hold up a mirror that reflects where and how you and others need to make changes. Through narrative inquiry, therefore, ‘the silenced can begin to articulate their own experience and make their own critical analyses of the social order from their own points of view’ (Clandinin & Connely, 2000:45).
Data generation with travellers

The objective that informed the data generation with the travellers was identical to the one formulated for the observers. The data collection strategy was, however, different, for two reasons: Firstly, as I anticipated that the travellers would disclose highly sensitive information and probably reflect on challenging times in their lives, it was essential to identify their concerns by means of individual interviews, during which rapport building would be effected and trust could be established (Sapsford & Jupp, 2006:114; De Laine, 2000:41). Secondly, my assumption was that the travellers could, by virtue of having travelled the drug use journey, add value in a first person’s voice, which in turn would enhance the attainment of the goal of the study. The travellers were hence invited to tell their stories through the use of the Life Grid, which is a visual tool for mapping important life events against the passage of time and has the potential to prompt wide-ranging discussion (Wilson, Cunningham-Burley, Bancroft, Backett-Milburn & Masters, 2007) (see Appendix C3). I provided the following prompt to the participants:

“*I am conducting research with the goal of developing practice guidelines for drug prevention amongst adolescents from the Northern Areas, and I have been informed by the person who introduced us that you can offer me valuable assistance to reach this goal. This page that I have here is called a Life Grid and has been structured according to developmental stages on the horizontal axis* [pointing to the horizontal axis]. *The vertical axis* [pointing to the vertical axis] *has a number of suggestions of different experiences that most people go through. I want to invite you to imagine that we are writing your life story, and you can choose what you include in that story and what you leave out. The life grid is merely a guideline to help you along, but where you start and what you talk or write or draw about is up to you.*”

The freedom offered by the life grid as a data collection tool aided in opening up the conversation and allowed me to contest any potential assumptions of a power hierarchy – an important consideration, given the participants’ possible encounters with helping professionals in the past. It furthermore also creates a more relaxed research encounter in a context that might otherwise appear intimidating. Wilson *et al.* (2007:144) caution that the drawback of the life grid is that it has the potential to elicit research participants’
discussion around discrete life events, rather than storying more diffuse events over a longer lifespan. This limitation also emerged during the present study, as most travellers, upon learning about the goal of the study, assumed that they had to start narrating their life story against the context of their experience on the drug use journey. However, at least three travellers refrained from this approach – these were also the travellers that requested less prompting and literally allowed me to be a travel companion on their research journey, rather than a miner that had to delve for information (Kvale, cited in Babbie et al., 2011:289).

Whilst I tried to restrict my influence to allow the travellers’ own perspective to be relayed, I provided non-verbal feedback as indication that their account was relevant and not uninteresting. Some travellers required prompting and probing, with some requesting direct guidance in terms of where to start with their narrative (refer to Section 3.3 in Chapter Three). The following interviewing techniques were employed in response to the travellers’ needs and also to encourage a rich description of their journeys: establishing rapport, attending skills, using probes, reflective responding, empathic listening, and summarising skills (Krefting, 1991:220).

The value of in-depth interviewing, as described by Mack et al. (2005), was evident during the data generation with the travellers. Many travellers commented that the research journey offered them a cathartic opportunity and that they felt really listened to. Others showed appreciation for the opportunity to add value and for being validated during the interview (refer to Section 3.5.5 in Chapter Four).

Riessman (1987) confirms that when researchers encourage their research participants to take control, it enhances the reciprocity of research. However, Prendergast, in Hallowell et al. (2005:137) points out that, in most cases, the research participants do all the giving, whilst the researchers are the ones that take their stories. Therefore, in order to enhance the reciprocity (Shakespeare in Hallowell et al., 2005:138-141), I invited the travellers to ask me any question they had about me prior to the onset of the interview. This was an offer none chose to utilise; however, this invitation appeared to reduce the initial discomfort that was present at almost all the interviews. The fact that the travellers were positioned in the roles of experts and teachers (Schostak, 2006:149)
also seemed to contribute to their openness and willingness to share their views. On more than one occasion the travellers used slang particular to the drug world and their phase of development, on which I requested clarification. Judging from their tone of voice and body language, it was evident that many of them enjoyed the opportunity to be the teachers of an appreciative learner, further authenticating the travellers’ position of authority on the discourse (Gillham, 2005:33). The interview techniques of summarising and paraphrasing enhanced the collaboration between the travellers and myself and further ensured that the intended meaning of their story was captured (Ollerenshaw & Creswell, 2002:332).

All the research interviews (with the exception of one that took place at school) were conducted in the participants’ homes; therefore, it was important to eliminate all potential risks to confidentiality and privacy. I found that most parents and caregivers were eager and cooperative and clearly had the covert expectation that the research interview would further enhance the traveller’s commitment to recovery (Gillham, 2005:16-17; De Laine, 2000). I addressed this issue in the presence of the traveler, emphasising that whilst my role was that of researcher and not therapist, I would effect the necessary referral, where it was deemed necessary, with the traveller’s consent.

Considering the developmental stage of the participants, and their vast experience accumulated on the drug use journey, I was cognisant that my appearance in terms of dress code, language use, gender and other social messages could influence how they experience me, and therefore the nature of the data that was collected. Hallowell et al. (2005:45) caution that whilst it is important to try and blend in with the research participants, researchers should ensure that they dress for comfort and not camouflage, and rather focus on being congruent with who they are. I also made a point of validating the privilege and trust granted to me by the parents, who allowed me into the privacy of their homes (some literally allowing a virtual stranger in their bedrooms to ensure the privacy of the research interview).
Data generation with practitioner and peer navigators

Two separate focus group interviews were employed in terms of the data generation strategy, with a sample of social work and social auxiliary work practitioners (practitioner navigators) from the two participating organisations. The two focus groups were conducted at the navigators’ places of employment, were approximately 90 minutes in duration, and consisted of four and five practitioner navigators respectively.

A focus group interview was also employed for data generation with the ten TADA peer mentors (peer navigators). The focus group interview was conducted at the peer navigators’ school during school hours and lasted approximately 90 minutes. The focus group interview was conducted at the end of a school term when no formal teaching took place, so that the learners’ academic programme would not be disrupted.

Hennink (2007) suggests that a focus group can be employed as a research tool, facilitated by a trained moderator who uses an interview guide to elicit interaction and conversation between the members of the focus group. The explicit goal of the focus group is usually to elicit the participants’ feelings, attitudes and perceptions about a specific communal topic. Mack et al. (2005) confirm this description, asserting that one major advantage of focus groups is the wealth of information that can be generated over a relatively short period of time. They are also effective for accessing a broad range of views on a specific topic, as opposed to achieving group consensus. It was for this reason that focus groups, as opposed to individual interviews, were regarded as a powerful mediation between the dominant story and the alternative story of the practitioner and peer navigators.

The following questions comprised the interview schedule for the focus group interviews for both the peer and practitioner navigators:

- What comes to mind when you hear the word ‘Coloured’?
- Can you share with me the drug prevention services that you render to adolescents from the Northern Areas communities? (in your school)
Can you reflect on your experiences of being involved in these drug prevention programmes? (in terms of the responses of the adolescents; resources available to you; specific challenges that you encounter in rendering this service).

What are your views regarding your current programmes and their impact on drug prevention among adolescents from the Northern Areas communities? (in your school)

The following interviewing and group facilitation skills were employed, in line with the transformative intention of the research design: challenging contradictions, drawing out of silent members whose body language reflected active engagement and the desire to make a contribution, probing, offering reassurance, facilitating ‘turn taking’, where more than one participant started speaking at the same time, focusing, and summarising at the end of the focus group interview (Toseland & Rivas, 2005). Specific attention was paid to how the research participants narrated drug prevention amongst adolescents from the Northern Areas, and who had a more dominant voice in the group, as well as how that dominant voice was used in relation to the construction of drug prevention messages (Corby, 2006). The focus group strategy of data collection added significant value to meeting the objectives of the study when compared to individual interviews, as the latter would not have allowed me the insight into the types of discourse that were accessed in the focus groups (Ezzy, 2002).

I approached the data generation process with caution, since two of the practitioner navigators were ex-students of mine, and a few others were colleagues, with whom I collaborated closely in practice. I therefore demonstrated, through my respectful treatment of the navigators that they were not being judged, that they were the experts from whom I wished to learn and that their professional practices were not being evaluated (Gilbert, 2002:229).

The data generation process with the peer navigators was initially complicated by the TADA supervising teacher’s incorrect assumption that she would be part of the focus group and the learners’ unfamiliarity with being audio-recorded. The clarification of the misconception, employment of an ice-breaker and allowing the peer navigators to test the audio recorder enabled us to proceed unhindered with the focus group interview.
Since the focus of the study was on meaning constructions, I also coached myself to listen to the unfolding story in terms of how it was told and why it was shared; whilst at the same time focusing on reducing any form of guardedness in the navigators (Gilbert, 2002:229).

The focus group interaction afforded the practitioner and peer navigators the opportunity and context to reflect upon their drug prevention practices and in the process interpret and negotiate their experiences (Morgan, 2000:9; Gilbert, 2002:224). Excerpts from the three practitioner navigators’ narratives, which confirmed the transformative value of narrative research, are cited below: “I’ve just become aware of this”; “I see that now”; “Now that I’ve heard you say that” (refer to Section 2.1 in Chapter Six).

The data generation with the four different sample groups (i.e. 10 individual interviews with travellers; 29 written narratives from observers, followed by a second round of data generation with 19 of the 29 observers; two focus group interviews with four and five practitioner navigators respectively; and a focus group interview with ten peer navigators) provided me with rich information towards meeting the goal of this study.

Reflexivity

In keeping with the transformative agenda of the research design, I offered each of the travellers the opportunity to assert their agency by reflecting on how they experienced sharing their stories. Three travellers articulated their experiences as follows: ‘I have never spoken to anyone before so, I feel much better now”; “I feel like a weight has been lifted off my shoulders”; ‘I feel so much lighter now”. A further two travellers requested copies of the audio recordings of the interviews. When prompted about the potential benefit, they confirmed that it would be a ‘helpful reminder of the many challenges they have overcome’. These responses by the participants confirmed the sentiments of Klein (2003:12) and Pennebaker and Seagal (1999:1251), that disclosing stressful experiences can present some psychological relief. In essence, it also illustrated the emancipatory benefit the travellers derived from discovering new stories of hope (Morgan, 2000). The participants’ request for copies of the audio-recordings of
the research interviews was discussed with my research supervisor, and it was agreed that, from a social constructionist perspective, the audio-recordings would provide useful reflection material for the participants during times of anticipated relapse or cravings or any related hardship.

The next step in the research process entailed the analysis of the data that was generated, and this is discussed in the ensuing section.

**3.8 ANALYSIS OF DATA**

Data analysis aims to transform the information generated from the data collection process into answers to the original research question (Terre Blanche & Durrheim, 1999:47), or put differently, to convert raw data so that it communicates something general or abstract, which contributes towards meaning making (Monette et al., 2011:432). De Vos et al. (2005:403) emphasises the importance of the data analysis process, calling it the stage in which the problems identified by the community become crystallised. Patton (2002:432-433) cautions that qualitative data analysis is a time consuming and circular process. This view is supported by Miles and Hübermann (1994, in Monette et al., 2011:433), who reiterate the close, interactive link between data collection and data analysis. This iterative process entails going back and forth between the data and the analysis. This affords the researcher the opportunity to amend the data generation process, based on learnings derived from the data analysis, and it furthermore enhances theoretical sensitivity (Miles, 2001).

Monette et al. (2011:433) draw a distinction between the two types of outcomes of qualitative data analysis, i.e. categorising and contextualising. This distinction is coherent with the analysis proposed by Bleakley (2005:537), which is illustrated in Table 3.2 below.

<table>
<thead>
<tr>
<th>CATEGORISING</th>
<th>CONTEXTUALISING</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Aimed at generating concepts and theories from data, which is displayed in terms of coding and themes.</td>
<td>➢ Focused on retaining the data in its holistic or coherent whole, and is displayed in terms of profiles, narrative</td>
</tr>
</tbody>
</table>
Categorising emphasises the structure or the content of the story. Contextualising emphasises the meaning or discourse of the story.

TABLE 3.2: Synergy between two types of outcomes of qualitative data analysis

[Source: Adapted from Bleakley (2005:537)]

The categorising approach essentially requires a reduction of the data, thus presenting the researcher with the dilemma of what to omit and what to include (Patton, 2002:503). The contextualising approach, on the other hand, focuses on retaining the data in a coherent whole in order to arrive at the meaning of the story. The second phase of the research therefore drew on the core concepts (and the relationship amongst them) that emerged from phase one. These relational concepts formed the foundation for the development of the practice guidelines for culturally sensitive drug prevention interventions in phase two of the study.

The categorising/contextualising approaches to data analysis overlap with the types of narrative analysis described by Riessman (2008:11). The author posits that narrative analysis is ‘a family of methods for interpreting texts that have in common a storied form’. The type of narrative analysis is determined by the following factors: a) whether the researcher is interested in the content of the narrative (i.e. what has been said); b) whether the interest is in the form or structure of the narrative) (i.e. how it is told); c) whether the focus is on the intention or why the story is being told (i.e. looking at who is telling the story and what their intention is by telling it); or d) on the context in which the story is told (i.e. whom the story is told to; when it is told, and where it is told) (Vincent, 2011). In keeping with the goal and objectives of the study, I was interested in factors A, B and D, i.e. the categorising (of content and form), as well as the contextualising of the participants' narratives, which are discussed in the ensuing sections.
Categorical content analysis

Lieblich *et al.* (1998:13) propose that when researchers work from a categorical-content perspective, they dissect original stories with the view of generating abstract **concepts** and theories from the data, starting with coding repetitive words and arriving at repetitive **ideas**, which become known as the research theme. Lieblich *et al.* (1998) assert that coding is frequently guided by pre-existing theories. Riessman (2008) agrees with this view, but adds that the development of the research theme can also be informed by the purpose of the study and the data itself. Each of these criteria was used in achieving the categorical content analysis of the participants’ narratives, and strived to follow Creswell’s (2007:175) advice to qualitative researchers to build their themes and categories *‘from the bottom up’* by interacting with the participants. In reading each of the written narratives of the observers, the transcribed narratives of the travellers and the peer and practitioner navigators, I was guided by the following questions:

- **What are the participants saying about ‘Coloured’ identity, drug use, non-use and drug prevention?**
- **What are the relationships that they construct between these concepts?**
- **Do the concepts that emerge from these narratives resonate with the two conceptual approaches of the study, i.e. the ecological risk/protective resilience conceptual framework, and the social constructionist framework?**
- **What is the degree of consensus and disagreement that emerges from the narratives of the various participants?**

The answer to each of these questions informed the identification of the themes, sub-themes, categories and sub-categories (where applicable). The Ecological risk/protective resilience conceptual framework served as one theme, as illustrated through an extract from Table 5.2 in Chapter Five. A descriptive code was assigned to the main theme, which formed the skeletal frame for locating the more abstract codes (i.e. the sub-categories) (Patton, 2002:497).
Theme 2: Risk and protective factors associated with drug use and non-use

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Category</th>
<th>Sub-category</th>
</tr>
</thead>
</table>
| Risk and protective factors located in the family domain | Family risk factors | i) Parenting factors  
| | | ii) Relationship discord and low family cohesion  
| | | iii) Family environment  
| | 2.2.2 Family protective factors | i) Parenting factors  
| | | ii) Nurturing relationships and high family cohesion  

TABLE 3.3: Example of theme illustrating categorisation of data

The interpretive codes became evident through the direct quotes from the participants’ narratives, which illustrated the socio-cultural context against which the participants constructed their narratives and which will be illuminated further when the contextualisation of the data is discussed.

Categorical form analysis

Apart from attending to the categorical content of all the research participants’ narratives, I also attempted to analyse the categorical form of all of the narratives. Riessman (2008) purports that there are many ways of relating how a story is told, and refers to structural analysis as the school of narrative analysis that is focused on HOW narratives are organised to achieve the narrator’s strategic aims. It involves the detailed analysis of forms of speech, focusing on the telling, rather than the told. Riessman (2008), cited in Vincent (2011), describes the following four forms of structural analysis:

a) Looking at the overarching storyline to determine if it is structured in such a way that it resembles the typical features or a prototype (Cain, 1991).

b) Conducting a close analysis of the function of clauses in the elements of a story in accordance with the Labovian model (Riessman, 2008). This model, described as an ‘evaluation model’ (Cortazzi, 1993, cited in Coffey & Atkinson, cited in Myers et al. (2008:18), 1996:58), identifies six elementary units in a narrative structure. These elements, which can be viewed as answers to the audience’s
implicit questions, are as follows: abstract, orientation, complication, evaluation, result and coda.

c) Analysis in terms of genre, in other words, identifying the basic structure that remains unchanged in stories with a similar genre (e.g. a satire, romance or tragedy genre).

d) A linguistic approach to narrative analysis, which entails analysing the deep structure of speech in a narrative (Gee, 1990:17).

I drew on the work by Coffey and Atkinson, cited in Myers et al. (2008:18) (1996:83) and Owen (in Overcash, 2003:183) to guide the categorical-form analysis of the participants’ narratives. These authors are in agreement that how people convey their meanings through language can be looked at from a variety of complementary perspectives. This includes looking at the figure of speech in a narrative, as well as the use of specialised vocabularies in the data (Coffey & Atkinson, cited in Myers et al. (2008:18), 1996:84). Owen (in Overcash, 2003:183), endorsing this view, suggests that in dissecting data, researchers need to look at the **forcefulness**, or emphasis, applied to a concept. The following procedure was therefore followed in analysing the categorical-form of the narratives: Each of the narratives was read with sensitivity, clearly denoting the following: the transition between the active and passive forms of speech, the use of metaphors, the degree of emphasis placed on specific concepts, the repetition of concepts and ideas, and silences on specific topics.

Incorrect grammar used and particular drug or cultural slang were retained in the original oral narratives, to accentuate the voice of the travellers. Most of the research participants chose to conduct the interview in English, whilst some used a combination of English and Afrikaans. I noted the linguistic elements imbedded in the telling of the narratives, in accordance with suggestions by Riessman (1993) and Mishler (1986). These included reflecting on the pauses; silences; change in tone of voice; participants avoiding specific questions; and changing the speed of speech. The observation notes from the focus group interviews also provided rich information, reflecting the dominant versus the submissive voices, with the peer and practitioner navigators illustrating how ideas and views were co-constructed and reconstructed during the course of the focus group interviews.
Lieblich et al. (1998:157) suggest that dialogical influences in a narrative ‘skew’ HOW a story is told, and therefore propose that researchers remove dialogical influences from the analysis. However, in keeping with the paradigm and goal of this study, I was particularly interested in how social interaction influenced the form of the narrative, and therefore included such reflections in my observational notes. Examining each of these dimensions in the narratives illuminated specific learnings about the research participants that would not have been apparent from examining the content alone. Two critiques of this analysis are that: (i) it omits looking at the dynamics of interaction between the researcher and the participants, and the particular meaning attached to this process (Grbich, 2007:127); and (ii) the fact that the dissection of text essentially compartmentalises different segments of the person’s experience, resulting in the meaning (or quality of life) getting lost (Langridge & Hagger-Johnson, 2009:445). It was therefore important to incorporate a contextualised approach to the analysis of the data, which is discussed in the ensuing section.

**Contextualising the data**

Lieblich et al. (1998:13) assert that contextualising strategies are aimed at retaining the raw data in as holistic/coherent whole form as possible, since the researcher is more concerned with a detailed understanding of the individual narrative or idiographic explanations than with nomothetic ones. This also implies that ideas and concepts should emerge from the data, rather than categorising the ‘evidence’ obtained according to pre-existing theories. Bleakley (2005:535) argues that holistic approaches ‘take a story as a whole, contextualised in a culture and history, and attempt to grasp the overall pattern or guiding metaphors’. The ‘journey metaphor’ emerged as the guiding metaphor from the analysis of the pilot study interview, which was reinforced in each of the narratives of the nine participating travellers. It was apparent that these travellers, who had advanced to the addiction phase of drug use, foregrounded the drug use journey as the prominent story of their lives, whilst the travellers who took an early exit from the journey, narrated it as an episodic experience (Strawson, 2004 cited in Bleakley, 2005:538). The journey metaphor illuminates the travellers’ sense of agency (i.e. their ability to act and change the course of direction on the journey) (Redden, Tracy & Shafer, 2009), the navigational power they assigned to socio-cultural influences
in directing the departure on and course of their journey, the goal that the journey served for them and, lastly, the goal they wished to achieve in selecting an exit route on the journey.

The socio-cultural approach to narrative analysis, proposed by Grbich (2007:130), was used to complement the journey metaphor. This approach focuses on the broader interpretive context that forms the backdrop of people’s narrations, and hence addresses the critique of the social linguistic approach. The following steps were followed in the synthesis of the travellers’ narratives:

- Step one entailed identifying the boundaries of the narrative segments in the interview transcripts. For the purpose of this study, the boundaries were around specific experiences with drug use, non-use and prevention, and not the entire life stories of the travellers.
- The second step entailed exploring the particular meaning that the travellers attached to their experience. This involved observing the emotions and feelings that were demonstrated through the narrations. Lieblich et al. (1998:12) suggest that meaning in a story refers to the implicit content and advises that one should listen for the traits or motives of the individual being displayed; or what a certain image used by the narrator symbolises. Gillham (2005:7), echoing this view, asserts that people’s descriptions of themselves are constantly revised through interaction and reflection. It was therefore important to listen to how consistently the travellers were in describing themselves during the course of the interview, rather than asking whether they were presenting a true picture of themselves.
- The third step involved comparing the different travellers’ stories around the specific focus area, for example, venturing off on the journey and taking an early exit route. This comprised vertical and horizontal comparisons of the narratives of observers to travellers, as well as to observers and the peer and practitioner navigators.
- The fourth step was to link the stories to the relevant political structures and cultural locations, which included geographical as well as cultural identity as context (refer to Theme 6 in Chapter Four).
The last step focused on the interpretation of the travellers’ stories, with acknowledgement that my own position and experience, with and reactions to the issues of drug use, non-use and drug prevention could affect the meaning that I ascribed to the narratives of the participants.

These interpretations are illuminated in the discussion of the core themes and sub-themes in Chapters Five and Six of the thesis. It is important to note that the participants’ narratives were not analysed in terms of whether they were authentic representations of the adolescents’ experiences, but rather as co-constructions influenced by the interpretive frames and procedures I employed as a co-_constructor of the participants’ narratives (Chase, 2005).

Henning et al. (2004:107) caution that ‘processed data do not have the status of findings until the themes have been discussed and argued to make a point, and the point that is to be made comes from the research questions’. For De Vos et al. (2005), this entails critically searching for other plausible explanations for the data and the linkages among them, and finally demonstrating how and why the explanation offered, is the most plausible.

Similarly, Kitzenger and Farquahar (1999) reiterate the importance of focusing on group dynamics in analysis and suggest looking closely at forms of interaction, such as arguments, mutual reinforcement, jokes and story-telling. In the groups, I noted the laughter, the ways in which participants addressed one another, expressions, teasing, challenges and support among the members and, with the moderator and the observer, tried to ascertain the meanings underlying these interactions. The focus on group dynamics highlighted the negotiation and construction of realities and identities during the course of talk and interaction (Hyde, Howlett, Brady & Drennan, 2005).

3.9 FIELD NOTES: REFLECTIONS ON RESEARCH PROCESS

In this section, I wish to reflect on my own experiences of being on the research journey. The conceptualisation of the study, and the use of the term ‘Coloured’ in the
data generation questions, evoked a fair amount of criticism from a segment of the academic fraternity, who argued that the use of the term had the potential to reinforce ‘race talk’. Following an extensive consultation with community members and researchers alike, I asserted my agency by retaining the concept in the data generation questions. This decision was primarily informed by the intention to use the concept in an evocative manner to spark a deconstruction of the concept and the historical narrow descriptions with which it has been associated.

The challenges encountered during the recruitment of a sample were alluded to in Section 3.6.2 of this chapter. I recall being pleasantly surprised about and proud of the parents’ protective behaviour towards their children. At the same time, I was concerned that the adolescents were deprived of an opportunity to make a unique contribution to the body of knowledge on the research topic. This concern was exacerbated by the subsequent research findings, which revealed the prevalence of a social construction of an inferior intellectual and socio-cultural identity.

During the process of negotiating entry into the community, I found myself feeling overwhelmed by the dire shortage of professional resources in the community. On several occasions, the latter threatened to derail my research journey into a therapeutic one. In retrospect, I became aware that it was these experiences and the helplessness associated with them that contributed to my decision to present the research findings at three different conferences, instead of prioritising the completion of the thesis. This realisation both reinforced my belief in my world-view that reality is socially constructed, and further alarmed me that I was focusing on short-term rather than long-term goals regarding my research and its potential outcomes. Needless to say, realising the similarities between my research journey and the travellers’ drug use journey, was both shocking and liberating at the same time. This realisation enabled me to distinguish between my story and the research participants’ story and energised me to refocus on the vision of my research journey and its envisaged long-term contribution to the field of drug prevention.
3.10 ENSURING TRUSTWORTHINESS

The concepts validity and reliability are more readily associated with quantitative research studies, which have a stringent focus on employing representative samples, developing reliable measures to test research hypotheses and ensuring the replicability of research studies in similar contexts. Quantitative studies are therefore concerned with yielding objective results that can be generalised to the larger population (Terre Blanche & Durrheim, 1999). Qualitative research, in contrast, employs ‘theoretical sampling of small numbers of people chosen for their special attributes’ (Yardley, 2000:218), in order to gain an in-depth understanding of the phenomena of interest. Ulin, Robinson, Tolley and McNeill (2002) furthermore emphasise that qualitative researchers are interested in multiple versions of reality, thus acknowledging subjectivity in research. Agreeing with this view, Gilbert (2002:228) emphasises that in narrative research, the ‘focus is on trustworthiness and credibility of the stories’. By telling the story, the narrator creates a new story, which the researcher also influences or changes, simply by listening. Babbie et al. (2011:276) present the following table to reflect quantitative and qualitative notions of objectivity.

<table>
<thead>
<tr>
<th>Quantitative</th>
<th>Qualitative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal validity</td>
<td>Credibility</td>
</tr>
<tr>
<td>External validity</td>
<td>Transferability</td>
</tr>
<tr>
<td>Reliability</td>
<td>Dependability</td>
</tr>
<tr>
<td>Objectivity</td>
<td>Confirmability</td>
</tr>
</tbody>
</table>

TABLE 3.4: Quantitative and qualitative notions of objectivity
[Source: Babbie et al. (2011:276)]

The authors describe objectivity and validity as ‘counterfactual, regulative principles,’ which are not appropriate in qualitative research. Each of the parallel concepts (evident from Table 3.4) that are more relevant in qualitative research will be illuminated in the ensuing discussion. The discussion is structured according to the four characteristics of good qualitative research proposed by Yardley (2000).
3.10.1 Sensitivity to context

Yardley (2000:219-220) proposes that the context of a qualitative study encompasses different aspects, which may all be equally important. These include sensitivity to theory, to the data itself, and to the socio-cultural setting, each of which is discussed below. I illustrated sensitivity to the theoretical context by undertaking a detailed overview of the two conceptual frameworks employed in the present study (refer to Chapter Two). This review revealed that several researchers used the concepts social constructionism, social constructivism and the social constructionist perspective interchangeably (Sifunda, Reddy, Braithwaite, Stephens, Bhengu, Ruiter & Van Den Borne, 2007; Cruts, 2000; Atwater, 1996). In the context of the present study, social constructionism and the social constructionist framework were employed as the conceptual framework, whilst social constructivism was reserved to refer to the research paradigm. The application of and rationale for incorporating a second conceptual framework was explained in Section 1.6 of Chapter One. The combined application of the two conceptual frameworks in the study illustrates how the concepts risks and protection can take on alternative social constructions in different socio-cultural contexts, thus contributing to the ‘theory-building work of vertical generalisation, i.e. an endeavor to link the particular to the abstract and to the work of others’ (Johnson, 1997, cited in Yardley, 2000:220).

Sensitivity to the data itself was illustrated through the triangulation of data collection methods and different data sources (Denzin & Lincoln, 2003), which not only surpassed the limitation of one method of data collection, but also allowed for the corroboration of theoretical predictions. The triangulation of the data sources also enabled me to assess and analyse the divergence between the adolescent and the practitioners’ voices (Pope & Mays, 1995, cited in Yardley, 2000:222).

I remained sensitive to the socio-cultural context by conversing in the primary language of the research participants, adopting the vernacular that they were using, and frequently paraphrasing to ensure that I had heard them correctly. By adopting sensitivity to the socio-cultural context, I came to realise that parents who allowed their
children to use legal drugs in their homes were exercising parental control (against the use of illegal drug use), rather than illustrating permissive parenting practices.

Yardley (2000:220-221) argues that the ‘social context of the relationship between the investigators and the participants in the research can be crucial’. Gillham (2005:6), agreeing with this view, emphasises that the qualitative researcher uses the self as the primary research tool. By acknowledging inter-subjectivity, and adopting a reflexive stance (refer to Section 3.9 above), I was therefore not invalidating my research findings, but instead demonstrating cognisance of how I influenced the ‘telling’ of the story, and thus the generated findings. However, consistency in the interpretations of the findings was supported by excerpts from the rich narratives of the research participants, which were presented in Chapters Four, Five and Six.

Being cognisant of and making my preconceived ideas explicit, assisted in bracketing my views and furthermore informed the decision to conduct all the interviews in the participants’ preferred language and at their preferred locations. By referring participants who needed professional interventions, I not only adhered to the ethical principles, but also guarded against the potential exploitation of the travellers (refer to Section 3.7 above).

3.10.2 Commitment and rigour

The detailed processes followed to gain entry to the research population and to prepare for the data generation process (refer to Section 3.7 above) attest to the commitment to the research study and the research process. Earlier sections in this chapter detailed the in-depth engagement with community stakeholders, and the researcher’s participant observation in two drug prevention programmes to establish the needs of the research community. I furthermore attended a narrative analysis workshop to enhance my competence in narrative analysis and submitted the first round of structural analysis of three travellers’ narratives to two experts at Rhodes University, adhering to the necessary code of ethics in the process.
Rigour refers to consistency and thoroughness in the data generation and analysis process (Yardley, 2000:221; Ulin et al., 2002), thus enhancing the dependability of the findings. The data was subjected to both content and narrative analysis, to enhance the depth and breadth of analysis and interpretation. The employment of different methods of data generation and analysis further ‘achieved a multilayered understanding of the research topic’ (Yardley, 2000:222). The criteria of commitment and rigour are also evident from the acknowledgment of my voice and biases throughout the research process, from the point of conceptualising the study, asserting my motivation for undertaking the study, and distinguishing between my story versus the research participants’ stories.

3.10.3 Transparency and coherence

Alston and Bowles (2003:48) assert that data verification in qualitative research is embedded in the quality of the data collection and data analysis processes. As a result, data verification occurs during data collection, data analysis and the writing of the research report. This process serves as verification that the research findings accurately represent what was happening during the research process and hence enhances the credibility of the interpretations and conclusions. Credibility refers to confidence in the truth of the findings (Ulin et al., 2002); however, as stated earlier, findings emanating from qualitative research are always subject to the social constructions of the researcher. Hardy et al. (2009) concur that the researcher’s evaluation of the collected stories may also change as the lenses that researcher wears, change. This is in effect regarded as a strength, because it means that the researcher is open-minded and flexible enough to revisit the data. Transparency in the presentation of the analysis was also achieved by presenting excerpts from the participants’ narratives to corroborate the interpretation, and by using an independent coder to analyse the data (Hübermann & Miles, 1994, cited in Yardley, 2000:222).

By detailing my discomfort about the use of the concept ‘Coloured’ and the subsequent decision to retain the concept in the data generation questions, I illustrated transparency about my assumptions and intentions.
The validity of data collected in a narrative inquiry centres around the internal coherence of the story as told by the narrator. The questions I subsequently asked to achieve internal coherence, were: *How recognisable is the story? How consistent is it in terms of theory around drug prevention? How plausible is the story? What is the kind of information the participant uses to tell her story? How consistent is the story-line? and How convincing is the narrator in telling her story?* (Gillham, 2005:7). The coherence between the research question, the research paradigm, method of investigation and analysis is illustrated in Chapters Two, Five and Six, as evidence of the ‘fit’ between the design and methodological aspects of the study. The literature control further served as an important verification strategy of transparency and coherence of the data.

### 3.10.4 Impact and importance

Yardley (2000:223) asserts that the ‘*decisive criterion by which any piece of research must be judged* is, arguably, *its impact and utility*’. The author proposes that the usefulness of findings can be assessed in terms of the intended purpose of the analysis, the applications it was intended for, and those to whom the findings apply. One strategy that can be implemented to enhance the impact of the research is to learn from unsuccessful programmes, as they can point the researcher to aspects that may be critical to enhance success (Fawcett, in Rothman and Thomas, 1994:32-33). The participant observation of two drug prevention programmes, the prolonged engagement with practitioners, adolescent users and non-users, and attendance of the FAD support group meeting, were all strategies undertaken to enhance the final research product. The geographical delineation of the population alluded to the fact that the produced knowledge would be situated in a particular context, thus limiting the generalisation and transferability of the findings (Neuman, 2006). The inclusion of four different sample groups, however, enhanced the vertical transferability of the findings. The practice guidelines furthermore stipulate the particular contextual factors that need to be considered when designing culturally sensitive drug prevention interventions. The research is therefore not only inherently political, but aimed at serving a particular social purpose and has specific social effects (Burman & Parker, 1993, cited in Yardley, 2000:223).
Responding to the critique that qualitative research methods do not allow for the generalisation of research findings, Merrill and West (2009) argue that people who can be classified in similar ways according to demographic characteristics, may actually turn out to differ dramatically. The authors, supported by Hardy et al. (2009), argue, however, that one single case study based on a biographical story can provide theoretical insight that can have resonance with many others and, by revealing contradictions, can generate understanding and give meaning to the experiences of others.

Section 3.7 detailed reflexivity by the research participants. Their comments endorsed the assertion by Gillham (2005:7) that people’s account of themselves is informed by their working understanding of themselves. The participants’ reflections not only revealed that they were developing an enhanced awareness of themselves, but also underscored the view by Riessman (2008) that narrative research facilitates one’s own on-going sense-making process. The explanation offered by two travellers for why they wanted copies of their recorded research interviews, was also understood as their journey of ‘on-going sense-making’.

3.11 ETHICAL CONSIDERATIONS

Hill, Glaser and Harden, cited in De Laine (2000:144), suggest that ethical dilemmas are defined as situations in which there is no right decision, only a decision that is ‘more right’. De Vos et al. (2005:63) define ethics as:

“a set of moral principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and participants, employers, sponsors, other researchers, assistants and students”.

Ethics can therefore be understood as a set of rules that prescribe how the researcher should behave towards people involved in the research. Beauchamp and Childress (2001, in Terre Blanche, Durrheim and Painter (2006:67-69), describe four philosophical principles that should guide ethical conduct in research. Each of these
ethical principles is discussed in the ensuing section, and is supported by a reflection on the strategies I employed in order to uphold the principles.

- **Autonomy and respect for the dignity of persons**

This principle revolves around respecting the rights of participants to provide informed consent for their voluntary participation in the research, as well as honoring the participants’ right to privacy and confidentiality. Sections 3.6.1 and 3.6.2 of this chapter document the challenges that were encountered when the rights of three parents conflicted with the rights of their children. The parents’ right to protect their children was juxtaposed against their children’s rights to contribute to a discourse on adolescents’ issues. An exploration revealed that the parents’ refusal to give consent for their children’s participation in the research was located in fear for their children’s safety amidst the growing drug-related gang violence in the geographical community where the study was located. The sentiment by Alston and Bowles (2009), that an ethically skilled qualitative researcher remains cognisant of the cultural context of her research, informed the subsequent change in research methods. The parents’ fears were addressed by altering the method of data generation and the location of where the data collection took place. Individual interviews were subsequently replaced with (anonymous) written narratives, administered in a group context in the participants’ classrooms at school. The participants’ identity were consequently protected and the confidentiality of their contributions was enhanced, as all written narratives were given a numerical identifier (i.e. Observer 1-29). The data generation process only proceeded upon confirmation that all participants understood and agreed to the content of the informed consent form (refer to Appendix C2). In this regard, participants were also reminded that their participation in the study was voluntary and that they could withdraw from the process at any stage.

The protection of the dignity of the travellers was of paramount importance, since I anticipated that many of them might have encountered ridicule by parents, teachers and significant others who might have been negatively affected by the choices the travellers made on their drug use journey. Specific strategies that I employed in this regard, were encouraging the travellers to address me by my first name, enquiring about how I could
address them, and attending to what they needed to reduce potential discomfort in the research interview. I extended an invitation for any question they wished to pose to me (Louw & Edwards, 1998:50), and reiterated that I wished to learn from their experiences, thus diffusing the power hierarchy (Brinkmann & Kvale, 2005:164). An ethical issue that emerged during the presentation of the findings from the biographical narratives was the possibility that the travellers’ anonymity could be compromised, despite my attempts to protect their identities by obscuring information (Langdridge & Hagger-Johnson, 2009:444-445). I subsequently chose to present the ten travellers’ biographical narratives as a collective, as opposed to individual stories.

The same strategies were implemented with the peer and practitioner navigators. Several of the practitioner navigators were my ex-students, and I therefore needed to guard against power imbalances. I clarified my role as researcher, drawing on their experience and expertise in the field of drug prevention. I also sought permission to tape-record the interviews as reinforcement of the participants’ right to provide informed consent.

- **Nonmaleficence**

This ethical principle requires of researchers to ensure that research participants do not experience any harm and that they are not deceived during the course of the study. As I valued the safety of the participants, I altered the method of data generation subsequent to some parents’ expressions of fears for their children’s physical safety.

It was essential to continuously distinguish between my role as a researcher versus my role as a therapist. Participants were afforded the opportunity to reflect on the experience of participating in the research as a means of assessing unanticipated emotional reactions triggered by participation in the research. I referred two travellers to treatment agencies in response to needs that emerged during the data generation process. The referral process was followed up telephonically to ensure that they had secured an appointment and were receiving the necessary services. I documented in Section 3.6.1 the decisions I had to take in excluding potential research participants, as their parents’ primary need at the time of sample recruitment was for a professional
helper intervention. I stated my background and the purpose of the study clearly to the participants to ensure that there was no deception.

I was aware of being a novice researcher in narrative research and therefore embarked on a pilot study, consulting frequently with my research supervisor who is experienced in the application of the narrative tradition of inquiry.

All the gatekeepers (teachers) excused themselves before the onset of the data generation process at school, which obviated any possibility that participants might have felt that they were being coerced or intimidated into providing socially appropriate responses (Coffey & Atkinson, cited in Myers et al. (2008:18), 1996). After securing the participation of one practitioner navigator in each organisation through the purposive sampling method, I employed a snowball sampling method to ensure that the practitioner navigators’ participation was voluntary and not in response to an instruction from the management in their organisation (who acted as gatekeepers).

- **Beneficence**

This ethical principle requires of the researcher to design research in such a manner that the research participants and/or society will optimise the benefits derived from the research. The envisaged outcome of the study was the establishment of guidelines for culturally sensitive drug prevention interventions that would benefit practitioners and adolescents as a whole. Several of the participants (travellers and practitioner navigators) illustrated the transformative value of participating in the research (Gilbert, 2002:224; Morgan, 2000:9) (refer to Section 3.7 of this chapter).

- **Justice**

This principle requires of researchers to ensure that: “those who stand to benefit from the research should bear the burdens of the research and vice versa” (Terre Blanche et al., 2006:68). Clandinin and Connely (2000) also caution that we need to be thoughtful of our research participants and the fact that people are sustained by their stories. An ethical researcher will therefore assume responsibility for the interpretation of the data.
and admit the existence of alternative interpretations, if necessary, and will show respect for the narrator, even when they do not agree with the dominant views.

The data generation was conducted at a time and in a venue that was most convenient to the participants. The data generation was also conducted in the participants’ preferred language (Afrikaans or English). Translation is particularly problematic in narrative research, as both the transcription and translation are not merely technical (Riessman, 2008:42). It was for this reason that the narrative was retained in the language in which it was generated.

3.12 CHAPTER SUMMARY

The first section of the methodology chapter introduced a reflection on the social self as a critical starting point in the qualitative research process. A detailed description of the research question, goal and objectives followed. The discussion illuminated the overarching paradigm in which the study was located as social constructivism. The synergy with my ontology, epistemology and subsequent methodological considerations was illustrated, followed by supporting evidence for the selection of the narrative tradition of inquiry as the most appropriate research design. The chapter provided a detailed description of the four different sample groups (of travellers, observers, peer and practitioner navigators) that were drawn from the geographically delineated population, i.e. the Northern Areas of Port Elizabeth.

A non-probability sampling method was selected to recruit all four the participant groups, followed by snowball sampling methods to recruit additional adolescent travellers and practitioner navigators. The chapter detailed the challenges encountered with gaining entry to the community and the subsequent changes in the method of data generation. The chapter detailed the three different methods of data generation, i.e. biographical narrative interviews with the travellers, written narratives by the observers, and focus group interviews with the peer and practitioner navigators. The two different methods of data analysis were described, i.e. categorical content and form analysis, followed by a socio-cultural approach to narrative analysis to contextualise the data. The researcher’s reflections on the research process sets the stage for the description
of the four characteristics against which the quality of the data and the research process was evaluated. These characteristics include sensitivity to context, commitment and rigour, transparency and coherence and, lastly, impact and importance. The last section of the chapter detailed the ethical considerations that guided the research process.

The ensuing chapter is a presentation of the travellers’ journey of drug use, non-use and drug prevention.
CHAPTER FOUR

PRESENTATION OF NARRATIVES FROM TRAVELLERS' JOURNEYS OF DRUG USE, NON-USE AND DRUG PREVENTION

4.1 INTRODUCTION

The previous Chapter encompassed the research design and methodology that guided this research study. The overarching research question that framed the study was: What is the socio-cultural construction of drug use, non-use and drug prevention amongst adolescents from the Northern Area communities of Port Elizabeth? The concern about adolescent drug use, and therefore the rationale for this study, was described comprehensively in Chapter One of this thesis. The SACENDU Report of 2012, reflecting statistics from 2008-2011 on the treatment of recipients under the age of 20 years in the Port Elizabeth area, highlights (in Table 4.1 below) that those under the age of 20 years were predominantly from the ‘Coloured’ race group (Dada et al., 2012:44).

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>African</td>
<td>21</td>
<td>30</td>
<td>17</td>
<td>17</td>
<td>18</td>
<td>23</td>
<td>29</td>
</tr>
<tr>
<td>Asian</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Coloured</td>
<td>37</td>
<td>52</td>
<td>66</td>
<td>65</td>
<td>34</td>
<td>44</td>
<td>70</td>
</tr>
<tr>
<td>White</td>
<td>13</td>
<td>18</td>
<td>19</td>
<td>19</td>
<td>21</td>
<td>27</td>
<td>19</td>
</tr>
<tr>
<td>TOTAL</td>
<td>61</td>
<td>100</td>
<td>71</td>
<td>100</td>
<td>104</td>
<td>100</td>
<td>78</td>
</tr>
</tbody>
</table>

TABLE 4.1: Race of patients younger than 20 years (Port Elizabeth)

Whilst a direct inference cannot be necessarily drawn that drug use is more prominent amongst people who describe themselves as ‘Coloured’, it does suggest that there is a steady request for drug treatment and intervention from this group. The statistics furthermore reveal that dagga is the primary drug of choice, followed by methamphetamine, which is rapidly increasing in popularity amongst adolescents in the Port Elizabeth area (Dada et al., 2012:44). These two drugs are both amongst the more
affordable drugs and therefore easily obtainable in low socio-economic neighbourhoods, complicating the efforts of drug prevention practitioners and interventions. The addictive potential of methamphetamine has been well documented (Erdmann, 2006:2; National Institute on Drug Abuse (NIDA), 2003), and its devastating consequences for the user and their significant others have been observed in practice and authenticated in interviews with a variety of community stakeholders (Stanley, 2012; FAD Support Group Meeting, 2012). The plight of these community stakeholders highlights the urgency for effective primary drug prevention interventions, i.e. those interventions that reduce the onset of use in the first place.

Numerous (varying) explanations exist as to why people use drugs (discussed comprehensively in Chapter Two). However, the different theorists agree that the onset of drug use is usually as a result of a combination of multisystemic risk factors, juxtaposed against the absence of protective factors required at the particular developmental and contextual levels (Kliewer & Murrelle, 2007:449; Liddle & Rowe, 2006; Kuntsche, Knibbe, Gmel & Engels, 2005:843; Flisher, Parry, Evans, Muller & Lombard, 2003:57). Similarly, different factors serve as a turning point for people to initiate abstinence from drug use (Goodman, Peterson-Badali & Henderson, 2011; McIntosh & McKeganey, 2000); likewise, a combination of factors maintain their continued use of drugs (Patrick et al., 2010:457; Hughes, 2009 in Miller & Plant, 2010:56; Buchanan, 2004:136).

The overall goal of the present study was to enhance understanding of the socio-cultural meaning attributed to cultural identity; drug use; non-use; and drug prevention in the Northern Areas community, towards developing guidelines for drug prevention interventions that are culturally sensitive and contextually relevant. In order to achieve the goal of the study, data was generated from four different sample groups, viz. ten adolescent drug users, 29 adolescent non-drug users, nine social service practitioners (i.e. social workers and social auxiliary workers) and ten TADA peer mentors. The focus of the present chapter is on the narratives of the adolescent drug users. The sample of participants was recruited with the aid of six different gatekeepers (i.e. professional and lay counsellors, and a Life Orientation teacher) who by virtue of their respective roles knew several potential research participants whom they either counselled for drug
related problems or referred for behavioural interventions. The procedure of meeting with the gatekeepers and coaching them on how to recruit the prospective participants in an ethically appropriate manner, guarding against coercion and creating expectations of potential benefits to be derived from the study, was detailed in Chapter Two. The difficult experience of balancing the researcher and professional helper roles (Hallowell et al., 2005:59; De Laine, 2000:135) and the ultimate ethical decision to exclude some of the potential research participants from the study in favour of activating my professional helper role were documented in Chapter Two. In meetings with the gatekeepers, I emphasised the importance of the potential participants' understanding and meeting the sampling criteria, as detailed in Chapters One and Two of this thesis.

I made personal contact with the participants and their parents only after receiving confirmation from the gatekeepers that the prospective participants were receptive to participating in the research. In keeping with the recommendations from the NMMU Human Research Ethics Committee (REC-H minutes, December 2010, Ref. H10-HEA-SDP-008), all the parents and/or guardians of the adolescent participants were approached for consent – eight of whom provided written consent, and two of whom provided verbal consent, as they were not physically present to sign the consent forms at the time of data collection. A total of ten adolescent drug users were recruited by means of non-probability purposive sampling.

This chapter takes the format of a narration of the participants' stories, without the interruption of a literature control, to ensure that their voices receive prominence. Their voices are presented primarily as verbatim accounts, accounting for the incorrect use of grammar and frequent mixing of Afrikaans and English vocabulary. The decision not to translate the participants' verbatim accounts was also informed by the decision to uphold their natural narrative (Wicomb, 2012), as translation could result in their intended meaning getting lost. The verbatim accounts are therefore presented to highlight the salient themes, as induced from the participants' narratives (Smokowski et al., 2000).
The scope of drug prevention is informed by the category and degree of drug use. This point was illustrated in the comprehensive literature review of theoretical approaches to drug prevention in Chapter Two.

Whilst the intended outcome of the present study is located in the arena of primary prevention or universal prevention (reducing and delaying the onset of first use), the narratives of the adolescent drug users provide valuable insights for interventions at both secondary and tertiary prevention levels. Excluding these insights would result in a compartmentalisation of the different levels of drug prevention, which would detract from the comprehensive drug prevention approach that has been advocated by experts in the field (Medina-Mora, 2005; Loxley et al., 2003; National Institute on Drug Abuse (NIDA), 2003).

Considering the length and the depth of the stories that were shared, it would be impossible to present the full biographies, given the space limitations in the thesis and the focus of the study. Extracts from the ten different stories are presented simultaneously, instead of as independent narratives, in order to protect the identity of the participants and to explore the similarities and differences in the meaning construction of the adolescents. Each of the ten participants (henceforth referred to as ‘travellers’) is identified by a pseudonym in order to enhance the authentic flow of the story, which also facilitates the reading process. The non-users will be called ‘observers’, as they were assumed to possess sufficient insights in the drug use journey, based on their observation of other travellers in their neighbourhoods. Their voices will receive prominence in Chapter Five. The TADA peer mentors, social workers and social auxiliary workers will be referred to as ‘peer’ and ‘practitioner navigators’ respectively, as they were in a position to redirect the course of the travellers’ journey. Their narratives will be presented in Chapter Six.

Chapter Four deals specifically with the ten travellers' biographical narratives of their lives, with particular focus on their drug use journeys. An analysis of the ten biographical narratives of the travellers identified six core themes, which will serve to structure the presentation of this Chapter. Although the presentation of the travellers' narratives is not complemented with a literature control in this Chapter, the core
categories are illuminated in bold throughout, which will enable easy referencing in Chapter Five, in which the literature control is undertaken. In keeping with the journey metaphor, the thematic labelling of the different phases in the journey is as follows:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description of the theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Venturing off on the journey with drugs</td>
</tr>
<tr>
<td></td>
<td>This theme deals with the different ways in which the participants were introduced to the use of drugs.</td>
</tr>
<tr>
<td>2</td>
<td>Accelerating on the journey</td>
</tr>
<tr>
<td>2.1</td>
<td>Travelling in the fast lane</td>
</tr>
<tr>
<td>2.2</td>
<td>Benefits derived from travelling in the fast lane</td>
</tr>
<tr>
<td>2.3</td>
<td>Risk signposts and dangers encountered in the fast lane</td>
</tr>
<tr>
<td>3</td>
<td>Reducing speed and approaching a number of exit routes</td>
</tr>
<tr>
<td></td>
<td>All the participants who were in the dependency stage reached a point where the consequences of the drug use were outweighing the benefits, resulting in a number of different considerations to reduce the harm.</td>
</tr>
<tr>
<td>4</td>
<td>Selecting an exit route</td>
</tr>
<tr>
<td>4.1</td>
<td>Speed bumps and potholes encountered on the straight and narrow exit routes</td>
</tr>
<tr>
<td>4.2</td>
<td>Benefits of travelling on the straight and narrow road</td>
</tr>
<tr>
<td>4.3</td>
<td>Navigational strategies to stay on track</td>
</tr>
<tr>
<td>5</td>
<td>Recommended road map to avoid entering the fast lane</td>
</tr>
<tr>
<td>6</td>
<td>Ethnic identity as marker on the journey</td>
</tr>
<tr>
<td></td>
<td>This theme consists of the participants’ recommendations regarding how others can avoid the onset of drug use.</td>
</tr>
</tbody>
</table>

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4 I purposely chose not to pose an explicit question about ethnic identity to this particular sample group, as it was important to observe whether they utilised ethnic identity as a context for their meaning constructions pertaining to drug use and non-use. Their narrations of these landmarks are presented in Theme Six as unique road markers on the journey.
TABLE 4.2: Thematic labelling of the phases of the journey (See Appendix H for schematic depiction of the phases of the travellers’ journey)

4.2 MEETING THE TRAVELLERS

The ten travellers whose narratives will be presented in this chapter comprised six males (Gavin, Andrew, Ralton, Charles, Tyler and Waydin) and four females (Zoey, Clarissa, Liezle and Gabby). The table below provides a summative picture of the biographical profile of the travellers.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
<th>Number of travellers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronological age at the time of the study</td>
<td>16 yrs</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>17 yrs</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>18 yrs</td>
<td>4</td>
</tr>
<tr>
<td>Age at onset of drug use</td>
<td>9-10 yrs</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>12 yrs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>13-14 yrs</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>15 yrs</td>
<td>1</td>
</tr>
<tr>
<td>Stage in cycle of drug use</td>
<td>Recreational use</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Dependence</td>
<td>7</td>
</tr>
<tr>
<td>Primary drug of choice</td>
<td>Tik (combined with dagga and/or the hooka pipe as second drug of choice)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>alcohol; alternating with hooka pipe</td>
<td>1</td>
</tr>
<tr>
<td>Other drugs of choice</td>
<td>Tobacco, Mandrax, cocaine, LSD</td>
<td></td>
</tr>
<tr>
<td>School Grade at the time of the study</td>
<td>Grade 12</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Grade 10</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Grade 9</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Grade 8</td>
<td>1</td>
</tr>
<tr>
<td>Out of school at the time of the study</td>
<td>Matriculated and unemployed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Dropped out of school and unemployed</td>
<td>2</td>
</tr>
<tr>
<td>Drug related consequences experienced</td>
<td>Gang involvement</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Criminal offences</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Suspended and later expelled from school</td>
<td>6</td>
</tr>
</tbody>
</table>

TABLE 4.3: Biographical profile of travellers

5 Pseudonyms to protect the travellers’ identities
As is evident from the table above, four of the travellers were 16 years of age; two were 17 years of age; and four were 18 years old at the time of the study. Four travellers had embarked on the drug use journey between the ages of nine and ten years, confirming the research findings that the onset of drug use is occurring at an earlier age (Dada et al., 2012; Potgieter et al., 2010; National Institute on Drug Abuse (NIDA), 2003). Three travellers who began their journeys at the ages of 14 and 15 years respectively were able to take an early exit route before the journey could accelerate, contrary to those travellers who started their travels earlier, and in the process found it harder to disengage from the excitement and freedom they experienced whilst travelling in the fast lane. Inevitably, their prolonged travels in the fast lane also resulted in them encountering danger zones and risk signposts, concurring with literature that the earlier onset of drug use often results in more drug related harm and potential for addictive use at a later stage (Morojele & Brook, 2006; Botvin et al., 2001; Johnson et al., 1990). Four travellers had all received drug treatment interventions, albeit in different formats. These ranged from in-patient rehabilitation to the attendance of support group meetings.

Although the majority of travellers initiated their drug use journey with alcohol and dagga, six travellers listed methamphetamine (tik) as their primary drug of choice, coupled with dagga and the hooka pipe as the drugs they used in combination with tik. Erdmann (2006:2) emphasises the danger of tik, claiming that 10% of the people who use alcohol are prone to addiction, whilst the propensity for addiction stands at 98% for methamphetamine users. The Health Society Guide (Addictions, 2012) further claims that the danger of this drug is escalated, as younger children are generally attracted to it (mostly for its stimulatory and euphoric effects; a view supported by Perkinson (2008)), and that an increasing number of girls use it for its weight loss benefits (Amaro, Blake, Schwartz & Flinchbaugh, 2001:260). The first South African Youth Risk Behaviour Survey (Reddy et al., 2010) also highlighted the concern around alcohol and cannabis use amongst an increasingly younger group of users, especially given the consequences for cognitive functioning (Ross & Deverell, 2010:176). It is curious that the three travellers who made an early exit from the drug use journey had experimented with legal drugs (alcohol and the hooka pipe), as opposed to illegal drugs, raising questions about the association between the drug use journey and drug type.
It was admirable that two travellers who had recently taken an exit route from the fast lane of drug use were in their Matric year at the time of the study. The role of their support structures will become evident later, under themes 4.2 and 4.3. One traveller had matriculated the previous year, whilst three were in Grade 10, one in Grade 9 and one in Grade 8. Two travellers dropped out of school as a direct result of being on the drug use journey – one whilst in primary school and a second shortly after starting high school. Six travellers had been suspended and later expelled from school as a direct effect of their travel in the fast lane with drugs. However, several of them continued their schooling, at schools located in different neighbourhoods, or in different provinces (in the case of two travellers).

Five travellers had been involved in gang related activities, and three in specific criminal activities (primarily stealing the belongings or money of family members, with no criminal charges being pursued), representing some of the consequences they experienced from travelling in the fast lane of drug use.

4.3 INVITATION TO TRAVELLERS TO SHARE THEIR JOURNEY

The narration of the travellers’ stories emanated from my invitation to them to give a narrative account of their lives, with me being an observer and hence co-constructing the meaning they attached to the drug use journey. This was guided by the Life Grid (Wilson et al., 2007:144) as data collection tool, as well as the content and phrasing of the follow-up questions. After the purpose of the study and the use of the Life Grid as a data collection tool had been explained, the travellers were presented with a clean A1 sheet of paper, crayons and koki pens and invited to depict their life journey (using the themes from the Life Grid, if they preferred) by drawing, writing or narrating it orally. They were further reassured that they could use a combination of the story-telling methods. The initial responses from most of the travellers suggested discomfort and unfamiliarity with the notion of talking about themselves. Five travellers sought clarification and guidance, generally requesting that I should rather pose direct questions to guide them. Some of their initial responses to the invitation to narrate their story were as follows:
“You can ask me questions, that will be better” [Andrew]

“What shall I write about? Can I write about anything?” [Tyler]

“Yoh, don’t know where to start. School, ya, must I like just say what happened in school?” [Waydin]

“What can I actually now say now, I don’t know actually know what to say, that’s my, that’s the thing, about myself.” [Liezle]

“Will you be my guide, rather..., tell me....ok, this is where you should start and, er, this is where you want me to end off.” [Ralton]

Only one traveller quoted above had been in consultation with a helping professional before or in a formal interview context, which could account for their lack of familiarity with conversing about themselves or may be indicative of construction of engaging with adults.

One traveller, who had spent a large section of her childhood in the Child Welfare system, being attended to by different helping professionals, offered unrestricted access to her story in the following manner:

“We can speak about anything, I will be comfortable.”

Following on this blanket invitation, she spontaneously proceeded to give a detailed biography of her life, focusing mainly on the unfavourable relationship she had with her mother, juxtaposed against the value she attached to her friendships and the one adult (a nursing sister in a Child and Youth Care Centre) from whom she received unconditional validation.

Four travellers narrated their stories spontaneously, requiring no further prompting other than the standard invitation provided to all the travellers, detailed earlier in the Chapter.

They started their stories off as follows:

“Ek kan nou nie so lank onthou nie, maar ek kan darem hier by nege en agt jaar oud onthou” [Gavin]

“Op skool, op skool, was ek ‘n baie teruggetrokke meisie.”[Zoey]
"I am Charles, I am a person who likes to play sport, be with my friends." [Charles]

"I am Clarissa, I was born in Port Elizabeth, I was born to the parents of [name of mother] and [name of father]." [Clarissa]

Four travellers narrated their stories in chronological order, starting from early childhood and ending off with their current life stage. The other six travellers varied in how they narrated their stories; four of these travellers focused on particular themes in their stories (i.e. school and family issues respectively). Despite the different approaches in how they told their stories, the dominant chapter in the majority of the ten stories centred on experiences with drugs, arguably because the purpose of the study was explained to them. Of particular interest is the fact that the seven travellers who had experiences of being harmfully involved with drugs, upheld a social construction of drugs being the problem, which became a dominant part of their story. The description of their experiences ranged from how their first encounter with drugs occurred, to the daily struggle to remain drug free. The three who implied that they used drugs only for recreational purposes, gave little prominence to drug use in narrating their life journey.

Each of the themes listed under heading 4.2 in this chapter is presented below, according to the verbatim narratives of the travellers. This will set the scene for the discussion of the themes and the literature verification that will be presented in Chapter Four, alongside the narratives of the sample of adolescent non-drug users, hereafter referred to as the observers on the journey.

4.4 NARRATIVE ACCOUNT OF TRAVELLERS’ JOURNEYS

4.4.1 Theme 1: Venturing off on the journey with drugs

All the travellers either volunteered or responded to an explicit question regarding the age at which they embarked on their journeys. It was important to trace the history of the journeys, as it would offer valuable information to practitioners about the recommended age to initiate drug prevention interventions. This theme would also inform the reader about the types of drugs that marked the start of the journey and the
combination of risk factors in the community, family and peer group systems that facilitated its onset.

Three travellers embarked on the journey at the tender age of nine years, starting off with the use of dagga and the hooka pipe respectively. One traveller joined the journey at the age of 12 years (smoking cigarettes); three boarded the journey between the ages of 13-14 years; and three travellers marked their departure on the journey at the age of 15 years. Their narrations around these experiences and the particular risk factors that facilitated the start of their journeys are as follows:

“Maar ek ken darem hier by nege en agt (jaar oud) wat ek begin rook het nou. Toe begin ek met n ‘daggazol’ mos nou…… Dis in die straat in hier in [name of street]… Ek het saam met hom begin rook [referring to a friend that was six years his senior], eerste daggazol toe eintjies [cigarettes] en daarvanaf het ek so opgegaan…. Dan gaan ek weg van hom af, dan gaan ek weer hier in YYY [name of street in his neighbourhood] straat toe; dan loop ek net so om die draai, dan gaan rook ek mandrax ,soos daai het ek aangegaan na Tik toe en Rocks.” [Gavin]

“I started at about eight or nine or so. I started smoking dagga then, I say for a couple of years I actually grew up smoking dagga, ..... but nine and ten, I started to smoke mandrax, but just like once now, then I don’t smoke again, cause I used to like dagga. Sometimes that was my thing that I always used to like. I used to love that. It used to calm me down, man. Coz there was a drug house opposite my house first. They, they got evicted, coz the community used to complain and all that, there I actually learnt and experienced all this stuff.” [Andrew]

“Ya, I was young when I used to smoke Hooka-pipe already, parents didn't know. I was in Grade Three. I had my first pull on a Hooka-pipe. .....Hmm, one of my friends just said – here take a puff and so I told him – no, no my bru, .....and so afterwards I took a puff, I blew out, so I did think, jooh, this is lekka this! So I smoked on, so afterwards, I just smoke the Hooka-pipe…… I started smoking cigarettes in Grade Seven; the end of Grade Seven… and alcohol.. also Grade seven, ja.”[Charles]

“Uhm, weed is like a, like in all Northern areas, weed is like a cigarette already, it's here, it's there, it's everywhere, you will like. Like in Grade Ten, I started with weed, ‘cause I started with cigarettes like the year before that so, it's weed……Ya, its like, if e, you can ask any child at any school have they, have they not tried weed before, because weed, but it's like building blocks to something stronger, to something that's gonna hook you, you build like that.”[Clarissa]

“Cigarettes, yes… The only thing I use.... and hookah pipe… here at home. I didn't drink, ya, I was smoking Hookah Pipe, ya.”[Tyler]

“Me and my mother came to stay here [referring to neighbourhood]. I was still young and I met a couple of friends. Most of the people always used to tell me ______ you must get yourself out of that group, because they are not right for you. But I didn’t listen; I just wanted to do my own thing, because they were fun also for me. And I was doing all the wrong things with them.
Walking out of the house, didn’t wanna go to school; 9 years… [giggling]… didn’t wanna go to school.” [Gabby]

“I tried alcohol before, wasn’t my first time… started at age 15.” [Liezle]

“I tried smoking cigarettes once, my eldest sister gave me a cigarette when she was drunk way back.” [Waydin]

The common factor emanating from the travellers’ stories is the fact that all, with the exception of one, were ushered onto the journey by friends (often older). Their receptiveness to join the journey was facilitated by the neighbourhood context in which drug use was normalised, exacerbated further by the easy accessibility of drugs. These neighbourhoods are characterised by high density housing and poor socio-economic circumstances. Embedded in the narratives of several travellers is the ignorance of childhood, which made their venturing onto the journey a relatively easy one. Several of the travellers also alluded to the immediate benefits they derived from embarking on the journey (this will be revisited in Theme 2.2).

Two travellers narrated how they were introduced to the journey by their peers during social outings and annual festivities. It transpired that their receptiveness to embark on the journey had been facilitated by the pressure of having a large number of peers present, and enabled by the absence of adults to supervise, the loud inducing music and the self-confidence they admired in their friends who were using tik, in particular. The travellers’ initial hesitation to accept the invitation to board the journey was overshadowed by their need to be accepted by their peers (the primary socialising agents in adolescence). It is also evident that the travellers regarded the use of illegal drugs as the actual onset of their journeys, as they held the social construction that the use of alcohol and cigarettes (and in several cases, the use of dagga) was part of normative behaviour, as illustrated in the previous category. Their statements follow below:

“Er, when I started smoking weed and stuff, I was thirteen. After, when I think I was fifteen, I was still playing soccer, when I was fifteen… I think, ya, ‘cause I played Under Fifteen, still, ya, with __ [name of soccer club]….. I can remember it was in the Easter tournament [referring to an annual soccer tournament in Port Elizabeth’], er, my first time, it was, with newspaper…… Go to rastas, went to go smoke there, I wouldn’t go to sport practice, and we, er, we swaai it in with newspaper [describing the manner in which the drug is smoked], and we were on our way
to the tournament, and I just felt high, I was laughing the whole time, it was a good feeling… starting smoking.” [Charles]

“Er, my friend, ___ [name of friend]’s father is a rasta. Er, but he lives in ___ [name of suburb] now, he sell dagga, I don’t know how did he find the dagga, but… Ya, and after that I asked him when are we gonna smoke a real one? And so ___ [name of a friend] became friends with a rasta there in ___ [name of a neighbourhood] and then with my Grade Seven farewell night…. Grade Seven farewell, er, I went down the morning, I came back the night when I was supposed to go to my farewell. I was stoned [being high on drugs] when I came here, after the, since the farewell night… Grade Seven farewell night.. that’s when I now started to become hectic on dagga.” [Charles]

“It was Ironman [annual sporting event] on the Boardwalk…. Er, I was drunk that night… And I had friends that always used to do it in front of me, but I never used to do it… I always wanted to try it, but something in my head told me not to try it, until that night on the Boardwalk…. Now I always used to look up to people like QQQ and YYY, cause they always used to get girls and things and they’re well-known people, so I also wanted to be like them, then I started smoking tik….. Er, I used Tik and dagga, and I tried Ecstasy once.” [Charles]

“My friend asked me to use it and so and then I tried it…. Last year, last year, uhm, September side October, last year, September, October, then I started using. They asked me to try it out and then I tried it…. I don’t know, he just, he’s a guy, he just asked me to, uhm, I must come with and don’t I… don’t I wanna try it out? He told me how to use it, how must I pull, to use it and all that…. I didn’t actually wanted to. We were four, it was three girls and my other friend the boy… But I don’t know was it their first time, it was my first time… It was my friend’s birthday party, but like it all happened there…. There was crowds, there was crowds, there was music playing and it was my first time. I felt like… uhm, I’m now gonna try it out and so, but first I didn’t want to, but then I tried it… Ya, and it’s how can I say, music playing and we were drinking and then, all my friends was there, and then they also tried it and then I didn’t want to be left out.” [Liezle]

“There are a couple of boys also that we are sitting with there. But in Grade 11, 10 [boys that are three years her senior]… they built like a shed behind my friend’s house. That’s now the place that we call the dungeon, where we sit in private. No adults allowed really.” [Gabby]

One traveller suggested that his primary need was for protection against being teased at school. The peers who could offer this protection, however, exerted pressure on him to embark on the journey, which, upon resistance, resulted in him being mocked by his peers, as narrated below:

“The year before that I met the wrong friends and I was hanging out with them and stuff, because they are the cool guys on the school. They also do this drugs and stuff, but I never done it with them and they always used to call me names and stuff at school and I eventually started to jump school with them and bunk… They are the cool gang and I actually wanted to be just left alone on school, ‘cause if you with them, nobody bothers you…… Smoking and stuff and I was like just standing with them smoking cigarettes, selling cigarettes…… And then they jump to go, er, smoke tik, this stuff, and I never used to go with them, then they started to call
me names and stuff, make fool of me, and I used to jump with them and go with them.” [Waydin]

The majority of the travellers seemingly longed for a closer relationship with their primary attachment figures, with only two of the ten travellers being raised by their biological parents in an intact family system. The rest grew up with their grandparents and moved between many different family members as their drug problems escalated.

It is evident that the travellers’ receptiveness to their peers’ invitation was informed by these unmet emotional attachment needs of belonging, which emanated from a physically or emotionally absent parent figure, and/or the death of significant others, as illustrated below:

“And at the age of two months, I went to live at my grandmother’s house, with my father’s mother and, er, I lived there. My mother, didn’t, I wasn’t living with my mother, just with my father and my granny them. That day that he [referring to his Great-grandfather] passed away, I think I started smoking cigarettes and throughout the year, man, I was never going to school, I burnt my CTAs at the end of the year, I was, I started smoking weed at the time, I started smoking. My father was still, you know being him, being ge-pl [referring to his father being on drugs] and stuff. And, joh, in 2000 and, 2010, ya, 2000 and beginning of, in the middle of 2009. I started using drugs, I was smoking from Standard Six already weed and cigarettes, and drinking, partying hardcore, but in 2009 I started, I started smoking drugs, using drugs, it started with, er, rocks.” [Ralton]

“But I don’t worry with my mother or my father. I grew up since I can remember 5/6 years old… No with my mother I can’t… I will never, ever, sit in a room with my mother or talk to my mother, hold a conversation… With my daddy also…” [Andrew]

“I had to change my attitude, my, myself to adjust to my surroundings, I had to, you know, you can’t be quiet anymore, you have to be that person that can defend yourself. Yes, how because to, I was actually, in the beginning I was against drugs, when I found out my cousin is a drug user, I actually, we had a big argument, and I told her don’t do drugs, and it’s bad for you and all these things, and it’s that people that said I will never do drugs, cause I was against it. I hated the sight that she was doing it. Then I started doing it, and to me it was like never is not the word that’s supposed to be said, because when you say never, it happens.” [Clarissa]

Clarissa’s narrative reflects how she became more receptive to embarking on the drug use journey following the death of a sibling and the subsequent change in living conditions and school placement. Similarly, Zoey’s narrative (that follows) highlights how embarking on the drug use journey became an adaptive response in a blended family context marked by a physically absent father, an emotionally unavailable single
mother (who worked long hours to provide in her children’s material needs), and older step-siblings who were fending for themselves:

“Ek het so omdat ek alleen gewees het, omdat ek nooit... ek het nie grootgeraak met n pa nie; maar ek ken my pa, ek weet wie hy is, en ek het nooit voltyds my ma gesien nie. En ek het, omdat ek so baie alleen gewees het, was ek lief om my eie ding te doen. Ek was in Graad 8 dan gaan ek met die intention skool toe. Kom ek by die hekke, dan change alles net vir my. Nou ek het sigarettes gerook, ek het begin met n sigaret. Begin met n sigaret, dit was nie genoeg vir my nie. Toe end ek op met marijuana, met dagga.... Ek het alleen, dan gaan sit ek in die bossies, dan rook ek alleen zolle, dan begin ek te rook. Ja, begin alleen rook. Want ek wil nie 'n vriend gehad het nie, ek was nie een vir vriende nie, want ek was altyd bang n vriend gaan altyd my wil piemp, of sovoorts. [scared that friends would tell on her].” [Zoey]

Zoey’s narrative illustrates how she initiated the journey on her own, motivated by the need for emotional connection. Her introverted nature and lack of trust in people, however, resulted in her starting the journey on her own. The narratives of the travellers pointed to a number of other personal correlates that enhanced their vulnerability to accepting the invitation to board the journey. These included sensation seeking and a low self-esteem (implicit in Charles’ narrative), and experiencing an ongoing sense of failure and a tolerance for deviance (as narrated by Tyler), as is evident from the narrations below:

“Op skool, op skool ek was ‘n...vir my... ek was ‘n baie teruggetrokke meisie, toe ek hoërskool reach. Dit was 16. Ek was ‘n baie teruggetrokke meisie, wil nie nog rerig met mense gemeng het nie.” [Zoey]

[Laughter] “Like we were naughty with er, er, girls in primary school, that time already. Primary school, me and my friends... when it was beach walk, we wouldn’t bunk school, but maybe if it’s now beach walk, then we all go to my friend’s house or something, the whole class, like all the girls and all the boys, then we go sit there. And just party [laughter] all day. Hmm... with girls and that stuff.” [Charles]

“They like to... they take boys that like don’t have “heads”.... They will do anything just to be popular. Everything is just about being popular: you want people to see you, want people to notice you. It’s just for people – you are doing everything for people.” [Charles]

“The Ma’am said I’m naughty, but I’m not rude.” [Tyler]

Several of the travellers also alluded to drug use in their biological families, implying the possibility that a genetic predisposition or observational learning enhanced their receptiveness to embarking on the journey, as illustrated by the quotations below:
“My father was a guartjie [money collector and door operator on a taxi] and he, he used to steal like and he also used drugs, like he smoked mandrax and weed. He was very just into like drugs and stuff.” [Ralton]

“Ek het geglo in die rastas [Rastafarian religion]. My pa is ’n rasta. [Zoey]

“Ya, he [referring to his biological father] was also naughty and stuff. But he stopped [using drugs] now. He told me that he did stop. He was also naughty like me.” [Charles]

The common factors emanating from the travellers’ stories are the fact that all, with the exception of one, started their journeys in response to invitations by their peers. Their neighbourhood context, marked by easy access to drugs; physically and emotionally unavailable parents; significant losses in the family; and in some instances a genetic predisposition due to parental drug use, juxtaposed against the powerful influence of peers as primary socialisation agents in adolescence.

The citations above clearly illustrate that the travellers initially associated drug use with the bonding and sense of belonging and fun that their friendship with their peer groups offered, rather than with the effects of the drugs itself. Ironically, most of the travellers accepted drug offers from their peers without any knowledge of the peers’ prior drug experiences, as illustrated by the narrations of two of the travellers:

“I don’t know, did they smoke for their first time, but I know it was my first time…

It was my first time – I don’t know about them…. ” [Lieze]

The next theme illustrates how the travellers accelerated on their journey. For some, it was a steady increase in speed, whilst others moved at a rapid pace, with the journey characterised by the numerous bumps on the road through when they inflicted harm on themselves and their significant others. As the narrations are read, it becomes evident that the factors that served as the initial attraction to the onset of the drug use journey now had a substitute meaning and that the continuation on this journey was enforced by a different meaning and altered function.
4.4.2 THEME 2: ACCELERATING ON THE JOURNEY

The travellers’ narratives reflected an exacerbation of the earlier cited risk factors, as well as a range of additional risks, as contributing to their acceleration into the fast lane. The important difference to be noted in this theme is that what the travellers constructed as the fuel accelerating them on their journey, often appeared to be their significant others’ responses to them being on the journey. These factors are discussed under the sub-theme travelling in the fast lane. The next sub-theme deals with the travellers’ reflection on the benefits they derived from travelling in the fast lane; followed by the final sub-theme, which constitutes the negative experiences they encountered as a result of travelling in the fast lane. The sequence of the categories under the sub-themes reflects the degree of consensus amongst the travellers.

4.4.2.1 SUB-THEME 2.1: TRAVELLING IN THE FAST LANE

The dominant voice pertains to what the travellers perceived as non-conducive family relationships, which ranged from feeling unloved and unwanted (lacking a sense of belonging) in the family system, family relationship challenges, loss of significant family members, to drug-using parents and family members. Their narrations suggest that this emotional disconnection with their families contributed to them taking the fast lane, with its sharp bends and high danger zones.

The travellers relayed feeling unloved and unwanted at home as follows:

“Hier het ek nie ‘n lewe gehad nie, soos ek kom in in die aande, dan word ek sommer uitgesit, dan moet ek hier agterin die jaart in slaap met die honde, soos daai.” [Gavin]

“Coz… they’re not like family, man, I won’t call them family. They’re just like, they won’t phone or think of you, my father is also so. But I don’t worry with my mother or my father.” [Andrew]

“But, like I was saying he [maternal uncle] just didn’t want me to be here [referring to her mother’s home]. He said it’s for my own good, and I asked him if I’m not gonna get my freedom, how am I gonna be a teenager. Then I am just gonna be with people being called children. I was speaking to him about that and crying and he said I mustn’t cry. Then I said, no man, if you don’t want me here, neh, then take me to my father, I want to meet my father.” [Gabby]
“That took me back to where I was like, oh, I was a mistake or something… she [referring to her mother] didn’t want me and all these things. I actually don’t see my mother as a mother, uhm, ya, and as the things were going on, it was just getting worse… I will, never, ever sit in a room with my mother or talk to my mother, hold a conversation.” [Clarissa]

“Because you don’t get attention from your house. It leads you to seek happiness other places, that’s when you become the class clown, so I’ve become the class clown in my time. Yet I see people laugh and smile whenever they see me, so that also kind of a bit of helped me.” [Ralton]

“Ya, my mother wasn’t there when I scored my first goal, my mother was on the field, but so she had to go look for that man [referring to his stepfather].” [Charles]

Each of these narrations depicts the traveller’s expression of being either detached or distanced from a primary attachment figure and family of origin, which evoked feelings of unwantedness and rejection.

Many of the travellers reportedly experienced **conflictual family relationships**, which precipitated or resulted in communication difficulties with their parents, further enhancing their attraction to the freedom offered by travelling in the fast lane with their peers, as is evident from the verbatim extracts below:

“Now, I am at home, what am I doing at home? I told myself the way I feel…. I feel like going back to ______ [the Children’s home] really. That’s what I told my mother and she said, ya, I can go. My mother always likes to shout me… also which makes me cross also, and I don’t care – I just, when my mother start shouting, I come out by this gate and I go up to my friend.” [Gabby]

“Die wrywing in die huis in. Ons is nie soos ‘n, ons het nie ‘n famieliebond nie.” [Zoey]

“Me and my step-father don’t get along very well… when was it, er, Thursday, when we had an argument, so he smacked me, and so, I got angry and I left the house… I think my step-father don’t care about me. The morning I had more stress, I was making peace signs, my grandfather said I’m making gangster signs; he embarrassed me in front of the whole school here. Ya, everyone was here, he was shouting, and I was already in a bad mood. I was cooling off that time, man; like in, forgetting about the problems… afterwards, he went on [grandfather continued shouting], so I told the G’s, ahoy, make me nice [requested drugs from a friend].” [Charles]

“Ja, an escape you, just, like just a route out away and even today, most of the time, I don’t find myself at home, because I can’t, I still feel traumatised, because things got so hectic between my parents that they actually physically abused each other in front of my eyes…. Yes, and you know, I actually broke down one day. I told them, you know, what huh, the reason that I want to smoke is because I have to look at you all the time…… Looking at you makes me want to smoke.” [Clarissa]
“Toe is dit nou weer ek en my ma se broer wat so stry, hy rook nou pille [uncle smoking Mandrax] – hy is hier in die yard [uncle shares a living space with them]. Dan stry ek en hy altyd so; dan sê ek vir my ma: ek gaan nie hier bly nie [threatening to leave home because of him and uncle’s conflicting relationship].” [Gavin]

The narratives below depict how the travellers experienced communication challenges in the family:

“And I was also speaking to him telling him that there is no understanding between me and my mother. When I tell my mother this; she’s gonna tell me that. Okay, I understand she’s my mother, I must listen to her, but as my mother want me to listen to her, but how she don’t wanna listen to me.” [Clarissa]

“Ja, after, that we just greet each other, hello, and don’t speak. The only time he can speak to me, is when he’s drunk, that’s the only time that he speak to me… can’t speak to me when he’s sober.” [Charles]

The third dominant factor that enhanced the travellers’ risk for peer influences and subsequent receptiveness to venture on the journey appears to be scholastic difficulties, which either emanated from school resistance/refusal or were the result thereof. Two travellers who both claimed to have taken an early exit route from the journey, narrated life stories characterised by schooling challenges from an early age. It transpired that these experiences contributed to others’ assumptions that they were journeying in the fast lane. Extractions from their stories to this effect are presented below:

“I never used to like crèche. I always used to cry when they took me. Actually, I used to run back to the car when my grandfather dropped me in the mornings. Then I used to run back to the car. And when we come back home, he used to find out here I am in the car. I was very naughty, on primary school, got suspended also a couple of times. The Ma’am said I’m naughty but I’m not rude. So it was something good. I was suspended in Grade 5, 6 and 7……It was friends, swearing, fighting. I fought in Grade 6, yes, uhm, uhm, and in Grade 7, I never went to school. I just decided to stay at home with my friends. So they caught me that day.” [Tyler]

“It is hard to understand the teachers and sirs. They don’t explain the same. I ask for help, but I never ask teachers for help, I always ask my peers around me. Some of the teachers don’t take note, like we’re there to just give you work and write down, like come here to get paid, this is my job – that’s their attitude.” [Tyler]

“I hate school….But the teachers still labeled me as ‘that boy’. Now whenever I tried to do something, when I do something right, it’s not a problem. Anything wrong then they phone my mother….. And they still don’t like me. There’s a teacher, she don’t even talk to me, she said I
can’t come into her class for the whole year and I don’t know for what… Yes, because of last year stuff.” [Waydin]

The narrations of these two travellers reflect the negative school related experiences they had on their journeys, ranging from a general resistance to the structure and formality associated with schools, difficulties in understanding the teachers’ explanations of the work, and negative attitudes from teachers stemming from the prior behavioural problems of the travellers. Several other travellers acknowledged that the school-related problems they encountered emanated from travelling at an increased speed in the fast lane. These will be presented under Theme 2.3.

A few travellers had experienced the (multiple) loss of loved ones, the effect of which was exacerbated by grieving adult attachment figures becoming less available. The lack of acknowledgement of the significance of the loss for the travellers contributed to the emotional abandonment that they experienced and their subsequent acceleration in the fast lane, as illustrated below:

“I’ve never really spoken to anybody about this, but the day when my grandfather died, I started to lose focus on everything. So I think the reason for me being disruptive in school is because of that matter. He was the only person that would help me with my school. He was actually the only one in the house that knew stuff that I did in school. He will offer me, but if I had to ask him, he wouldn’t have a problem with it. He used to take me to soccer practice, also. And people always thought it was drugs and they were wrong. Yes, I do sit with friends that do these things, and I learn a lot from them, because drugs ain’t a nice thing.” [Tyler]

“I thought I just lost my mother then… Where is she going to? (referring to his aunt emigrating) Why isn’t she staying then? I started high school at the time, so I was like very emotional about it, my aunty going away.” [Ralton]

“Uhm, like I said, time went on. I started using drugs; she [his girlfriend] went away. For someone, another person to go away like that from me… every time I get close to someone, they go away. I thought it was me, at first. So the drug, I started throughout the year, it started off slowly, slowly, slowly. I was a full-blown addict before I knew it, but I never knew it at the time and so I was still, when you start using drugs, you are first in denial, you will never, you will say, no, I’m not addicted, and you will go on.” [Ralton]

There was consensus amongst the travellers that the lack of recreational facilities and activities in their neighbourhoods and subsequent boredom served as a significant risk factor, especially since it was completely contradictory to the fun and
excitement they experienced when travelling in the fast lane, as described by one traveller:

“To keep me busy and also keep me not bored, I was starting to get like bored, sitting on my own and stuff. And the thing is, I get quickly bored there in _______ (name of neighbourhood)..... I can’t sit whole day in the house, I don’t have friends there... All the people, all my friends, are at the bottom of _______ [name of neighbourhood where he grew up and ventured onto the journey]. I don’t have friends in _______ [name of neighbourhood he relocated to with his mother].” [Charles]

The one traveller who was involved in a club sport also lost interest and quit the sport when his family stopped supporting him during matches, seemingly also as a result of financial difficulties, as is evident from his narration below:

“I just left. No-one was interested in soccer anymore in the house, so I left also. Didn’t have transport also.” [Tyler]

Closely associated with the lack of recreational activities in the Northern Areas was the travellers’ tendency to structure their social activities around the use of drugs, purely out of habit and also for the benefits that they derived from travelling in the fast lane, as will be illustrated under Theme 2.2. It appeared that the perceived secrecy surrounding this habit-forming activity further reinforced its continuation, as cited below:

“Ek het nou rêrig nie geweet nie... maar daai tyd was dit, like, hoe ken ek sê..... ons kom net uit die skool uit, dan sé ons op die skool vir mekaar “hey, dis huistoetyd ons gaan nou lekker gaan daggazolle rook, dit was al like ’n gewoonte vir ons gewees.” [Gavin]

“Then I stopped again, and then I smoked again. But no-one ever used to know it was just me and my friends like sit together and stand on corners looking for money and stuff.” [Andrew]

“Like one day also, I told them guys, come, we go a bit to the swimming pool, we leave this hookah pipe, we go swim a bit. They said No, Gabby, ’we take the hookah pipe with’; I said, No man, leave the hookah pipe’. They said, ’No Gabby, no, otherwise we not going and we use this money for the hookah pipe’. Then I said No, I’m not gonna smoke, and I came home. Me and my other friend, then we went to the swimming pool; then we came back the children was just laying there at the back in the shed.” [Gabby]

Whilst Gabby’s narration is a good illustration of how she successfully reduced her speed in the fast lane and tried to steer her friends towards an exit route, their resistance illustrates how the perceived benefits of being on the journey resulted in the avoidance of available exit routes, even when pointed out by co-travellers.
Several travellers presented the lack of clear boundaries and the absence of adult supervision as risk signposts in the fast lane. Ironically, this also prevailed at a Child and Youth Care facility to which one traveller had been removed at a young age, due to her mother’s inability to control her behavioural difficulties. Their narrations follow below:

“And, I like also got out of hand, because that place is like, you can almost say it’s like your own house. You can leave when you want to; children also back-chat teachers. And do their own thing; Children are drinking there, and I was once also with a group of friends of mine. They came, I came home without the teachers even knowing I came home. I went back, and then my friends went the night out.” [Gabby]

“Like, I would go late at night out, at the age of, like a very young age, ten, nine, then I would be out with friends, but not bad friends at the time, but that’s where it like, like going out and sleeping out. I used to like doing that. “[Ralton]

“Ja, I was always stopping this [referring to parents’ arguments] and this but they just didn’t come up to the point where they wanted to separate. So I just and at times that I feel I must be, that I’m not being the child…that I’m feeling that I’m the parent.” [Clarissa]

“Yoh, his mother’s like, that, she don’t worry. They just there…. she give them food and stuff. She’s not like my mother. Like six o-clock I must come in, and that isn’t nice that, but it’s safer also for me, cause I also don’t trust ______ [name of neighbourhood. “[Waydin]

One traveller implied that the instability brought about by moving between two cities and different neighbourhoods in a city (and subsequently having different caregivers), enhanced her vulnerability to engage in drug use as a coping mechanism. She experienced the moves as particularly stressful, as the standard of education and living was very different in the two cities.

“Ja, I was repeatedly moving up and I started at _______ High [school located in Northern Areas of Port Elizabeth], which to me was a big change from being at a Model C primary school to going to a public school.”[Clarissa]

“In ____ [name of the city she moved to] cause my mother stays at her sister's house, and it’s like seven, eight people in one house, and to me that was a big change [as she was used to living in a big house that she shared with her father only].”[Clarissa]

It is evident from the narratives above that the travellers’ journey in the fast lane were fuelled by factors that were very similar to the ones that facilitated their departure on the
journey. The next sub-theme deals with the benefits that the travellers derived from travelling in the fast lane.

4.4.2.2 SUB-THEME 2.2: BENEFITS DERIVED FROM TRAVELLING IN FAST LANE

The primary attraction to travelling in the fast lane related to the perceived benefits derived from the social interaction with fellow travellers on the journey. An additional benefit was the central nervous system effects that the particular drug induced, ranging from the stimulatory effects of euphoria, heightened energy levels, confidence produced by methamphetamine, and the perceived calming effect produced by dagga. The perceived benefits as reported by the travellers are presented in sequence, from the most significant benefits reported first, followed by the secondary benefits. One traveller summarised the total benefits of being on the journey in one line:

“Being on drugs is the best feeling ever.” [Andrew]

Another, who took an early exit route from the fast lane, but remained an active observer during his peers’ journeys, recited their responses to his question about the benefits of drug use as follows:

“I ask them what is so nice about the drug? So they say, no, it’s the feeling.” [Tyler]

A common denominator from these two narrations is the feeling that is produced by being on the journey, the detail of which will become clearer as this sub-theme evolves.

The primary benefit of drug use, as reported above, related to the expansion of the travellers’ social connections, as depicted below:

“And I started smoking, and I got to know lots of people and I just felt everyone is good around me. Ja, and most of my friends, I have friends, friends, I had friends on top here. All of them used to smoke… And they were a gang also, they used to hang out with gangsters, and I was also part of the gang, I also felt cool.” [Charles]
One traveller described the **loyalty** he experienced from and reciprocated towards his **fellow travellers** as follows:

“And you can, you can easily get [drugs] and use it again, maybe if you don’t have money [wait first neh], maybe if you don’t have money and so and your friend has money and then you’re just maybe standing in front by your house, your friend come pass, maybe uhm, don’t you maybe have money, het jy nie half way haa nie, they say mos a half way [reaching out to friend for supply of drugs]. Coz I was always like friendly to my friends, man, I always used to look out for them. I used to do stuff for them.” [Andrew]

One traveller described as follows how the **presence of music** added to the **relaxing atmosphere** that prevailed at these social gatherings, further enhancing the perceived benefits:

“I am sitting with my friends, just taking time over and sitting, smoking, listening to music.” [Gabby]

The power of music was also illustrated in the preceding theme, with high energy and loud music serving to incite their receptiveness to venturing on the journey.

What is particularly significant, is the degree of **goal-directed planning** (with the view of deriving immediate gratification of needs) that informed the travellers’ social engagements activities from which they seemed to derive an **implicit sense of purpose**, as portrayed below:

“My role was just to get dagga friends, maybe if someone come and buy a half, then I must take the money then I give the money to the, the person inside and the person inside would tell them where’s the skuif [referring to dagga] or something, then I just run to go get the skuif, then I give the skuif to him, then that person walks away.” [Charles]

The travellers also reported on the **benefits of acquiring status power they earned from travelling on this journey.** This status both emerged either in a **formal gang affiliation** or an **informal circle of drug-using peers.** Several travellers appeared euphoric upon recalling the power they derived from socialising with (older) friends in the fast lane. A sense of **self-importance** was also enhanced by the **amount of attention they received** from their older peers. Their narrations to this effect were as follows:
“I was always matured, ‘coz I used to walk with like boys, they are men now, they are like 30-35. And I was 11/12, and I used to walk with them, smoke dagga with them, or smoke buttons [mandrax]. They would maybe ask me if I wanna pull a skuif.” [Andrew]

“Gaan sommer hoog skool toe, hoog van die Tik, dan kom ek daar en niemand gaan my sê wat om te doen nie. Die klas is myne, soos daai, die juffrou gaan my ook nie sê wat om te doen nie. Niemand kan my keer nie.” [Gavin]

One traveller (Waydin) remarked on the protection he enjoyed from his peers against the taunting and emotional bullying by fellow learners.

Most travellers referred to the increase in confidence that emanated from being on the journey (especially with stimulants like methamphetamine serving as fuel). Their narrations also suggested that they felt in control, to such an extent that they believed that their adult caregivers were oblivious to them having ventured on the journey. Below is a selection of extracts from their stories:

“I could ...get myself out of any situation.... Get girls, confident, and get money...anything just to succeed; ....I don’t know how I did it, it’s like, maybe there’s days that we would catch on nonsense, like we would steal and stuff, then we still get away with it... We wouldn’t come in trouble... What’s different is, the time that I used to, I was on it [referring to the time he was using drugs], people never know I was on it.” [Andrew]

“When I was tikking, ja, when, because of the positive outlook it gives you on life, you can go to any random person and have the best conversation of your life.... And to me, it... that like when I was high at times made me open, like, I had that openness to just go to my mother and tell her, look here, I can’t do this anymore...... Yes, it gave me that confidence, that boost that I needed to just open up to them..... And that, I actually think that was supposed to be like that, so I can open up, like just let it out.” [Clarissa]

Some travellers believed that their travelling on the journey contributed to them being faster and smarter. They narrated their perceptions about having enhanced performance and being more focused, as follows:

“I used to be a runner (long-distance athlete), I got like four or five medals, that’s when I used to like smoke a lot of dagga.” [Andrew]

“I used to like smoke about R50 every day. So when I like, when I smoke, go into my, not into my own thoughts, but it takes me away from there, because you think deeper then, if you think about something, you think very deep on it, and you won’t dwell off to other things.” [Ralton]
It is evident from these narrations that the increased confidence and perceived enhanced performance contributed to a sense of competence and mastery in the travellers.

The third most important meaning that journeying in the fast lane had for the travellers was a sense of carefreeness. They cited the stress-relieving properties as ranging from the calming effects produced by the use of depressants and/or the euphoria produced by stimulants, as reported below:

“Like, I would be all stressed out, then I smoke to relax, man, and it takes all my stress away. Honestly….. relaxes me. For everything that is gone in my life, neh. And for what mistakes I made… I just feel like that [dagga smoking] is soothing for me, man.” [Ralton]

“Because when I'm, when I'm high, then I won't realize all this pain that they have put me through in this past few years and stuff. And I went there and it felt, it just, when I was drugging, it felt as if I didn't have any problems….. I was problem-free…. You just, you happy-go-lucky and everybody you see is your friend and….. To me, that was what I was seeking.” [Clarissa]

“It takes all my problems away, I, like when I'm feeling now hurt or something, when I feel people don’t care about me anymore, I will also think why am I living. Like some days, I just feel like I don’t wanna live anymore, and then I just go smoke, then all that problems will go away.”

4.4.2.3 SUB-THEME 2.3: RISK SIGNPOSTS AND DANGERS ENCOUNTERED IN THE FAST LANE

Each of the travellers’ individual stories as well as their collective story emphasised the numerous risks and dangers they encountered on the journey. The detail in which the latter was presented, appears to overshadow the benefits explicated above. Each of the consequences will now be discussed in turn, with the number of quotes depicting the degree of consensus amongst the travellers. The structure of this theme depicts the sequence in which the impact of the travellers’ drug use became apparent.

Most travellers reported on the impact their drug use journey had on their scholastic performance. As indicated earlier, it appeared that scholastic challenges were precipitating factors that contributed to an inferior view of self for many of the travelers. Ironically, their drug use resulted in a self-fulfilling prophecy of non-achievement and
lack of competence. They reported on the consequences of their drug journey at scholastic level as follows:

“So I failed, failed Grade 6.” [Tyler]

“I’m supposed to be in Grade 10, but I’m sitting in Grade 8. Because I went after my addiction and cravings.” [Andrew]

“Grade Nine is getting boring… I failed one year – it feels like three years that I failed, doing the same work. I wanna make finish with Grade Nine.” [Waydin]

“Joh, then, I failed, I failed Grade Nine by the way. That’s when I failed. 2010 came, joh, that was a hectic year. I failed Grade Eleven, cause I didn’t write Accounting, so I wasn’t getting Grade Eleven now in that year, which was last year.” [Ralton]

Their non-performance at scholastic level was closely linked to their regular attendance, which was reported as follows:

“En ek het nie skool toe gegaan nie. Ek het begin nie meer worry van skool nie, maar ek het altyd as ek uit die huis uit gaan en dis skool, dan het ek gemaak asof skool toe gaan.” [Zoey]

“Cause I wasn’t really, I was bunking school and so and not being in school… No, we go to the place, then we smoke, then I ma stay ’til school come out, and so then go back home, but my parents don’t even know about it and so, and my teacher phoned and tell her do my mother know about me not coming to school.” [Liezel]

Two travellers’ caregivers moved them to different schools where drugs were perceived to be not as readily available, whilst some of the others changed schools after being disciplined for behavioural problems. The initiatives to steer the travellers in a different direction from the fast lane towards an exit route become evident from the narratives that follow:

“Coz, at my school, boys used to just come up to me and give me money…at that school it was like a coloured private school, first it was for Whites, then it became for Coloureds, then my ma put me there. She thought maybe I was gonna be better off there.” [Andrew]

“I was by three schools so far, I was by _____ [name of school] and now I’m by _____ [name of school]. Er, the time I was at _____ [name of school]. I was on Tik, so I had a temper problem. I fought with security guards on the school and I was always in fights on school, so I moved to _____ [name of school]. And there also, it wasn’t right also for me at that school, because that time I was a bit, I think l, made the wrong choice, because I was still on the stuff that time and
when I came to _____ [name of school] so things changed, because I sat with different people at that school.” [Charles]

Several travelers had either been expelled from school because of their conduct problems towards educators or for their trading and/or use of drugs at school. One of the travellers had also dropped out of school voluntarily. These experiences were reported as follows:

“So I got expelled off the primary school.” [Tyler]

“My first few months on the school, then I got expelled. Because I used to smoke mandrax.” [Andrew]

“My ma het altyd gewerk en so, en my ma kon ook nie na die skool toe gekom het en so nie. Baie keer dan skors hulle my. En die dag wat ek mos gerook het op die skool in die toilet, wat hulle mos nou bel na die huis toe, wat hulle mos nou uitvind, my ma het nog nooit gekom nie. En dis op so manier wat ek ook nie meer wou skool geloop het nie.”[Zoey]

“I had an incident where I sold drugs twice already. The first time I sold, was just after my grandmother passed away. The second time was close to the end of the year, this all happened, with my friend and his phone. We were gonna go pawn it, told me a gram cost about R250 and I would make packets, like smaller R50 packets, then sell it… To get money for myself, because currently nobody would actually like was there to take care of me.” [Ralton]

One traveller reflected how travelling at such a rapid speed in the fast lane caught up with him. He narrated how dagga use depleted his physical energy and subsequently resulted in his withdrawing from participation in soccer, previously an area of mastery for him:

“Ok, I used to like sport and stuff. I was good in sports and stuff. I stopped sport when I came in high school, and it’s, the reason why I stopped, because I started smoking weed. I couldn’t cope with my sports, I was very young. Every day I went to Rastas. Go to Rastas, went to go smoke there. I wouldn’t go to sport practice.. Ja, I feel too lam [exhausted] to go play soccer… I think that’s the reason I get quickly tired, is because of the smoking, so that’s also the reason why, now I need to gain stamina.”[Charles]

Several other travellers noted how their prolonged travelling in the fast lane impacted on their physical appearance and body weight, which they narrated as follows:
“You start, you start not caring about yourself, you look thin, you look slordig [untidy]. I looked thin of all the mandrax and stuff, and I used to smoke all the drugs at that time like, except heroin.” [Ralton]

“It’s not nice, man, look how my face looks. I’m 16, I look like a 19 year old turning 20. Ja, coz I always like to look in the mirror, man, now that I’m clean…drug clean. I look in the mirror now I always think how I would look without doing drugs, how would I be, what kind of person.” [Andrew]

They also observed changes in their vegetative functioning as follows:

“Not sleeping and can’t eat and like it affects you.” [Lieze]

“I think I went on a, like whole drugs spree, that like a week, it was, it was cool at the time. I was using it from the Sunday to the Sunday. The Monday morning I almost collapsed in the office, I never ate, because it, you don’t wanna eat when you use it, you just up and full of energy, I never ate, so I had no energy in my system, so I was very sick the Monday.” [Ralton]

All the travellers recalled the impact that drug use had on their behaviour towards, especially, their significant others and the subsequent consequences for their interpersonal relationships. As their drug use increased, they became more restless, especially when searching for their next fix. Their narrations illustrate the disinhibiting effect, high levels of agitation and aggression that stimulants, methamphetamine especially, caused:

“Want die rook maak my mal. Niemand gaan my keer nie. Ek het my oompie ook hier, ek was hoog “getik” gewees toe maak ek my oompie seer dat hy hospital toe moes gegaan het. Sy oor het so gehang. Toe gaan hy hospital toe. Dis wat die drugs gemaak het. Hy control my, daai ding.”[Gavin]

“Ja, when I used it, maybe a week after that, or so, and then I want, I’m mos now smoking, up and down and all of that, wanting money and maybe drinking and so… Walking up, like walking up and down… With friends and so, around in the area and then, ja, it’s walking with friends, up and down, sitting here and then maybe I’m coming late at home, when I maybe smoke. Coming late at home and not evens coming …and so of using it.”[Lieze]

The travellers reflected on the emotional consequences that emanated from their being on the journey. These included feelings of isolation, insecurities, self-doubt, paranoia, and emotional volatility, which they articulated as follows:
“Being on drugs is the best feeling ever, but it brings yourself down, it makes you lonely.” [Andrew]

“No, I felt things changed, like the environment and here at home, the environment at home and like people maybe talking outside and so. Ja, and I wasn’t maybe feeling myself also, I go out then I feel people is talking about me, ja, that’s all I can… That maybe I was, I smoke now and maybe I am going to fail this year or what, so… Ja, everybody’s watching you…Ya, a few times, I heard about it and my, me and my friends, evens were fighting about it, like they were speaking about me and so, and we were arguing and I’ve heard a few times people speaking and so, but then I ignore it sometimes, or sometimes I get angry, then I speak back to them and so on.” [Liezle]

The travellers were also cognisant of how their personalities started to change the longer they remained on the journey. They reflected on these observed changes as follows:

“But I never used to like it, man, ‘coz drugs made me another person, man. It actually made me realize who I am really. It’s hard for me to figure out who I am really, man. So I actually for the few years I done drugs, not a few years, you can say two years… it changed me. I was first a people’s person, now I don’t like to speak. I don’t know what I have in me, but I’m always watching my back, I don’t know how to answer people right. It was always in me now I’m trying to get it out of me. ‘Coz if someone looks at me, I will just react in another way. I will always ask you like, why are you looking at me so.” [Andrew]

“Ek het aanhoudend begin rook en dan is ek nie myself nie, dan is ek ‘n ander tipe meisie en ek is net …..vir my het dit gevoel ek is nie ‘n dame nie. Ek het my pride van dame om ‘n dame te wees – ek het gevoel ek het dit verloor.” [Zoey]

The travellers expressed how denial was a normal response and reinforcing factor to prolonging the travellers’ journey. Their narrations around denial were shared as follows:

“So, for someone, if you not close to someone and you want them to admit they’re using drugs, even if it’s…, they just started last week, they will never admit it.” [Ralton]

“Never, denial is the first thing, because they don’t want to seem as if their drugs beat them, they don’t want drugs to beat them. They’re in denial.” [Andrew]

It was evident from the manner in which the stories were narrated that most of the travellers were embarrassed by the deceptive and illegal actions they embarked on to sustain their addictions. The degree of innovation and entrepreneurial spirit that accompanied these actions is also noteworthy, especially since the principles could have been applied to achieve more positive adaptive outcomes:
“My ma-hulle dink ek is in die skool, dan kom ek dronk huistoe….. Ek het al my klere verkoop wat ek nog gerook het.” [Gavin]

“Ja, my ma het altyd gewerk en so, en my ma kon ook nie na die skool toe gekom het en so nie. Baie keer dan skors hulle my, dan vat ek sommer ‘n ander auntie in die straat in, om maar nou net my ma te speel. ‘n Auntie wat drink en so. Sy moet maar nou net my ma is – ek het haar altyd gaan haal. En die dag wat ek mos gerook het op die skool in die toilet, wat hulle mos nou bel na die huis toe, wat hulle mos nou uitvind, my ma het nog nooit gekom nie.” [Zoey]

“En ek het begin steel in die huis in, geld, om aan drugs te kom. Begin geld steel… ek het begin goed verkoop.” [Zoey]

“So everyday it went on like that, and no-one never really took no notice of me, so I started stealing, so I stole, er, I stole from my aunty them also, like gold bracelets, took it to pawn shops, I started stealing phones from my granny them, from my cousins in the house, I stole almost eight phones in that time and a gold watch from my cousin, I’m not proud of it, but, er… But that’s what I, that’s what I did.” [Ralton]

“I used to like rob people, I used to make fun of them, when I rob you, I used to tell you “Hey, take off that shoes” and then I give it the children in the road. Maybe they come there with glasses, maybe, or bakkies, like Africans and Coloureds, then I used to give them the shoes. But if it was my size, then I wear them, jackets and stuff that I can sell that look nice.” [Andrew]

Three travellers who sold dagga at school indicated that they did so in an attempt to fund their own addiction to more expensive drugs, also demonstrating an ability to actively secure what they needed to ensure that they did not run out of fuel on the journey.

The travellers’ narratives detailed their engagements in a range of harm inflicting and criminal actions, which extended to being arrested for drug dealing and gangsterism, as illustrated below:

“The Police pulled up, and, er I was arrested, they took me to the police station, questioning, they questioned me, but I never said anything like, came out with anything. They told me they’re gonna leave me, they opened a case against me, but they never gave it in [he was never charged].” [Ralton]

“Coz I stole my Pa’s car that one night.” [Andrew]

“Toe is dit wat ek nou niks meer het nie, niemand trust my nie. So toe begin ek met gangsters deurmekaar raak. Ek het poste begin loop, dan maak ek vir hulle, hulle kitchen skoon laat hulle vir my die goed wat agterbly, laat hulle vir my dit kan gee om te kan rook. En dis wat ek begin
"They bring drugs through here for the people in ___ [name of neighbourhood], then we must sell it, and every time they used to bring it, then we used to steal it… And then some of our friends did get hurt or get smacked with a gun or something in your face… Ja, they can see when some of the drugs is missing." [Charles]

"Toe raak ek nou gangster en soos daai… al opgegaan om mense te roof en al daai goed – so het ek begin om stout te raak." [Gavin]

As the travellers’ journey with drugs established an entrenched pattern, their family relations disintegrated even further. Their own reflections in this regard are cited below:

"En die ding is die met my ma se verhouding; as ek rook, dan wil my ma my nie R1 of ‘n 10c gee nie. Sy worry nie oor my nie. Sy het my gesê ook as ek nou weer begin rook, dan gaan ek niks weer kry by haar nie." [Gavin]

"People who I thought was there for me, ended up judging me…. I lost the family also not my immediate family only – my other, my bigger family." [Clarissa]

"Ek het my ma afgebreek op elke manier wat ek kon kry om drugs in die hande te kry het ek haar afgebreek en my susters. Hulle afgebreek." [Zoey]

"At the time, ja, like arguing and all of that, when I started using it and it affected here at home also and all of that. Arguments about…my friends and so, ‘cause I’m not coming home or I want money or stuff like that." [Liezle]

"They [referring to his family] never ever asked me to leave, I ran always out of my own way, they said they’re gonna call the police, and then I ran away from there, also. So I had now nowhere else to go but to this gangster." [Ralton]

The majority of the travellers had also either been evicted by their families, or moved to relatives in different neighbourhoods, cities, and even another province, to create physical distance between them and their drug-using peers. Their narratives cited below, illustrate how they responded to being derailed from the fast lane, with some making a quick return to the fast lane, whilst others yielded to the respite offered to them on the exit route.
“Hmm, it was decided [that she relocate to another city] by my mother when they caught me out and stuff, all that stuff. So I stayed there for two weeks, so after that two weeks, I was clean and I went home and I again did drugs. I was just there the Wednesday and the Thursday, ‘coz the Friday I came here [different city].” [Clarissa]

“Toe gaan bly ek by my auntie, toe sê my auntie ek moet daar by haar kom bly; my pa se suster. Toe sit hulle my daar bo ook uit, toe kom bly ek weer by my ma. Toe gaan bly ek later weer hier by my auntie – my pa se kleinste suster, toe is dit daar waar my lewe nou heetemal uitdraai.” [Gavin]

“Afterwards we were speaking, speaking, speaking and then I met my social worker there, very long 2 hours and then she told me don’t I wanna go to a place where I am gonna feel more comfortable and I asked her where is that then she said ____[name of Child and Youth Care Centre]. So I said, no, I don't wanna go. Then my uncle was speaking to me about it; then I said no, it’s fine then. They took me for one day there. I was there with the teachers speaking and then the following day I went to ____[name of Child and Youth Care Centre], I went to go and take my forms and all that; and I went there. And I was there for 2 years.” [Gabby]

“Ek was Joburg [Johannesburg] toe vir ‘n jaar. Ek was net by twee boere ["white"] vrouens, wat my weggehou het om eintjies te rook en drugs en so.” [Zoey]

All the travellers whose excessive speed in the fast lane culminated in them plummeting down an abyss (i.e. addiction) were able to narrate the risk signposts warning them of the impending abyss they were approaching. These included compulsive drug-seeking behaviours, volatile mood swings, with high levels of irritability, a loss of control over their emotions and the use of drugs, cravings for drugs, and continued use of drugs, despite the effects on themselves and significant others. Their narrations follow below:

“Ja, jy moet dit doen. Dit was ook nie soos ek nou is nie. Dit was eers soos daai, ek kom in die huis in ek stress net vir enige ding. Ek stress net, maar ek weet nie vir wat stress ek nie. Sommer nou stress op my klein sustertjie, ma’ sy het my niks gemaak nie. Dis daai tyd wat ek nou lus het om te rook.” [Gavin]

“Drugs, I won't tell anyone to go on drugs, coz drugs… it gives you a mentality of just speaking of drugs, money…. You will do anything for drugs, man…. whatever you will just sell anything, just for that craving in you. It’s not a craving, it’s an addiction, it’s all in your mind that you must do it, you must do it, you must do it.” [Andrew]

“Ja. En ek het aangehou doen wat ek doen. Ek het gedrink. Ek het gesteel. Ek gaan na my suster toe wat getrou is, en dan vat ek goed daar, tot en met hulle my uitvind dat ek steel. En die goed raak weg as ek daar is. En ek het begin, begin myself, ek was so in staat om alles te doen, dat ek slaap met ouens om vir my alkohol te gee. Ek slaap sommer met groot manne, net dat ek… ek was addicted. Net dat ek dit kan gebruik. En soos dit aangegaan het.” [Zoey]
“Ja, they think they’re in control, but its, so uhm, I was a Tik addict. I left rocks, as quickly as I picked it up, I left it, because it wasn’t for me, apparently. Like all day everyday, it's just rocks. Went to, to the place where they sell it, bought it, came up, started, just doing it all day, go home, go sleep, get up in the morning, first thing you do is drugs. Whole day and you come in early hours of the morning, like four or five, go sleep, get up ten-o’clock, back into the same thing, went on like that for two months, so I was smoking.” [Ralton]

The travellers’ narratives also depict how the negative consequences escalated, culminating in eventual self-destruction, fragile to nearly non-existent relationships with significant others, and devastation in the community, as an increasing number of younger children took to the use and production of the drugs in the communities. These narrations are cited below:

“I used to go there when I was in trouble like my ma maybe doesn’t want me. Or I just used to go there, maybe sleep out without permission, I was like 12 or 13. I never used to go home. Walk the streets, look for money, just for drugs.” [Andrew]

“That’s where I escaped to, me alone, not them, just me for a week I stayed there. ‘Cause that’s what real teenagers do, they’re living a teenager’s life. I did. I did mess my teenage life up. Like the very bad drugs, man, and all the bad elements, cause there used to be just guns, knives and sex and it’s just a whole lot of bad elements mixed together….. So I put them [referring to his family] through a lot of hell over here.” [Ralton]

“En die dag toe ek gerape gewees het, toe voel dit nou vir my, nee, nou moet ek nou als doen wat ek voel ek kan doen en so. Want nou werk niks meer vir my uit nie. Dinge werk nie uit vir my nie, dinge raak net al worse en worse en goed is net nie dieselfde en soos ek wil hê dit moet wees nie. Dan het ek altyd, as ek…hulle het my altyd toegesluit in die huis in want ek wou altyd probeer my eie lewe neem. Ek wou altyd pille gedrink het, my atyd soos oopgesny het, ek wou altyd weggelloop het, ens. Baie kere dan het ek selfvertroue in my verloor, dan voel ek baie keer dat ek my sommer wil verkoop en almal was net snaaks met my in die huis. Maar dan weet ek nie is vir die dinge wat ek gedoen het nie, wat ek hulle ook seer maak. En ek het maar toe nie meer geworry nie, as my ma met my praat dan, ek loop net oor haar woorde, ek stel nie belang in wat sy sê nie.” [Zoey]

“Then I saw my friend’s mother actually then I realized that look what drugs is doing. It’s bringing everyone down in the area. You won’t say people are using… now today Tik is top market, everyone can make it now… everyone is trying to make it. Their brains are just on Tik and Tik and Tik and Tik”. [Waydin]

One traveller noted that the fast lane lost its attraction when the secrecy and anonymity of it ceased:

“Now that people know everything, people’s always gonna watch you… Can’t do the stuff that you used to do.” [Charles]
Reviewing the narratives above, it is evident that the dangers the travellers encountered, outweighed the benefits they derived from being on the journey. The next theme illustrates those intrinsic factors that informed the reduction in the travellers’ speed and eventual consideration and selection of an exit route from the fast lane.

4.4.3 THEME 3: REDUCING SPEED AND APPROACHING A NUMBER OF EXIT ROUTES

At some point, the majority of the travellers arrived at a crossroad on their journey. This served as a key turning point and subsequent attempts to refrain from continued drug use. It is evident from the preceding sub-theme that the majority of them were initially motivated by external factors (i.e. visible warning signs and responses from others), and the need to reduce drug-related consequences. The desire for personal change and self-investment (i.e. internally regulated factors) usually followed as a secondary motivating factor. The three factors that prompted the reduction in speed included: a) recognising that the personal cost attached to the journey was not worth it; b) becoming fearful; and c) identifying the inner longing to quit. Some arrived at this key turning point by visualising a better future.

The travellers’ recognition that the cost of the journey was exceeding its benefits mostly resulted from the depletion of their emotional and physical resources. This evoked concern for their own safety and overall well-being. Their own concerns, coupled with the interest and concern shown by significant others in their lives, provided the motivation to consider taking an exit route. One traveller (Ralton) saw the opportunity to link the ‘new beginning’ he was contemplating with the start of a new year of his life. Below, the travellers described how they reached the turning point on their journeys:

“Not doing anything, and I could feel, man, by myself, that I can’t go on living like this now, I have to get out of here. My aunty asked me one day, why don’t I change? Told her that would be nice, like you know, my birthday came also around this time of the year. Why don’t you go back to your family – you have family – why must you sleep on other people’s couches? …… Er, say the 27th of May, I met up with my aunty them again, I asked apologies, I begged them for their forgiveness and all of that …… Ja, the next day came, we, I went back to my aunt she
came to fetch me. I could feel the warmth in my heart, like it’s in my heart, like I came back to somewhere I belong”. [Ralton]

“I, actually like discovered something, uhm, I actually when I couldn’t take it anymore in my life, I… I took pills… And I ended up in hospital, uhm, almost died, but luckily I was saved and I survived and I’m grateful to be alive. I’m very grateful to be alive.” [Clarissa]

“Ek het mos gesien in die vervolg wat het dit gedoen aan my, wat die drugs doen. Toe besluit ek vir myself, nee. En die ding is die met my ma se verhouding; as ek rook dan wil my ma my nie R1 of ’n 10c gee nie. Sy worry nie oor my nie.” [Gavin]

“Hulle het gepraat oor daai goed en gewys wat maak die drugs toe het ek vir myself besluit nou as Tik nou dit maak – ’n gaat in ’n stuk vleis in; nou wat maak dit nie binne-in my liggaam nou net nie? Hy maak seker klomp gaatjies in my liggaam. Toe besluit ek vir myself, nee, ek gaan die goed los. Want daai ding is so, hy maak hom rou, hier, dit lyk so, hy maak hom rou hier af, dis nie lekker nie.” [Gavin]

“Ek het begin slaap daar, né, en dan moet ek met dié een slaap en met daai een slaap en dan begin hulle nog kwaad te raak ook want die een wil hom ding doen en daai een wil hom ding doen, so en van daai dag af net, het ek net, wat die een my begin klap het… toe vra ek myself net af wil ek so lewe, wil ek so tipe lewe hê?” [Zoey]

“And I went to ______ [name of child and youth care centre] and there I got a young girl, teenager and I told myself from here I don’t want to go anymore further than this, and I started cooling down a bit, reading books… And I had people that was coming to me every day like Dutch people the, students. They spoke to me, every day.

I was for 2 months there and I told myself from there I don’t wanna do anything that I did in my past, and the reason I did that was because I saw there are people out there that care for me. I don’t have to do the things that I am doing. I must just change my life then I can help myself also. Not only to help my parent, my mother and my uncle them; but to help myself because when they are not there anymore for me, I am gonna wanna do the same thing. And I told myself from here not further than this.” [Gabby]

It is evident from the stories above that the majority of travellers became receptive to the interest shown by others only after reaching a point of no return or having their emotional resources depleted. Similarly, their insight into how drug use affected their own well-being and their relationships with others also only emerged after their personal experience of a significant degree of hardship and rejection by significant others. This sparked a reflection on their personal future goals and a renewed appreciation for support systems, as illustrated below:
“I’ve realized that, that it took over and I’m in Matric now and all of that, and I can like, a lot of things I want to do and become and so, that’s mos like affecting me and keeping me behind from things.” [Liezle]

“Like I just woke up one morning, was positive on my own life, because if my parents die now tomorrow, then where am I? I didn’t build anything for myself.” [Tyler]

“When I saw my mother cry and I saw what it’s doing to my mother, because it was like every second day she got a phone call by the school for this problem and that…Because of me going through all of this catching on all of this nonsense, because I thought my sisters was never even like that in high school, but there is Sirs that is willing to help me. For my mother, because she had like a heart problem, sugar or something, low blood yes, then this the school story and stuff. Then one day she also she felt her lung and wanted to fall over, yoh, then I was worried, then my sister told me I must stop with this stuff, because my mother is gonna get sick and stuff.” [Waydin]

“En die dag was hier ‘n show [talent opvoering] by die kerk en my suster se vriende hulle het my geforce toe vra hulle wil ek nie sing nie? Ek sing mooi… wil ek nie sing nie? Dit was ‘n talent show. En ek het kom sing. Dit was laas jaar, en ek het kom sing. En daai selfde dag wat ek kom sing het, toe voel ek hier is, hier is mense wat vir my omgee hier. Dis maar die dinge wat ek doen moet ek afskryf.”[Zoey]

The same traveller also likened her key turning point to a spiritual awakening, prompted by the non-judgmental persistence and care that she received from a minister of religion. This sparked her curiosity, especially since the Christian faith was different to the one she had followed up to that time, as described below:

“Ek wou net, ek het nie belanggestel aan kerke nie, waar ek sê ek het ingegee… hier is nou ‘n nuwe ding soos die illuminate [Satanic symbolism]. Ek het nie geglo in dit nie; ek het geglo in die Rastas. My pa is ‘n Rasta. Ek het geglo in ‘n man wat in ‘n prent in is, nou daarmee wat ek sê ek het ingegee, was my bedoeling ek wou mos ontmoeeting maak met God. Ek wil my hand uitstrek, dat Hy my hand kan vashou, dat ons saam kan loop. Dat Hy voor kan loop en ek agterna moet kom. So het ek gevoel, ek wil net weet, gee God my die krag om op te staan. Ek het mos nou nie geglo in ‘n God nie.”[Zoey]

4.4.4 THEME 4: SELECTING AN EXIT ROUTE

It was apparent that the process to navigate towards an exit route and remain on the newly constructed straight and narrow road was a rather challenging experience, particularly for those travellers who needed to emerge from the abyss. This theme contains the travellers’ reflections on the speed humps and potholes they encountered on the newly constructed straight and narrow exit route (i.e. the challenges to remain
drug free), the benefits they derived from travelling down this new road, and the navigational tools they utilised to stay on course.

4.4.4.1 SUB-THEME 4.1: SPEED HUMPS AND POTHOLES ENCOUNTERED ON THE EXIT ROUTES

Many travellers expressed how difficult it was to navigate towards the straight and narrow road, as the fast lane remained within sight and easy reach. The presence of former travel companions, who continuously extended invitations and exerted direct pressure for their return to the fast lane, further complicated their ability to remain focused on this narrow pathway. The social nature of drug use and the environmental context, which were characterised by easy access and normalisation of drug use in the Northern Areas neighbourhoods, constituted the primary potholes and speed humps they encountered, as most of them continued to live in the same neighbourhood where their drug use engagements occurred. It is evident from the narrations that some were actively pursued by their peers, whilst others were subtly coerced by being reminded of the benefits of the drug use culture. Their expressions below depict the challenges that they experienced in this regard, as well as the compromises that some of them made by using licit drugs (i.e. landing in a pothole) or what they deemed less harmful drugs during these encounters:

“Ja, you isolating yourself in that time, and that’s what gets most recoverer’s down and let them relapse because they miss that social life.” Clarissa

“Ja, hoe kan ek sê, die hele Baai [Port Elizabeth] is vol dwelms. Oral waar jy kom, is vernaam hier in die ______ [name of neighbourhood in Northern Areas]. Van die ______ af in is net Tikkers [youth using Tik] wat daar bly. Van die kant af in, kry jy nou allrounders [polysubstance users]: Tik, dagga, pille, eintjes, drank allrounders van die kant van ______ [section of the neighbourhood in Northern Areas] af nou in, maar daai kant is net Tikkers daar. Die hoë mense, hulle gebruik nou Tik.” [Gavin]

“Maar once ek nou net weg van hom [his non-drug using friend] af gaan en ek gaan loop nou weer saam met sy neef dan rook ek nou weer.” [Gavin]

“Ja, er, everytime I try to avoid that people when I see them in the street or something, then I try to avoid them, but then, if they see me, they will always come like come to talk to me or something, then I tell them I have to go now or something…. But I can't tell him go away, you
don't belong here or something… I told them I’m not allowed to be with them, but they still came”. [Charles]

“One of my new friends, one of my new friends, got beat by my old friends last year. Because they’re now taking me away. I don’t know what they were trying to prove or anything. They have the power, everybody feels that here in ______ [name of neighbourhood]. Maybe they think, they gonna get me again so like I was man, I always used to have the money and stuff… Ja, the way they are, cause I always used to make them [i.e. supply the drugs for them], I always used to make them the stuff… Ja, but now I see they can’t cope without me anymore.” [Charles]

“Maar dan het die gangsters altyd vir my gesê, “nee moenie worry nie, sien jy dan nie as jy hier is dan kry jy van alles.”” [Zoey]

“I used to stay clean for a month or two months, clean, all my friends they’re sitting around me smoking here. Now I just maybe smoke a dagga zol with them and then they are smoking drugs in front of me.” [Charles]

Apart from the normalisation of drug use in the Northern Areas communities, the travellers highlighted the celebration of public holidays and special events as particularly challenging periods during which to resist the use of drugs, especially as so many people converge onto the fast lane, leaving the ones on the straight and narrow road feeling more isolated. They expressed these challenges as follows:

“I was just thinking I am… I’m just gonna try it once again and see and so, and it’s mos holiday and so and then I maar try it out again and when the school, when it’s back to school, it’s gonna be normal again and then it just affected again in some way but then it came back to me… Do it again and then when the school, I will just be normal.” [Liezel]

“I think I smoked also, smoked on my birthday, just once and because, like I had nothing, nobody came to me to say happy birthday, only my girlfriend, nobody came to say happy birthday, nobody said here’s a present or nothing, so I just felt so emotional. ‘Cause, whenever you feel emotional or whatever… smoke.” [Charles]

The response from most parents was to remove the adolescents from the ‘toxic environments’, not realising how lonesome the journey on the newly constructed road would be. The travellers reported on this as follows:

“I can’t be alone like that, I must have someone with me to speak to or otherwise I will get mad….. I need company man…. My mother don’t understand that. When I’m alone, I just think about what can I do tomorrow…. Then I will think all the crazy things, like, I maar smoke tomorrow again, but when I’m with people, I won’t think so stuff.” [Charles]
It is evident from the above that social isolation gave rise to negative thinking patterns. However, the same traveller suggested that closer proximity to the fast lane (i.e. risk factors) enhanced the vulnerability to relapse, by stating that:

“I don’t know how, but when I’m alone or, or when I see someone that used to do it, that craving come back. “ [Charles]

It is further evident from the narrations above that the journey on the road to recovery can be a tense, conflict-ridden one, when the travellers’ need for autonomy and self-regulation is restricted by their parents or caregivers’ vigilance against potential triggers. Naturally, this results in challenges in the trust relationship, especially when the caregivers have been victims of the deceit that often characterises a drug use journey. The travellers narrated their frustrations around being constantly monitored and questioned as follows:

“Then I am trying to look for friends and stuff, but my mother, cause whoever I bring to the house is a problem, she found something now out about that friend – he he does this, he do that.” [Waydin]

“, and the thing is, when I come here to ______ [name of neighbourhood], my people think I’m with the gangsters and stuff, but I’m not with the gangsters, I still have friends that’s here in ______ [name of neighbourhood] that doesn’t do drugs… Think when I’m here in ______, that I’m with the gangsters and stuff.” [Charles]


“To break me down, like, you know, I was in recovery, I was in recovery in ______ [name of city] for nine weeks. I couldn’t take the constant, oh, you can’t have money, you’re untrustworthy, you can’t do this, you can’t do that, when you doing that you are pushing them to the limit, you’re pushing a recovering addict to the limit. After nine weeks on this day I failed my driver’s license exam also….She was just putting on and on and on and I just walked out of the house and I told her, you know, I can’t take it anymore and I left and I relapsed.” [Clarissa]

It is obvious from the narrations above that the caregivers’ lack of trust served as a particular impasse for most travellers. However, the concern is that only one traveller
showed some empathy for caregivers’ reactions, whilst the others were largely left indignant by their parents’ suspicions.

The negative judgment that they received from those who observed their difficult journey on the straight and narrow road contributed to a reduced sense of self-worth and self-care for most of the travellers, and often served as a trigger to yield to these negative labels, reinforcing their drug use identity. These negative associations were either based on their physical appearance, or their presence at an altercation, as illustrated below:

“Ja, a lot of people judge me, even now that they, people is hearing that I’m on drugs, that I was on drugs, people is judging me. She’s [referring to her mother] probably ashamed that I, that I’m a drug user.” [Clarissa]

“I couldn’t talk to my mother ‘cause my mother believe everything that the school say… She didn’t listen to me… Because of those incidents that happened, I knew that I didn’t do it, but my mother still like allowed the school to suspend me and stuff.” [Waydin]

“The one teacher, she keep on telling me no, it’s because of my gold teeth and stuff, I’m not gonna make it far… I can just as well leave school…. She just said, er, if I was her child, she would’ve smack it out of my mouth.” [Waydin]

“The type of music you listen to determines the type of person you are. If you listen to gangster music. Somewhere where poverty is a lot, they’re expressing themselves through that music… Playing thug life, like 2pac is that thugs life and whatever. In their mind, that is the life that they’re living…in a way and so I think it’s just the way things work, man. So me, I listen to all types of music, to a point where I listen to something because it means something. I mean if you go to [neighbourhood in the Northern Areas] now, I bet you… there will be a lot of gangster music playing…songs about skarrelling [a term used to refer to searching and “begging”] and whatever.” [Ralton]

Many travellers also had tumultuous relationships with their caregivers and their nuclear families, as depicted earlier under Theme 2.3 (i.e. those factors that enhanced their acceleration in the fast lane). Similarly, these same factors complicated the travellers’ journey to recovery from drug use, representing the potholes and speed humps on the straight and narrow road. A few quotations to illustrate this experience follow below:
“Ya, I was angry while I was walking home, I, I was just in a rage, I thought how no-one wanna believe me, no one wanna believe me, that man did just hit me now, always wanna be like my father.” [Charles]

“Die rede hoekom ek, ek so swaar vat om van dit af te kom…die wrywing in die huis in. Ons is nie soos 'n, ons het nie 'n familiebond nie. Ek eet nie by die huis nie, ek sal my was ek sal enige tyd skoon maak, ek sal loop en skarrel soos altyd. Elke keer is ek net my opwerk in die huis dan werk dit my na drank toe…..Hulle [referring to her family] druk my altyd af, hulle gaan my nooit uplift nie, hulle gaan my altyd net afdruk.” [Zoey]

“She could be blaming me for everything that went wrong…… And I, to me, my father’s like my sole parent, like my mother to me is, uhm, this might sound very harsh, but she is dead to me.” [Clariss]

Many travellers articulated how feelings of rejection and disappointment resulting from strained interpersonal relationships and being mocked by their peers served as potholes on the narrow road of recovery. These views were expressed as follows:

“There was a feeling of being unwanted, also like because they moving me up and down and all these things… There was even a period where I just let myself go because why, why, why, why.” [Clarissa]

“En is die dag wat ek nou ‘n boyfriend meet en my boyfriend het my seergemaak, toe val ek maar net weer terug daar waar ek gewees het. Toe is dit maar net weer van die begin af, toe begin ek maar net weer oor. Toe rook ek maar nou net weer pille.” [Zoey]

“There’s lots of groups at school, church groups, YCMB and stuff, like that. The Sirs have, that’s Mr ______’s group the YMCMB. Now I never, I don’t wanna join them, because that groups also called the church people the nerds and stuff, because break times they have their prayer meetings or so stuff, whatever you call it also.” [Waydin]

The challenges in the travellers’ interpersonal relationships were further exacerbated by their difficulty in confiding in others, either because they were not accustomed to sharing their feelings, or because they did not have a trusting relationship with their significant others. Their quotations below illustrate their challenges in this regard:

“I’ve never really spoken to anybody about this, but the day when my grandfather died I started to lose focus on everything.” [Tyler]

“I don’t, I feel, like there’s no-one to speak to, man. I can’t open up, nothing, like I can’t speak about a father thing to my mother, I can’t speak like that to my mother. And I don’t have a relationship with my step-father.” [Charles]
“Like nobody knows it, not even my aunt them, but to me, neh, I don’t think they would understand if I explained it to them.” [Ralton]

The travellers’ commitment to remain on the narrow road was complicated by the prevailing challenges that many of them experienced at scholastic level – a problem that often also culminated in conduct problems. None of the travellers linked their concentration difficulties to the effects of drug use, but the discrepancy in how they depicted their scholastic challenges prior to and after the onset of drug use would suggest a link to drug use. The travellers’ narrations depicting their **scholastic difficulties** follow below:

“I feel like when I sit in class, my mind is always on something else, almost like I can’t hear what the teacher is saying. When there is a crowd around me, I don’t feel comfortable, I don’t like a lot of people around me, then I don’t feel comfortable, I always feel uncomfortable. If somebody maybe talks to me, then I would just ignore them. The next person come then I’d maybe speak to him, I won’t speak to everyone. I would just ignore you if I don’t want to speak to you.” [Andrew]

“I don’t concentrate in class and when my concentration isn’t there, then I have an attitude.” [Charles]

One traveller shared how his poor progress at scholastic level served as a double stressor, primarily because he was continuing with school only to please his caregiver, who had provided him with a second chance after his destructive journey in the fast lane. His frustration was therefore exacerbated by the **conflicting aspirations** that he and his caregiver had for his future. His narration was as follows:

“It’s not that, it was always in me, man. I always wanted to work, I never used to want to…Like when I reached Grade 5 and Grade 6, and then I didn’t want to go to school anymore, I wanted to work. I didn’t know what happened to me, I just wanted to work. Always used to look for work, just wanted to work. Didn’t want to be in the house and that I just wanted to get something for me to do, for money.” [Andrew]

It transpired that many travellers experienced **socialisation difficulties** without the mood-altering component of drugs, therefore experiencing social interaction as very stressful. The **associated lack of confidence** was often masked by a portrayal of either **aggression** or **lack of assertiveness**, as narrated below:
“Most of the time, I don’t feel comfortable, like when somebody walk maybe with me or when we are all pushing, now then I would watch now who is pushing so. Go and maybe grab him or something.” [Andrew]

“I don’t know [laughs], I don’t know what did she [referring to his girlfriend] see in me, because, me and she, she’s too nice for me [laughs]. I don’t know.. Ja, I think she’s too good for me, cause I always end up hurting the next person, I don’t know why, but I won’t do it to her.” [Charles]

“And I got like a anger management thing I just shoot blank if I fight now. Then I try to prevent it I walk away… just walk away, then they tell me, no, I’m scared and stuff.. I just know I shoot blank… I can’t control myself.” [Waydin]

“I, when someone, I was, er, my friends knew I can fight, ‘cause I was always quiet, take long for me to snap like and stuff, but when I snap and then I just go mad. Ja, I, my friends is scared of that of me, also, I can’t fight just for the fun of it, just to go now, you must make me first and after that I just get mad… Ja, violent, or if I snap and I see I can’t get my way now or and that person isn’t here with me now maybe, like really, now really angry, I just go out now, go look for trouble in the street and start fighting.” [Waydin]

“Now _______ [name of friend] told me these children are taking advantage of you. Because you are very soft on the inside, really, if you ask me something, maybe it’s a sweet, I will give that sweet to you because I’m not… my mother didn’t [raise me] make me big like that, being nasty to other children.” [Gabby]

The travellers narrated the wide array of negative thinking patterns that complicated their ability to remain on course as follows:

“Er, I saw that long time already, cause before I started with drugs, it’s because, I don’t know, bad things will always happen to me, man, and then somebody else would get hurt, like, if you trust too much in me or if you do something, I over-trust myself and then something will maybe just happen.” [Charles]

“So when I, like, when I smoke, go into my, not into my own thoughts, but it takes me away from there, because you think deeper then, if you think about something, you think very deep on it and you won’t dwell off to other things.” [Ralton]

“So, like it plays through my mind all the time, I’m a mistake or I’m a problem or something.” [Clarisssa]

“As much or I smoke, or they say I’m smoking, I mean not that I’m being negative, but everybody’s gonna’s die, you just choosing the form or whatever in which you want to.” [Ralton]

There was agreement amongst the travellers that these potholes (i.e. thinking errors) were powerful triggers for making a U-turn to the fast lane (i.e. relapsing), especially
when considering all the other speed humps on the way (i.e. variables that compound the recovery process). The narrations that follow, illustrate how certain parents inadvertently facilitated the travellers’ return to the fast lane by allowing the construction of a private meeting place and permitting the use of licit drugs as a substitute to the use of illegal drugs. The excerpts below depict their experiences in this regard:

“The other boys, they built it (teenage den) and now the mother bought a bed, then the big bed came to the back, then it’s now the benches, the chairs, and I took for us like a glasses up, for cooldrink. And _______ (name of friend), I took her also once there, and she didn’t even wanna go home that weekend, I said, no ______ you must go home! You didn’t bring any clothing!” [Laughing] [Gabby]

“Maar my ma worry nie as ek drink nie, sy is net geworry ek moenie rook nie, soos daai. Want die rook maak my mal.” [Gavin]

“My ma used to allow drinking [at home]. When we drink on the streets, there’s always like arguments.” [Andrew]

Many travellers expressed how people’s lack of insight in the complexity and loneliness associated with recovery from a drug journey served as further triggers to return to the fast lane. The following quotes represent their views in this regard:

“And you know people who doesn’t, who never experienced this drug before will always tell you, oh but you can leave it. It’s not that easy, it’s really not that easy, you can stay for however long clean, something will trigger it, smallest thing will trigger it. You feel moody and stuff and just thinking, honestly now that’s the stuff you think in rehab, when you come home, you gonna relapse, you gonna do it again, no-one will find out, but like you know when you come back everyone is gonna be on your case, that’s why they say, when you in rehab it’s a five-star hotel.” [Charles]

“You are as dead tired and you wanna eat a whole house, ya …..Ooh it’s like when you not driving you don’t have anything to do. You, you don’t hang out with your same friends because they’re drugging. You, you in your house, you either sleeping or eating that’s it… you don’t get, I don’t even get the energy to watch TV. I was so tired I just slept. But one thing, recovery is boring and it’s depressing….. People is judging me, and you know I have that… that when I go out and I look at life and smile, because nobody has the right to judge me, you haven’t lived a day in my shoes.” [Clarissa]

“But weed, I couldn’t, I didn’t wanna leave it, I mean you can only leave something if you’re really, if you put your mind to it, I didn’t want to leave it, because coming back from all of that, like Tik is a very powerful drug, it’s very powerful. Coming from that I felt I have to fall back on something else, not just because, like the urge when you get it, it’s yoh! Its hectic and, er, you just need something to cool it down, man.” [Ralton]
“Ek was eerste, ek het gerook gerook, dan los ek die goed so vir twee maande. Dan gaan rook ek weer. Toe dink ek vir myself, nee man, ek kan die goed vir ewig los. Toe los ek dit....vir ewig gelos. Ek kan nie sé vir ewig nie, ek weet nie wanneer kan ek weer miskien net 'n mislike maak nie, dan rook ek weer nie. Maar nou op die oomblik, ek worry nie meer met drugs nie.”

[Gavin]

The last narrative in particular suggests that the traveller regarded the journey to recovery as a lifelong process and that he was entertaining the possibility of a potential relapse, despite his earlier self-affirmation that he would stay clean.

The importance of identifying and remaining in contact with a genuine support system was also emphasised by one traveller, who articulated how vulnerable she felt when she failed to maintain regular contact with her support group:

“A few months, few months, because I've been moving up and down and you know in the time that I've been moving, I haven't been to FAD (Families against Drugs support group) and that's when I relapsed...... From my source of hope ja, it's like you crash.”[Clarissa]

The sub-theme that follows, escorts the reader into the more inspiring part of the travellers’ journey, i.e. where they shared the factors that enhanced their motivation to abandon the fast lane and the specific strategies that enabled them to navigate around the potholes and speed humps.

4.4.4.2 SUB-THEME 4.2: BENEFITS OF TRAVELLING ON THE STRAIGHT AND NARROW ROAD

The initial factors that prompted the travellers’ exploration of an exit route from the fast lane were largely similar to the actual benefits they derived from being drug free. As a result, there may be some overlap in the narrations cited under the preceding theme and the current one. Several of these protective factors are also the inverse of the risk factors cited under Theme 1. The most dominant motivation to remain drug free centred around the sense of belonging, caring, emotional cohesion and positive affirmation that the travellers experienced in relationships, especially with their primary caregivers and other significant figures in their lives. The first set of narrations relates to the positive effect that was brought about for the travellers in response to the caring they received from their caregivers. These recollections were shared with such
intensity during the interviews that it confirmed the importance of having a secure attachment, even in adolescence. The following views were articulated:

“We were speaking, over the phone. When she don’t come, she phone, and we speak very long over the phone. And then she encourage me, then she’s say ______ I don’t want you there in that place [Child and Youth Care Centre].” [Gabby]

“Ja, the next day came, we, I went back to my aunt she came to fetch me, I could feel the warmth in my heart, like it’s in my heart, like came back to somewhere I belong. Ja, slowly but surely I was on my way out of the drugs, because I wasn’t around the bad elements so much, there was just positive. They like just on positive things….. I feel and think of that feeling and that space in that atmosphere in the house – it caught on to me slowly.” [Ralton]

The travellers ruminated about the affirming effect of having their caregivers recognize their talents, show an active interest in them as individuals, or provide active protection. These views were expressed as follows:

“Van daai aand [that she participated in the evening of song] het hulle my aanhou kom vrae en baie het gesê hulle het nie geweet ek het sulke talent wat ek weggooi en so. Toe sê ek vir myself ek kan van myself ’n beter persoon maak as ek net wil. As ek net ondersteuning kry.” [Zoey]

“Lots of people told me, that life isn’t right for me. They not like me, man, and I don’t wanna be like them.” [Charles]

“But I started to go sit by the clubhouse just look there, hear what they talk about and stuff. There was a woman there a prophet or something I don’t know what you call her, she tell your future and stuff. She then she told me I’m gonna become something and stuff. She just called me out of assembly, just said I must stand up, then she told me, and it was true stuff also, I never evens knew how she knew, then I sat… I’m gonna become something and I’m very good in sports, she didn’t say which sport but she said I’m very good in a sport and I’m gonna look after my mother one day and stuff so stuff she told me.” [Waydin]

“Now last year they [referring to teachers] didn’t like me or care for me. I just feel there’s teachers who don’t take note of me actually. Yes and there’s a, my maths sir also, I got like weak in maths after I came to high school because of all of that. And then I… he started helping me again, catching up and stuff, ja, he started from the start of my book, he helped me with that.” [Waydin]

It is evident from the last narrative that the traveller not only appreciated the attention he received, but also the commitment from teachers to assist him academically, following his experience of non-support the previous year.
Narratives by five additional travellers indicating their **appreciation for being acknowledged** are cited below:

“**It was only me, because I was very close with her. As the day we were by the hall we all had to speak about our things that we wanna achieve one day and then she was also sitting there and then when I was starting to speak [giggle] I don’t know why she cried also. My mother was also there and from that day onwards she would come and call me every day. And I got used to her. And she was saying also it’s also because of my respect that I have for the adults, because most of the children that was there back-chat to the teachers.”** [Gabby]

“**Al die klomp goed [pointing out his technical and music equipment in the lounge] het ek gekry, die goed, dis my goed wat hier staan, is alles wat ek gekry het by haar. Als, ek kry van als nou by haar, maar toe ek gerook het dit het gekyk soos ek het ‘n ma gehad nie.”** [Gavin]

Several travellers recalled the rewarding effect that these positive reinforcements from others had on them and how that inspired them to resist rejoining the journey of drug use.

One traveller derived motivation from **being entrusted with responsibilities at home.** These ranged from assisting with household chores and babysitting a toddler. Besides **feeling positively affirmed**, the responsibilities also assisted in keeping her **occupied and hence away from the attractions of the fast lane (i.e. drug-using peers)**. She articulated her story as follows:

“My, my aunty went back to work, and so she needed someone to watch him [referring to her toddler nephew], so I started watching him and then I get paid like every month from, from her and so watching him, ‘cause she went back to work now... ‘Cause he’s growing up, he’s getting big also, and I wanna be there for him also. Ja, and after school I must go fetch him and I’m just at home and I’m not in the streets. “ [Liezle]

“My mother taught me, she always tell me I must come stand in the kitchen and like I must see what she’s doing and so. I’m just, sometimes I cook also and so for my mother. My mother she tells me maybe I must put on rice and then she’s gonna come cook when she come out of work or she leaves things like to cook, then I must come cook after school and I must go fetch him and so I like cooking.” [Liezle]

Three travellers who were in **romantic relationships** articulated how their **partners had been a source of inspiration** to them to stay clean, either by threatening to terminate the relationship or by remaining at their side, and **literally serving as a positive distraction** from the fast lane. Below are their narratives in this regard:
“So the beginning of the year, basically for the half of the year, I was still out of it, way out of it, but I was starting to get slowly but surely my life back on track. The person that gave me the most strength was my girlfriend... threatened to leave me if I don’t stop... Since she’s the only one I can hold on to, my mother them being gone, keep her close, ‘cause she was there all the time.” [Ralton]

“I have a girlfriend, she’s now in Grade 11. She’s in [name of a city]. Her relationship with me is like totally different. We like experience everything together, not experiencing drugs, but she was... She used to know I was on it, she always used to look on my.” [Andrew]

“Evens in December, also, the December that went pass, she kept me away from all that stuff... I told her also, she kept me away from all that stuff... but I told her mos now I don’t do that stuff anymore... (laughs) no, er, it’s just, me and she would be whole day together man... Then I wouldn’t wanna go home, or she wouldn’t wanna go home, like that... It was just, the way we are with each other, man, it’s like we know each other for years already.” [Charles]

The following travellers relayed the value of having trusting friendships, which provided them with a sense of belonging, emotional safety to express themselves, and a space where they could give each other feedback on how they were being experienced. Their narratives articulated these aspects as follows:

“I have one best friend. Her name is ______ (name of friend). She doesn’t stay here she stays at ______ And we are very close, we speak everything. If I maybe don’t feel fine in the morning, then she would on my face expression I don’t feel okay and then we speak about it and then she encourages me just to get through the day and all that. She understands me through everything that I am trying to say to her and we have a good understanding between each other.” [Gabby]

“Ja, like with me and my cousin, we’re very close, we will speak everything to each other. We will open up to each other, and we’ll give back feedback to each other. Er, we will always like open to each other and she will like give me advice what to, man, or if... no matter how big is the problem she would help me through the problem. Or if I wanna keep something away from someone, then I just tell her, but she would understand me... we understand each other, man.” [Charles]

“And they listen to me, we, we always kept kept like girls’ meetings and so, then we have to speak about what do we like about each other and what don’t they like about each other, stuff like that we did.” [Liezle]

A significant motivating factor for most travellers was their efforts to avert a repetition of the drug-related harm they experienced and/or the negative consequences they observed. One traveller (Tyler), who was in the experimenting phase, expressed a fear of addiction [especially based on witnessing drug-related harm in at least four different contexts, i.e. at school, at soccer, at home and in his neighbourhood] whilst
those in the dependency stage cited drug related harms that included the impact on the users’ views of themselves, their physical health and well-being, their academic and sport performance, interpersonal relationships, and the impact on the community at large. Their verbatim narrations are provided below:

“No. I always have a positive side. I always say no… Seeing them do the stuff what happens to them afterwards… Like when they smoke then some of them just feel lam [lethargic] like they don’t wanna work in school. Then they don’t have, like, strength to do work, they are just lam [lethargic] and they sit, it’s boring. Like they don’t care afterwards. They are actually losing their lives, but they just don’t pick it up. They just continue doing the things over and over. Every day it’s like the same thing.. Dagga, weed, Tik also, on schools. They just laugh for anything. It doesn't look right, man. Ja that's one of the things, those giggles. Everything is a joke.” [Tyler]

“It’s through them that I’m on earth so I wouldn’t wanna disappoint them by doing drugs. My brother done drugs, but I didn’t, he experienced it before, but I don't wanna experience it at all. (Giggling) I saw my father them hit him, so I asked, why you are hitting him. So they explained to me. But now I’m at ______ (name of school) and it’s happening to me. I won't do it. ‘Coz I have actually seen it happen.” [Tyler]

“Yes, there’s a boy at ______ (name of soccer club) also he uses Tik, but he does it before he plays. And he says it makes him energetic. That's all; I don't know what else it does… But his eyes are big also, very white, his pupils is also big, and he’s energetic, speak fast also. Not normal. But when it kicks out, then he looks like he needs it again. …… And I wouldn't wanna try it. I'm too scared… what if I get addicted? Like there is a boy in the school a Muslim boy. He does drugs; Tik. He doesn't wash, he doesn’t dress properly, but he lives in a house. He sells his mother’s stuff for drugs. And that stuff I wouldn't wanna do.” [Tyler]

“Yes, because I see lots of people here in ______ (name of neighbourhood) also. In the middle of the night there’s people walking up and down, and that’s mos Tik. They are here all over in ______(name of neighbourhood). But why would you wanna do a drug that make you walk up and down in the street at night.?” [Tyler]


“Maar die rede hoekom baie vrywillig is om nou te praat is, ek het daai… ek het agter my… wat ek daar in Joburg gewees het toe sê ek vir myself, ek maak my ma seer, ek maak haar baie seer. Op die einde van die dag, dan is ek maar die een wat die seerste kry.” [Zoey]

“It’s because I, I wasn't only friends with them: I had other friends also. The other, my other friends, was the only friends that I was with, they didn't wanna be seen with other people, and I thought I can't be friends with them only, I'm not a gangster.” [Waydin]
The three travellers (who made an early exit from the fast lane) reflected on the positive role they themselves had played in the lives of others, and how this extrinsic source of motivation encouraged them to continue reaping the positive rewards from these and related interactions. This included providing instrumental support and caring to others, as is evident from the following quotes:

“Ja, I tried talking to him, but he don’t wanna listen… He’s his own boss… He didn’t answer me and stuff, and since the time I started talking to him, he didn’t sit with me anymore and stuff. It’s like he didn’t want me to help him.” [Tyler]

“Ja, I have two pitbulls there at the back, then he asked me for the medicine, because the dog is like weak and stuff, then I gave him the medicine.” [Waydin]

“But I feel like I am going back to him [referring to a resident in a frailcare centre whom she befriended during a community outreach programme] because, as I told myself, I am out of ______ (name of child and youth care centre). Now the way I am feeling is the way he is feeling, I’m not coming to him and I was very close.” [Gabby]

“Helping other children and we went to ______ (name of child and youth care centre) again and we went to give modeling lessons there with our people.” [Gabby]

Only one traveller, who spent an extended period travelling in the fast lane, identified altruism as a motivation to stay on the straight and narrow road, as reflected in the following quote:

“But I did most of the getting up at night, and helping him [referring to his terminally ill uncle]. I was very patient with him. He died the Friday.” [Ralton]

Most travellers identified goals and dreams for their future that they were aspiring towards, and which reportedly served as a guide, especially during challenging times (i.e. in approaching the speed humps and potholes on the narrow road). They used these as positive affirmations to keep focused. Their narrations of their aspirations for themselves (intrinsic source of motivation), and their goals pertaining to attending to the needs of significant others (extrinsic source of motivation), are cited below:

“I want to finish my Paralegal Diploma and then go into a Social Work degree and then use that to work together. I want my life, my future to be….. something that I can look forward to.” [Clarissa]
“Ja… ek wil in beheer is van my eie lewe, ek wil ook sê… ek wil rêrig nie, ek wil nie alkohol… ek wil nie meer drink nie. Ek wil net hê dit moet weggaan van my af… ek wil hê die alkohol moet bitter raak vir my. Want ek wil van oor af begin. Ek wil. Ek wil nie in die jeug en goed is en ek is nie skoon nie. Ek bid dan sê ek is geskonde; ek is nog vuil, maar ek strewe na die beste……. Ek het altyd gesê my droom was om ’n social worker te wees, en ek wil ’n singer gewees het.” [Zoey]

“The sport and stuff and I’m gonna look after my mother, that’s one thing. I, that’s why I think I wanna make finish with school. Long time already I just knew that I wanted to I – never told her. It was actually hurting me also what I was doing in high school and stuff and I realized it’s not working out, this.” [Waydin]

“I don’t wanna study further, I wanna apply for a policewoman or for someone who do nursing and so, that’s what I wanna do, either policewoman or nursing. Helping people, crimes and all of that; that I know of, being for others also. I thought of nursing, studying further and what can I do, helping people and also helping people through, and all of that. I would like to make a difference. There is people who need help and like so and I can be that person and so and being there. Like people whose injured, and sick and is addicted in some way. I’m focusing on my school work now, studying and being in school every day and so and listening in class, all of that, concentrating. Studying even if like there’s no exam, going on class tests and so, just going over my work and so.” [Liezele]

“Passing this year. And making everybody happy here, and myself. Ja, I just wanna steal my mother’s heart a little, I never do that, I never did that. Like making something special for her a little…..I’d like to stay, stay clean. Every time I just think:Stay clean!, Stay clean! If I stay clean, everything will go right for me; I’m looking forward to meet my real father again. Since a long time, ja, I think I last saw him when I was eleven, but now I saw him two months ago. But it’s just, I just, wanna know more about him.” [Charles]

“I would surely change the whole mindset, attitude towards people. Be a better person and not be shy. Ja, and like speak out, man, that’s what I’ll do, be more responsible. “ [Charles]

“I would like to study Psychology, like Behavioural Psychology…. That’s something I would like to do, because I see myself with people that needs help….. Psychologically, all comes down to their thinking man. ……There’s no use of me dying right now when I have such a long life to live, so, and I did it mostly for my girlfriend, also.” [Ralton]

4.4.4.3 SUB-THEME 4.3: NAVIGATIONAL STRATEGIES TO STAY ON TRACK

The sub-theme that follows, deals with the specific strategies and approaches the travellers implemented to stay on track to being drug-free. The strategies are discussed chronologically, according to the degree of consensus amongst the research travellers.

The most prominent strategy that the travellers implemented, was withdrawing from their earlier travel companions (i.e. avoiding negative peer associations). The starting point to this important drug resistance strategy, however, was preceded by a
change in thinking patterns for some travellers – i.e. they mentally coached themselves not to be affected by the negative comments, labelling and mocking of others; using thought stopping and actively matching these strategies with positive actions. The narratives that illustrate the strategies to effect this change in thinking patterns are cited below:

“You yourself have the choice to, to, to educate yourself…. I mean, you could live in the ghetto and still be educated. You don’t have to walk outside up and down. It’s your mindset …..you wanna prove people. If you wanna prove people, that is your downfall. I was by myself that I stopped using drugs, and gotten to the part where I am now, so basically my own feelings and my own choices is what really matters to me.” [Ralton]

“Don’t think of it…just don’t think of it… but I smoke a lot of cigarettes, also; Drinking – I used to drink a lot, even during the week.” [Andrew]

“It’s [referring to children mocking him] still a problem but I, I don’t take note of the people anymore.” [Waydin]

“This was at six in the morning and I told her that you know, what you need to just build a bridge and get over it, life is moving on….. Ya, from negative energy ya, and I just cut myself off from the negative energy, and I continued like I will go to FAD and tell them uhm I’m very happy today because I woke up positive.” [Clarissa]

“What you associate yourself with, if you associate yourself with drug dealers that’s what you’d wanna do ‘cause you’re seeing someone else doing it. Psychologically, all comes down to their thinking, man.” [Charles]

Travellers appeared to be more amenable to making cognitive shifts after either experiencing or witnessing the negative effects of drug use, as evidenced below:

“I was a long period away from there, and that’s what just…slowly but surely I learnt there was better things in life, than sitting and smoking, cause after you smoke you just sit there with your eyes big and wanted, that doesn’t, didn’t really enjoy it, I didn’t enjoy it that much. I can honestly say I know life, not all of it but basics. That you need to survive and to keep sane, I think I know it. Through living the hard life, by living that life, it made me wiser.” [Ralton]

“I would rather show people, walk rather with your age group and if nerds or whatever walk rather with them. Don’t walk with boys who wanna keep them this or that… in the school, when I look at this boys…on this school now, _______ (his new school) I just look at this boys during school intervals, then I used to look at them, now. They think now it’s kwaai [cool] and this is kwaai [cool], but…. it’s not right, man… There are boys that do drugs on the school, ‘coz I can already see who do drugs, and how the effect come to you, and so man.” [Andrew]
These efforts involved engaging in active steps to **reduce physical contact with their drug-using peers**. This strategy amounted to changing earlier behaviour patterns that communicated their receptiveness to involvement in the drug journey. Active tactics engaged in, included the following: **changing the route taken to school; changing schools**; while others ensured that they **remained with their class group instead of selecting individual new friends**. For some, it also entailed making a concerted effort to remain polite towards **their earlier friends** (as an attempt to disengage systematically instead of abruptly); thereby reducing potential alienation. Others were able to avoid the negative association by **providing medical reasons for declining the drug offers; pretending that they had other tasks to complete or** that they had been **sent on errands by their parents**. One traveller removed **all his tattoos as a symbolic disengagement from the life associated with drug use and gangsterism**. Narratives illustrating the drug resistance strategies are cited below:

“I don’t wanna be like them, I thought they were cool, but now they not cool anymore for me, they will go hit anyone in the street, just like that for no reason.” [Charles]

“[Waydin]"But they leave me alone now, that friends. I just started to, I still greet them and stuff and I sit one side by my classmates, boys in my class. No, it was easy, actually I thought it’s not gonna be easy, I thought it’s gonna like, but then I told myself, I thought I’m not gonna care anymore. I just kept far away from them, go, went my own way. And eventually they started to greet me and stuff. I just prevented going to them and stuff, walking, I used to walk ______ Road through, but I walk the long way rather, instead of ______ Road… My direction yes, my routes and stuff…Break-times I go through the building, or if I sit in the office also sometimes then I just go if the bell rings to class. I used to like stand in the corridors for a few minutes after break, I no more do that – I go straight to class.” [Waydin]

“I don’t know, they just started to sit one side and I picked up also, but I didn’t actually take note of it… They, most of them left ______ (name of school), went to other schools and then they… First started to sit one side, still went on with the boys and stuff.. I also wanted to go to another school, but nobody wanted to take me, was too late also, then I told my mother I’m gonna try here by this school. I at least wanna have my Grade Ten.” [Waydin]

“I know what is right and wrong. I told them [referring to his peers] no I got an asthma problem.” [Waydin]

“Ja, er, every time I try to avoid that people when I see them in the street or something, then I try to avoid them, but then, if they see me they will always come like come to talk to me or something. Then I tell them I have to go now or something. Like that once also, one of my friends came to come look for me, one of my old friends came to come look for me, here at this house, and so my grandfather chased him away.. But I can’t tell him go away, you don’t belong here or something. By just avoiding them the whole time. No, I told them, I’m avoiding them, or I
must tell them I must go somewhere. Hmm, they would always ask, nah, just come stand there by the pos or something. Then I say, nah, I don't go sit there anymore. Then I say, I will go quickly somewhere. Then I disappear from them.” [Charles]

“So not being around it, also, and not having access to it, being around positive things, will get you away from it. The change in environment is definitely. I mean, if you go to [historically a former “white” neighbourhood] just for example and you were an addict, you know no-one there. Nobody gives you money maybe, you don't have money for taxi fare, you don't like they cut you off, man, there's no way you can get it, make use of what you, so you just do whatever that is there, you will eat a lot surely, watch TV, because you have no access to it, as soon as you go back to the source, you have access to it, you gonna start using it and I think I was like a very long period away from there, because I distanced myself also.” [Ralton]

“I actually burn my tattoos out now.” [Andrew]

Travellers’ narrations reflect on how they tried to reduce the amount of time they spent in interaction with their former travel companions (i.e. drug-using peers) as evident from the following:

“Hmm, ja, they stand here in the parkie, here opposite our house, and then I walk 'til there and then [wait first] and then I sit in the parkie and then I go ‘til by them and then I just sit there by them and hear what they're speaking, then I just come back home again. I'm not most of the time with them.” [Liezel]

The narrations below are by five travellers who explained how they removed themselves from situations that enhanced their vulnerability to drug use. In some instances, it was a gradual reduction, as they would initially remain with the same circle of friends, substituting their drug of choice with a legal drug (such as alcohol) or substituting with dagga, which most of them did not regard as a drug, due to its prevalent use in the community. Others found a positive substitute, as narrated below:

“I was there in December. I didn't smoke. My friends, they were surprised actually they thought when I'm there I'm gonna smoke. I didn't smoke. I just drank.” [Andrew]

“Ek sal nie so sê nie, maar nou op die oomblik worry ek nie nog met dwelms nie. In die omgewing hier is daar baie mense wat rook, vernaam hier onder. Partykeer gaan ek hier op na my broer se neef-hulle toe, dan sit hulle daar agter in die jaart, dan sit en rook hulle die goed, die pille en die cream, dan sit en rook hulle daar. Dan worry ek nie om n skuif te vra nie, dan klop die een dan vra hy gaan ek nie 'n second trek nie? [share in some of the drugs]. Dan sê ek nee ek is oraalt, ek gaan maar net my eintjie klaar rook. Dan rook ek my eintjie dan kom ek af huis toe of ek gaan om dan gaan sit ek daar by my oompie. Hier in ______ straat dan sit en kyk
ek maar movies daar by hom. Of ek kom huistoe, dan kom hou ek my maar besig op die computer.” [Gavin]

“But weed, I couldn’t, I didn’t wanna leave it. I mean, you can only leave something if you’re really, if you put your mind to it, I didn’t want to leave it, because coming back from all of that, like Tik is a very powerful drug, it’s very powerful, coming from that I felt I have to fall back on something else, not just because, like the urge when you get it, it’s yoh!” [Ralton]

“I’m not the only one that doesn’t do the drugs with my friends. There are quite a number of us. But when they do it, we just sit one side, maybe smoke hookah or something … It’s easy, because I know, they won’t really ask ______ [name of prosocial peer] do you want. Coz they know he will actually give them a, like an answer that they never expected. They are like scared to ask him. They are scared he’s gonna hit them or something, he doesn’t like play. He doesn’t like people that do drugs.” [Tyler]

“Eating chocolate and yoghurt, being at home, maybe go and buying a movie and then I’m just at home watching TV and movies and then it gets late and so.” [Liezel]

Most travellers managed to withdraw from the negative peer association by replacing their contact time with that of associations with prosocial peers and adults and/or finding an alternative healthy and productive social outlet, as is evident from the quotations below:

“Maar as ek hier opgaan (name of neighbourhood) toe, dan sit ek maar daar by my auntie hulle of by my neef. Nou wat ek like van my neef, is hy is like ‘n huiskindjie [home bound], hy worry nie nog met die straat nie. As jy hom soek, hom ma sal nooit sê hy is daar by daai een of by daai een nie – hy is maar altyd in die huis in, en hy loop nie rond nie, hy gaan net winkel toe, dan kom hy terug. Dis dit wat ek like van hom. Hy meng nie… hy het nie chommies daar nie. Hy kom af na my toe dan sit ons hier onder of dan gaan ek saam met hom op of ek gaan op na hom toe. So is hy, dis wat ek like van hom.” [Gavin]

“Maar hy wil mos nie sulke verkeerde bra’s [friends] het nie sulke chommies wat ek mee loop nie. Want my chommies wat ek gehad het, is almal net rokers, hulle rook net. Nou hy is beter, dis beter as ek by hom is en hier onder by my auntie-hulle.” [Gavin]

“Ja, slowly, but surely, I was on my way out of the drugs, because I wasn’t around the bad elements so much, there was just positive, my aunty them are very, like not conservative, like they very prim and proper, they, they don’t like, they cool and all, but they like just on positive things, I feel and think of that feeling and that space in that atmosphere in the house. It caught on to me slowly, I still smoked maybe, but I wouldn’t go out of my way for it.” [Ralton]

“I had them (prosocial peers) long time already, before I started using, long time already, now I just went back to, but it’s not easy to get your old friends back also. ‘Cause they, they still think I’m like I used to be. Like I was, doing drugs and stuff, then I tell them I’m changing, trying to change and stuff. Ja, showing them that I’m not with this (drug using peers) people also anymore, I don’t wanna be seen, people mustn’t see me with that people, or I don’t wanna be with that people also….. Er, er, having clean friends around me, having clean friends around
me, yes, just staying away from them, cause when you’re with friends like that, your mind don’t go to that stuff. Like when I’m with my cousin, I won’t even think of that stuff.” [Charles]

Several travellers identified the importance of an intrinsic locus of control; focusing on their own interests. Again, it appears evident that they arrived at these insights only after experiencing a significant degree of drug-related harm, especially after the withdrawal symptoms emanating from their addictions ceased. Their narratives reflecting these insights are cited below:

“First when I came here, I used to stay in the house. I used to know no-one here. It made me….realize what is drugs. I used to crave drugs… now I don’t get it anymore. I used to like taste drugs in my mouth now I don’t taste it in my mouth anymore. That’s the time when it was all going out. I wanted to apply for a part-time job here by Spar – the man said I must do a drug test… That’s how it is, I’m just looking out for myself trying to be myself and find myself.” [Andrew]

“Maar dan kom ek kerk toe. Maar ek was darem nou nie meer so desperate dat ek sal steel en alles doen om nou te rook nie, as ek nie gehad het nie, dan het ek nie. As ek het, dan het ek. Ek het altyd gesê ek gaan skarrel vir myself. Dit het aangegaan, en op die age wat ek nou is, toe sê ek mos nou vir myself, almal het my uitgeskel en ek het nou uitgekyk om ook nou bietjie reg te kom.” [Zoey]

“Ja, and when we drifted, I wasn’t living for myself, I realized I’m not living for my own future, I’m living to please them and by pleasing them I’m gonna end up hurting myself, because I won’t have a secure future and that’s just when I came to be positive. I need to, turn, like they say at FAD [Families against Drug Abuse], turn to the higher power and I turned and He… I’ve found a lotta sayings verses in the Bible that appealed to me and I use it every day, I read it every day.” [Clarissa]

Two travellers reported how they realised that recovery from their addiction would be a long process, requiring patience, perseverance and application of the strategies they had found effective in staying on the straight and narrow road. A third traveller backtracked from his absolute statement about quitting drugs for good, by anticipating that he may have a relapse in future. However, he reported that he was not actively using drugs. Travellers described their insights as follows:

“Now when I started to realize now that I’m… now that I don’t wanna be on drugs any more… I didn’t like just snap my fingers, saying I don’t wanna be on drugs any more.” [Andrew]

“You have special classes also to stay away from that things, when you come back it’s all up to you, to keep that skills.” [Charles]
One traveller who had a school resistant attitude in secondary school, reflected on his primary school years and how successful he had been academically. He used this reminder to affirm his ability to avoid the drug-related temptations that he was experiencing at high school and the subsequent negative attitude towards school.

“Primary school stuff, primary school is mos just you go to class. I was very clever in primary school and stuff… knew all my work. I thought to myself, I have ability, I can use it and stuff.” [Waydin]

Two travellers relayed that they implemented strategies such as setting small, achievable goals, while remaining positive about the small accomplishments and noting how they contributed to the realisation of their long-term aspirations. These strategies were verbalised as follows:

“Life….. if there’s nothing, and I’m just taking it slowly, like rebuilding my faith again after losing it and trying to put a pillar of strength, something that I can fall on…. Ja, that I can have that assurity that my future….. Yes, be like independent, because you know I’m also thinking very far ahead now, I don’t want my children to go through any of this, this all of this has been a life lesson to me…… I’m still positive, I want to have a family, and I want it to be a better and stronger family than what I’ve been through, because I was the only child through all of this.” [Clarissa]

Some travellers recounted the strategies of detaching themselves from people that did not serve as active motivators, or who could serve as detractors from positive accomplishments:

“But I think I should distance myself from people that’s not gonna push me in life.”

Several travellers shared how spirituality and the ritual of religious activities served as a drug resistance strategy. The importance of having faith as an effective coping mechanism was articulated as follows:
“And I was going to church like every Sunday. I was listening to the message; putting it on the phone, writing it down, and one day the pastor spoke with me, he called me one side, he spoke with me. And I was starting to cry. I don’t know why was I crying, but I was just getting hot and crying. Then the pastor said I mustn’t cry, because God was speaking with him and saying I need help. And he asked me what was the problem, and I spoke with him calling these things that I went through. He said I mustn’t worry; God is with me. He is going to make a change in my life. Then I also used to bring my Bible with, and on a Sunday when I come from church, I go to them, to tell them what the message all about and also this year at ______ [name of school] I got a gift also from God. I can speak in tongues, too.” [Gabby]

“I, I just, when I started at FAD I was not very, like, religious, I didn’t pray and all these things but I realized nuh, if I don’t turn to the higher power things might get worse. In this case maybe He’s trying to bring me closer to Him and I just started reading my Bible and reading my verse books and all these things and while reading my verse books I found verses that was really appealing to me, even our FAD verse, our opening, is exactly what you need to hear.” [Clarissa]

Another useful strategy used by one of the travellers, in combination with involving herself in faith-based activities, was to compare her own situation to those of other worse off than her. She explained this as follows:

“Ek het kerke geloop, ek het gegaan by kinders, wat worser [worse off] as wat ek is, wat dinge deurgemaak het worser as wat ek deurgemaak het. Hulle het met my gepraat en so, en toe ek huistoe kom, toe gebruik ek niks drug nie. Tot vandag toe wat ek, ek rook cigarettes, ek rook nie meer dagga nie, ek rook ook nie meer pille nie.” [Zoey]

The traveller who was motivated by being entrusted with adult responsibility, explained how this duty served as a diversion strategy, since it kept her occupied and created a positive expectation, despite the fact that these duties distracted her from focusing adequately on her schoolwork. The traveller shared her strategy and its impact as follows:

“Babysitting him and being at home and I’m going through my work then he’s writing and doing his work also here, but then I can’t really do my my school work and so then he always come and interrupt me... Keeps, keeps me out of the street and so, he always have luxuries and lunch in his bag and so I watch him, ja... And keeps me positive with my things I’m doing and so.” [Liezle]

Three travellers shared the belief that they were able to derive a particular purpose from being on the drug-use journey, which they articulated as follows:

“Because God, God gives us obstacles that we must overcome and then it’s a learning curve or something that’s coming.” [Gabby]
“Everything happens for a reason, I was supposed to end up on drugs, I was supposed to take that decision in life, I was supposed to experience that pain and all the things I went through…… ‘Cause I believe it’s turning me into, it’s, It’s training me or putting me in that way, that I’m, for something bigger that’s coming my way. I’m supposed to be out there, uhm, speaking to the young children about drugs and like just like keeping people whose been in this situations like separately on their own or even combined that there is still hope, don’t give up because life…. life turns out your way, if you set it to be like that, don’t get your own life down.” [Clarissa]

“I would say, bad and good, because I will get to tell my children what I done also, naughty stuff, I experienced something… then it’s bad, also, ‘coz I got suspended.” [Tyler]

4.4.5 THEME 5: RECOMMENDED ROAD MAP TO AVOID ENTERING THE FAST LANE

The final theme depicts the travellers’ recommendations for drug prevention. Some travellers incorporated these recommendations spontaneously whilst sharing their biographical narratives during the research interviews. A direct question was posed to those travellers who did not make reference to what would have prevented them from abstaining from drug use. In listening to the travellers’ narratives, it was evident that the factors that served as motivation to abstain from drug use, or to abort the journey of drug use, were also indirectly recommendations for drug prevention – some being more relevant as universal prevention approaches, whilst others were more appropriate for selective or even indicated prevention interventions (discussed in Chapter Two in greater detail). These strategies will not be repeated in this section of the Chapter, but merely referred to. The drug prevention interventions that were reportedly implemented by the families and community members, and the travellers’ evaluations of these, will also be incorporated.

From the analysis of the data, the picture that emerged, was that those travellers who boarded the journey to drug use after the age of about 12 years, had some degree of awareness of the dangers of drugs. They acquired this information from either their parents, their teachers at school, their peers and/or Police drug awareness campaigns undertaken primarily at schools. Their description of how they acquired this information follows below:
“I, I knew the, what’s the, what’s the effect gonna be and stuff, like you gonna get addicted and maybe you’re gonna die… My mother always used to speak about it… And she knew how bad it was there in _______ [name of neighbourhood where he grew up].” [Charles]

“Because I heard stories about using it and all of that and you can get addicted to it and all of that. You can … the effects of it, you can’t sleep and you can’t eat, ja it’s all that I know of…information obtained from … my friends and so on at school, and the Police people came also to our school.” [Liezle]

The travellers who had less information about the dangers of drug use at the time of experimentation, expressed themselves as follows:

“Ek het nou rêrig nie geweet nie. Ek sou gese het, nee dankie, dis oraait, ek sal nie meer worry met dit nie, want ek weet mos nou wat gaan vorentoe gebeur, ek het nie ‘n future nie.” [Gavin]

One traveller reflected on the presence of a community-based crime prevention project in his neighbourhood. It is the same Neighbourhood Watch that served as a deterrent to this traveller as he reported being monitored by them:

“They opened a Neighborhood Watch there, because we were like for the area, coz we were like a bad influence there. That’s what I heard. This Neighbourhood Watch they always used to keep them quiet and then they heard like I am the boss now of them.” [Andrew]

The travellers' caregivers responded in various ways on discovering their drug use. One traveller shared how her mother destroyed the drugs while she watched. Her mother also later warned her about the dangers of the Hooka pipe, based on an article she had read in the local community newspaper. However, it is evident from later in her narrative that this response did not succeed in keeping the traveller from using drugs. Her story follows below:

“They were smoking a cigarette, I also wanted to be naughty, I took a puff, then I said no it’s not right for me then I left it. My mother found out and my mother hit me! My mother made me almost eat the cigarettes then I said no, I’m not gonna do it anymore.” [Gabby]

“My mother knows I’m smoking hookah pipe. She told me I must leave it because she saw what’s written in the Daily Sun. I must leave that. And then I bought me, last year I bought myself a hookah pipe. My mother threw it broken, she said that’s enough now for me, she threw it broken and gave me my money back. And I bought me something else, a jeans with that money but now again, I am just smoking it.” [Gabby]
As indicated in an earlier section of this chapter, several of the travellers were relocated to different neighbourhoods, and one to a different province, as a secondary prevention intervention by their parents and caregivers.

The travellers made recommendations for drug prevention that could be implemented at intrapersonal level. These recommendations allude to the importance of having an internal locus of control, which includes assuming responsibility for one's own life by identifying one's needs and finding ways to have one's needs met. Their quotations below provide further detail in this regard:

“I just told myself, I learn better, always in primary school, I wanted to sit there [referring to the seat in the front row]… I somma lie to say I got a problem with my eyes and stuff. Then I sit in front.” [Waydin]

“Dis jou eie besluite wat jy neem. Gaan jy dit doen of gaan jy nie… hulle kan jou nie force om dit te doen nie… as jy nie wil nie. Hier in die plek waar jy kom, is dwelms, as jy daar kom, is dwelms. Allover is dwelms, dwelms. Jy moet jou vriende kies. As jy verkeerde vriende kies, dan, dan moet jy maar… dis jou besluite wat jy neem. Maar as jy regte vriende kies, dan kies jy vir jou regte vriende.” [Gavin]

“I think it’s just their own decision; they need to make a decision in life.” [Tyler]

Applying an internal locus of control also included the ability to make productive decisions, such as excluding negative peers – a strategy that was referred to earlier in this chapter.

Linked to accepting personal responsibility for one’s life, is the importance of self-reflection. The narratives below illustrate how the travellers were able to translate very difficult experiences into life’s lessons, which also enhanced their sense of self-efficacy:

“But I didn’t think as clearly that time and there was poverty around me, drugs is where I escaped to, so if you’re gonna escape, alcohol is the first you gonna run to, but if you had to think clearly about what you gonna do first then you don’t need to take drugs or drink alcohol…Even if you are living in poverty, because I’m sure you’ve heard of a lot of stories where doctors, lawyers came from rural townships. But if I could say, I’d just say they must be eager to learn from their mistakes, instead of repeating it all the time, I don’t think, I would think the reason why I think so is because I went to the lowest of the low, so I had no other choice but to die, to go to prison or I could just turn my life around there.” [Ralton]
“Ek ken dit los, want dit gaan my nowhere bring in die lewe nie, ek wil nie my lewe weggooi nie.” [Zoey]

One traveller suggested that his recovery from drug addiction, and hence prevention of further harm had been facilitated by **positive personality characteristics of optimism, spontaneity and genuineness**, as explained below:

“My character, would think it’s my character, optimistic and er, spontaneous, I’m very lively. Ya, ya, never necessarily outgoing, when I smile I do it genuinely, I don’t smile because I’m not false, I’m not, I’m not like that, or being the up, that upbeat happy person that I am, I think that also prevented, because never once have I turned to suicide or was I depressed and wanted to kill myself not once.” [Ralton]

The travellers placed significant emphasis on the **selection of prosocial peers** and **engagement in prosocial activities** as a drug prevention intervention. These strategies were referred to earlier in the chapter, but the additional narratives below illustrate the importance participants attached to this aspect:

“Omdat hy nie rook nie; nou is dit like hoe kan ek sê…. ek het nie… nou ek het ‘n chommie wat rook dan gaan ek ook rook. Nou hy is nie n roker nie, dan dink ek by myself, okay, jy rook nie, nou vir wat moet ek rook?” [Gavin]

“Ek het by ‘n outjie wat die eerste span van die brigade geleer het. Ek was die eerste meisie wat tot nou nog toe in die brigade blaas. Ek is al meisie in die orkes. Hy het my geleer.” [Zoey]

A traveller emphasised that the **rewards offered by prosocial peer associations needed to be genuine and attractive enough** to hold the adolescents’ interest. The suggestion of how this could be accomplished, is narrated below:

“Uhm, wat moet gedoen word hier by ons in die Northern Areas, dit moet, vernaam die jeug, dit moet ‘n challenge is vir ons wat die misbruik van dwelms doen. Die jeug moet vir ons inspirasie, hulle moet ons uitdaag om te kom, dit moet vir ons ‘n uitdaging wees om aanhou daar te wil wees.” [Zoey]

“Miskien ek kan nie lees nie, nou het jy my gevra om uit die Bybel uit te lees. Paar van hulle het miskien nou gelag en nou van daai tyd af wat ek nou nie meer sal bother om terug te kom nie. En nou doen ek nou nog al die dinge, ek is op drugs and things en ek was daar gewees, en verstaan. En hulle moet vir ons soos in, hulle moet wys hulle wil ons hier hê. In die jeug is dit mos so, ons almal is broer en suster. We all are one. Ons moet saam kan staan, ons moet saamwerk. Ons moet almal equal treat, ens.”
Travellers recommended that at family level drug use could be prevented if children had secure attachments and experienced a sense of belonging in their families, especially in reconstituted families. They furthermore emphasised the importance of the protective function; the caregivers’ monitoring of their children. Their recommendations were described as follows:

“My huisgesin, as hulle net ’n bietjie protective gewees het, dan sou dit seker nie, dan sou ek nie nou al die dinge gedoen het wat ek gedoen het nie. Dan sou ek, dan sou my leeftyd beter gewees het, dan sou ek ’n beter persoon gewees het. As ek, altyd support... as ek beter getreat gewees het. As ek, as my susters, as ek soos ’n suster getreat gewees het. En as hulle bekommend gewees het oor my, en my, al was dit net ’n bietjie protective oor my gewees het.” [Zoey]

From participants’ responses, it was evident that drug prevention could also be effective by giving children the opportunity for ownership of some of the household chores, especially since the completion of such tasks would also contribute to the positive affirmation of their worth. These narrations were cited under Theme 4.3 of this chapter.

Similar to the earlier findings, the travellers placed significant emphasis on the role of the family in drug prevention. They suggested that parents should be positive (non-drug using) role models and be physically and emotionally available to their children.

“Ouers moet ’n voorbeeld wees vir hulle kinders. Hulle moet laat die kinders opstaan, soos my ma met my gemaak het. Hulle kan dieselfde doen. Soos my ma met my gemaak het, vat hulle hier SANCA toe, stuur hulle SANCA toe, laat hulle gaan leer oor drugs.” [Gavin]

“Ja, ek het my eie ding gedoen. As my ma nie in die omte is nie, is ek my eie groot vrou. Ek doen alles vir myself en so, tensy my ma nie by die huis is en instaan vir my nie. Maar my ma was nooit rêrig by die huis nie.” [Zoey]
The travellers suggested that parents should get to know (and accept) their childrens’ friends:

“There must be, uhm, like… you must always keep the boy’s friends… you must always keep them close. Always keep up to date with them and that.” [Andrew]

“(To not) speak bad things of the friends, saying you mustn’t be with this one and with that one… Not label them and speak behind their back; like gossip.” [Andrew]

The travellers narrated experiences about feeling unsafe at school, since they observed the security officers being bribed by scholars and drug peddlers, in return for selling their supplies on the school premises. This suggests recommendations for the screening and appointment of security officers with integrity and competence for the task.

“The securities that they had before …..you give them a ten rand, then they leave you alone. It’s like that also, and there was once there was a security, _______ was his name…And I always used to see him when I lived that side. In the morning I see him walk with a bottle of I don’t know what, ship sherry, before I go then he come there at school, jiss, then he smell like liquor!” [Waydin]

“Securities also, ja, they scared of the children…Once that ______ [name of a drug peddler] jumped in the school and smacked a other boy, the security was standing dead still, then the security let them go out by the gate, but they swear the child and spit in the child’s face, I don’t know what did he do…Ja, and it’s like that you don’t feel protected also and that, like if you’re a nerd – you are tackled at school then you gonna get hurt, this guys they know the guys that come to school and stuff they not gonna forget also… I still don’t feel safe.” [Waydin]

A second recommendation for school-based prevention was to conduct random drug searches at school, which was narrated as follows:

“Search the school… Search the bags and stuff, like they normally tell the children, what’s the use you tell the children tomorrow we gonna have a big search; obviously they gonna now leave the stuff… Ja, like just come, ‘cause in the toilet the boy’s toilet, then we hear some of the boys talking, put this away and stuff, they did hear there’s a search and stuff.” [Waydin]

Another traveller appealed for a change in teachers’ attitude towards learners, suggesting that certain teachers were prone to perpetuating negative labelling and even ostracising or engaging in the emotional bullying of learners who had previously presented with drug-related conduct problems. The narratives point to a
need for increased emotional control in teachers and the effective management of learners with challenging behaviours, as cited below:

“Like, nowadays, the school, like they making me change back to who I was, like back to sitting with those guys. Like back to how those guys was, they’re still labelling me, yes…I don’t know, I try everything, I sit right in front of the class, and the one Mam even stand with her back towards me, ’cause she don’t wanna, I sit just there in front and then if I move back she looks there in front and talk to the children, like she don’t wanna see me. She gives notes, she don’t give me and if I tell the principal or whoever, they don’t take note of me…I don’t know what to do to change that.” [Waydin]

“In class also, like how can I say, I maybe like ask her a rubber or something then she will like throw remarks at me and stuff, say that’s why I’m still sitting in Grade Nine.” [Waydin]

The same traveller reported how a discussion between his parent and a teacher resulted in a different approach from the teacher, pointing towards the benefit of closer collaboration between parents and teachers:

“Another Sir, my father went to go talk to that Sir and stuff but he’s no more like that, that Sir was, er, the people with the low marks must sit in front and that, that’s mos not right and stuff, the people with the low marks sit at the back I mean and the people with the high marks sit in front.” [Waydin]

A traveller recognised the initiative of a voluntary community-based organisation (FAD) in monitoring so-called “hotspots” or high frequency areas for drug peddling in the neighbourhood. His narrative below also makes suggestions on how the effectiveness of monitoring could be enhanced:

“Ja, but that FAD’s, that guy is no more also there, since they made a difference. A certain time we must be at school. I saw them taking photo of the children that don’t wanna listen, go their own way… They did actually help, but they come at the wrong time, they come like from seven, no passed seven, then they only come to ______ Road (name of street). Now in that time then the children do their thing… Then they walk another route to school, smoke, walk another route.”

The travellers recommended a demand reduction drug prevention strategy which amounts to reducing access to the drug source. Their narratives in this regard are cited below:

“Get rid of the source! Get rid of the source – that’s all, the source of drugs….Get rid of the main source then, stop the main source, look past the small drug dealers cause there you’re not
gonna find more than five grams, which is close to nothing, that five grams comes from somebody that sells it in wholesale, somebody that sells it, fifty, he gets it at fifty grams….. Go to that person, he’s maybe the person that’s making it, stop him, you cancel sales for the whole week. If you stop each and everyone from making that pot of Tik, you cancel sales for the whole week.” [Ralton]

“The change in environment is definitely .....Nobody gives you money. Maybe you don’t have money for taxi fare, you don’t like they cut you off, man, there’s no way you can get it, make use of what you, so you just do whatever that is there, you will eat a lot surely, watch TV, because you have no access to it, as soon as you go back to the source, you have access to it, you gonna start using it and I think I was like a very long period away from there, because I distanced myself also.” [Andrew]

“Daar is nie drugs daar in daai plek [referring to rural area he moved to during his rehabilitation period] nie; die mense drink net daar in daai plek. Dis beter daar, ek was nou Desember daar gewees, die hele maand en in Januarie toe kom ek Februarie huistoe. Toe ek terugkom, ek was lekker dik gewees, maar ek het weer afgeval. Toe ek daar anderkant gewees het, eet net skaapvleis en daai tipe goed. So dis beter daar anderkant vir my as om hier [neighbourhood in Northern Areas] te wees.” [Gavin]

The travellers recommended educational drug prevention interventions involving discussing the dangers of drug, and bringing the youth in contact with people who are in active addiction. The last quote, however, suggests that adolescents need to believe that they are susceptible to the same consequences for the preventive intervention to be successful. Their suggestions are narrated below:

“Hulle moet like ‘n program oopmaak en almal bymekaar kry en praat oor wat drugs maak en al daai klomp goed. Jy moet like ‘n voorbeeld vir hulle wys, like iemand wat drugs gebruik het wat gesterf het van drugs; ‘n voorbeeld laat hulle kan sien wat het drugs gemaak. En like soos Rehab toe gaan; hulle gaan skoonmaak.” [Gavin]

“Yes, like I saw what happened to people so I won’t do it if I know it’s gonna happen to me also.” [Tyler]

One traveller, however, expressed that he regarded a fear-inducing drug awareness programme he attended as unauthentic, especially since he was already experimenting with drugs. He could not reconcile the exaggerated information with what he was experiencing or witnessing in his large circle of drug-using peers. His narrative articulated the following stance:

“Hulle kom hou miskien die show, dan praat hulle oor dwelms; ek is die en wat dit gebruik, dan dink ek by myself ….ag, man daai is niks. Ek gebruik dit, ek kan myself sien in die spieël, ek lyk nie soos daai een nie, maar ek gebruik dit.” [Gavin]
This same traveller, however, later expressed being alarmed by an **equally graphic presentation of drug related harms**, since he was then at the stage of drug addiction and could associate with some of the signs and symptoms relayed to him in counselling. It appears that he had been more **receptive to this information**, as it focused only on his drug of choice. It was presented to him individually, and he had experienced several drug related harms already. The excerpt below expresses this traveller’s fear and the impact it had on him:

“Maar soos ek nou kan sien met my, hulle het gepraat oor daai goed en gewys wat maak die drugs toe het ek vir myself besluit nou as Tik nou dit maak ‘n gaat in ‘n stuk vleis in; nou wat maak dit nie binne in my liggaam nou net nie? Hy maak seker klomp gaatjies in my liggaam. Toe besluit ek vir myself, nee, ek gaan die goed los. Want daai ding is so, hy maak hom rou hier dit lyk so hy maak hom rou hier af, dis nie lekker nie.” [Gavin]

At **societal level**, the travellers recommended that economic inequality and hence **unemployment** be addressed, since it contributed to drug addiction. Zoey expressed the following sentiment in this regard:

“Ja, en meestal ook as jy nie… werkloosheid, pak ook aan dat jy drugs, dat jy daai ernstig addicted ook raak.” [Zoey]

The travellers suggested **involvement in sport** as a productive drug prevention intervention, since it alleviated boredom and enhanced social interaction. One traveller cautioned, though, that the **selection of the particular sport code was influenced by peer approval**, especially since certain sports are regarded as less ‘manly’. The travellers expressed their views as follows:

“Problems… mostly peers forcing them, and I think sport would get them out of drugs, playing sport will help them stay away from drugs.” [Tyler]

“Hobbies, I have a lot, had actually, tennis in primary school, I like and I still like it, but there is no tennis by ______ [name of school] and stuff, and if you do sport, they call the children a nerd and stuff, but I’m gonna go into rugby and soccer now in school, I’m starting I told the Sir that I’m interested….Ja at high school, but at primary school it was never like that, I used to like sport….tennis. I got medals and stuff for sport, I done soccer, everything but tennis was the main one… Yes, and what I’m good at…”’cause it was called like a girly sport and stuff at high school… Ya, tennis and hockey and stuff, I actually like hockey.” [Waydin]

“Sport, yes to keep me busy and also keep me not bored, I was starting to get like bored sitting on my own and stuff.” [Charles]
A traveller relayed how he actively sought a **positive alternative**, which he found in a **youth Christian organisation at school**. From his narration, however, it is evident that he had been **averse to being associated with this group initially, as it was being mocked by the other peers**. He therefore first adopted **observational status** before he joined the group – his decision was facilitated by the **positive affirmation he received during one of his visits**, as described below:

“There’s lotta groups at school, church groups, YCMB and stuff like that there…. The YCMB, now I never, I don’t wanna join them, because that groups also called the church people the nerds and stuff, because break-times they have their prayer meetings or so stuff whatever you call it also. But I started to go sit by the club-house just look there, hear what they talk about and stuff. There was a woman there, a prophet or something I don’t know what you call her, she tell your future and stuff, then she told me I’m gonna become something and stuff she just called me out of assembly, just said I must stand up, then she told me, and it was true stuff also, I never evens knew how she knew, then I sat… I’m gonna become something and I’m very good in sports, she didn’t say which sport, but she said I’m very good in a sport and I’m gonna look after my mother one day and stuff so stuff she told me…. It is true, actually.” [Waydin]

The travellers who were in the addiction stage of drug use reported on how they were working on **disengaging from the drug use journey**. The narrations by at least three of the travellers, who described what is known as the drug substitution approach, where they weaned themselves off the one drug by substituting it with a seemingly less harmful drug, were presented under Theme 3 of this chapter. Two travellers also referred to the power of association, and how important it was to **change the type of music that one listened to** and one’s **dress code**, in an attempt to deconstruct the drug use identity.

A few travellers described how they were perceived by others whilst they were still actively on the drug use journey, and how the **positive shift from the earlier negative labels to the revised views others had of them following their recovery**, served as a drug prevention strategy:

“It leads you to seek happiness other places, that’s when you become the class clown, so I’ve become the class clown in my time yet, I see people laugh and smile whenever they see me, so that also kind of a bit of helped me, since I’m not that way now. I have attention and all of that I don’t turn to making fool in the class, so, my focus now is on school work.” [Ralton]

“Lots of people told me, that life isn’t right for me… They not like me man, and I don’t wanna be like them.. I don’t wanna be like them, I thought they were cool, but now they not cool anymore
for me, they will go hit anyone in the street, just like that for no reason... That’s not me “ [Charles]

“If I, if I take a guess, I would say maybe I did, cause many people told me I’m not the same person I was, I’ve changed drastically. What happened to me, all of a sudden I’m prefect, I’m class monitor, what happened, why, why’s there such a change.”[Ralton]

The travellers listed a range of coping resources that aided them in the prevention of a relapse, and in some cases, the prevention of the onset of drug use. Their coping resources, which were mostly cognitive in nature, ranged from engaging in self-reflection, identifying and focusing on priorities, applying determination, claiming their right to a second chance, altering negative thoughts, and staying focused on their goals.

“Primarily focus just on school work and sports.” [Charles]

“I was by myself that I stopped using drugs, and gotten to the part where I am now, so basically my own feelings and my own choices is what really matters to me.” [Andrew]

“To me, I am, I know I’m determined, because I’m determined to finish my diploma.....When I’m determined I’m gonna be hardworking, because I, because of everything I’ve been through, I don’t want to be like that, a per, a lady that’s married and unindependent on herself because he can up and leave any time, then you have nothing.....To make my life a success, also like I said for future, for my own children, I would like to be there, I won’t want to be in debt, I want to be able to give them what they want, and let them enjoy life..... And so I just want them to have a better life, so that means I have to work hard.”[Clarissa]

“Die beste tyd nou in my lewe is van ek nou begin kerk toe kom, is my beste tyd. Ek, sal verkies om elke dag... ek sal meer as, ek sal, al moet ek 6 ure of 8 ure in die kerk in sit, ek sal dit sit. Is my beste tyd wat ek het, my beste. Ek kan nie sé dit was my, haai tyd was my beste tye nie, want daai tyd was net hartseer, nou is my beste tye wat ek het.”[Zoey]

“Because people need a place to escape to and I know people have a lot of troubles in such areas, with worries, ‘cause I know I lived in such a community... is very tight-knitted also.” [Andrew]

Three travellers reflected on the benefits they derived from participating in the research. These reflections were reassuring, especially since they matched the ontology and intentions of the narrative design of the study. It is evident from these narrations (quoted below) that the travellers were able to reconsider the limiting views they held of themselves, and to start reauthoring an alternative identity, filled with possibilities of the contributions they could make to their own lives and those of others.
“Cause it’s gonna benefit you at the end of the day, I came, I would say I made a very good decision because I will walk out here today, like I have nothing on my chest anymore. I never speak with people really, except my girlfriend, so for me to help you was a pleasure, because you uhm it’s something that you gonna carry forward, you maybe helping others, they could help the next person also." [Ralton]

"Ek voel skoons glad beter. Ek voel glads… ek voel net ek wil huil van blydskap… want ek, ek (sobbing) ek sien myself, ek is alreeds by die wenpaal ek…gaan dit overcome, ek gaan dit oorkom. Ja, ek deserve darem ‘n tweede kans.“ [Zoey]

“I think that, er, I didn’t really take notice of it at that time but when I look at it now I can see now later in life it would affect me.” [Tyler]

“If I see something to help people, I’ll help. ‘Coz I know how it is and how do parents feel to find out their children is on drugs, it’s my ma, for so long I done drugs, she found out last year, she only found out.” [Andrew]

Three travellers expressed their own uncertainty about how to avert the onset of drug use in children and adolescents. They were clear about the fact that talking to young people about drugs would not make them refrain from experimenting with drugs, but concluded that the final decision to take drugs rested with the individual. The implication is that drug prevention efforts need to include mechanisms to help young people arrive at health promoting decisions. One traveller related how he invited some of his former drug using peers along to counselling at SANCA, but that his invitation was met with hostility. Quotations by three travellers follow:

“Yoh, I don’t know what to make them stop, I know talking won’t make them stop. Talking won’t make them stop…it’s actually their own decision and stuff.” [Charles]

“Want ek het baie van hierdie outjies hier in die straat gevra om ‘n bietjie saam met my te gaan; want ______ (the social worker at SANCA) het gesê ek moet kyk is hier nie mense wat ook miskien (that can benefit from their services)...Dan sê hulle vir my nee wat moet hulle daar gaan maak? Dis jou eie besluite wat jy neem. Gaan jy dit doen of gaan jy nie... hulle kan jou nie force om dit te doen nie. Dan sê ek nee, dis oraait, dan los ek hulle maar, want dis hulle eie besluite wat hulle maak." [Gavin]

“Ek sal rêrig nie weet wat om te doen nie." [Zoey]

**4.4.6 THEME 6: ETHNIC IDENTITY AS MARKERS ON THE JOURNEY**

As indicated at the beginning of this chapter, the overall goal of the current study was to enhance an understanding of the socio-cultural meaning construction of drug use, non-
use and drug prevention amongst the Northern Areas urban communities, with the view of making informed recommendations towards the development of culturally sensitive and contextually relevant drug prevention guidelines. However, the data collection method followed with the travellers did not include any direct questions about ethnic or gender diversity issues in relation to drug use, while the observers were asked direct questions about what came to mind when they heard the word ‘Coloured’. The discrepancy in the data collection methods was intentional, as it was imperative to observe whether the travellers would construct their narratives around ethnicity or cultural aspects, in order to listen for the relevance of a culturally sensitive underpinning in the drug prevention guidelines. Nine travellers relayed narratives that included reference to diversity in terms of race, gender and/or socio-economic status. Their narratives alluded to suggestions that drug use was a normalised phenomenon in the ‘Coloured’ communities, that they regarded so-called ‘White’ neighbourhoods as safer areas to live in, as drugs were not as accessible in those areas and that people’s social interactions were not organised around drug use, but rather around productive, intellectually stimulating conversations. The travellers’ expressions furthermore suggested that ‘Coloured’ neighbourhoods were associated with poverty and a collectivist culture, where people approached their neighbours for material assistance. However, they observed that the despondency levels were higher in these communities, making drug use a more regular escape route. The findings also imply that ‘Coloureds’ and ‘Blacks’ are subordinate to ‘Whites’, and that the latter group should be the providers of employment. One traveller felt entitled to steal items from the ‘Whites’ to distribute amongst the poorer non-whites. Their narratives, which speak to internalised view of ‘Whites’, are cited below:

“Ek is op soek na werk nou eintlik. Ek sou vanoggend gaan werk het, maar toe het daai larney [common pre-democratic description that was used to refer to a white employer] nie gekom daar bo nie.” [Gavin]

“I stayed in _______ the Coloured area, ‘coz at my school, boys used to just come up to me and give me money… at that school it was like a Coloured private school. First it was for whites, then it became for coloureds then my ma put me there, thought maybe I was gonna be better off there.” [Andrew]
“It was just in me, man, I used to like to rob people. I used to make fun of them, when I rob you, I used to tell you “hey, take off that shoes” and that then I give it to the children in the road. Maybe they come there with glasses, maybe, or bakkies, like Africans and Coloureds, then I used to give them the shoes.” [Andrew]

“Ek was net by twee boere [vernacular for “White”] vrouens, wat my weggehou het om eintjies te rook en drugs en so.” [Zoey]

“Six o-clock for the latest, cause that time there’s an African that also smoke.” [Waydin]

“So from what I saw, I was still very small, but from what I saw, her boyfriend, she used to have a lot of boyfriends, she had a White, a White boyfriend at the time, yes, and at that time when she was so sick and so thin, I used to look after her then, so one night, er, he was shouting at her and, I think he was hitting her or something and I wasn’t OK with that, but I didn’t say anything, cause I was small.” [Ralton]

“…In a way and so I think it’s just the way things work man, so me, I listen to all types of music, to a point where I listen to something because it means something. I mean if you go to _______ [neighbourhood in the Northern Areas] now, I bet you… There will be a lot of gangster music playing…songs about skarrelling and whatever.” [Ralton]

“I mean you can go next door and ask for a cup of sugar…Or borrow something and they will come borrow from you, they guys that would live there would not be like go borrow sugar, they would, like look for a escape from this, but the norm, they would run to drugs or to weed… Or to becoming alcoholics… Whereas as you would find people in the white area, they’re hardly out of their houses, when they’re there they’re in the house, when they’re not, they’re out socializing… About proper things… I mean speaking about maybe businesses or, or positive things… In such a way, that’s why I don’t like people saying jy hou jou wit… It’s just you’re more mature, you’re more knowledgeable. You yourself have the choice to, to, to educate yourself… I mean you could live in the ghetto and still be educated you don’t have to walk outside up and down… Trying to be the strongest person in the street or why don’t you just try and be the most educated person in the street… I mean if you educate yourself, the people around you, your friends, I guess would educate themselves also, because that’s the type of people you want to be cliqued with, educated people why would you wanna stand around an ignorant person if you’re educated? Not unless you’re gonna teach them.” [Ralton]

“I only finished Grade One and then we had a big move to ______ [name of city]. When we were in ______ I went to this new school. It wasn’t a Model C school, it was a, like a normal public school….went there and my mother taught at the school and it was actually very good there it was good, and then I changed schools after that and I went to _____ a Model C school in ______. It was a big change for me, but I found it to be more active, more things to do and, uhm, after that I applied to _______ (tertiary institution).” [Clarissa]

“I knew a few people but it was not the same set as when you’re in a private school, do certain things and a certain discipline so then through that years of moving there I had to change my attitude, my, myself to adjust to my surroundings, I had to, you know, you can’t be quiet anymore you have to be that person that can defend yourself.” [Clarissa]
“And I would say that they, children should start learning about it at a younger age, even for children especially in the Northern Areas, where it is, it’s natural, it’s life around us. They can come out of primary school and they will see people sitting on a corner, smoking a zol, and they will see lighting their pop and everything. It’s there, it’s life.” [Charles]

4.5 CHAPTER SUMMARY

The Chapter provided a thematic description of the travellers’ narratives, starting with the community, family, peer and individual risk factors that pre-empted their venturing on the drug use journey; followed by those factors that accelerated their journey into the fast lane. The early exit routes by three travellers who decided to take an exit route from the fast lane were highlighted. These three travellers had supportive, involved parents and caregivers who collaborated closely with either the welfare system for support or the school, to source the necessary early interventions for the travellers. The travellers who journeyed to the fast lane received several reinforcements to accelerate their speed, further reinforced by the benefits they derived from being on the journey. This culminated in numerous negative consequences at the different levels of functioning for the travellers (i.e. individual, family, peer, school, and community levels). Most travellers were ushered from the fast lane by concerned, financially and emotionally depleted family members or school authorities who either expelled or suspended them. Those travellers who remained committed to the redirected journey in the straight and narrow road focused on avoiding the negative peer influence, clinging to the parental, family and school support systems, and driven by an internal locus of control. The penultimate theme constitutes a range of recommendations to other adolescents on how to avoid the onset of the drug use journey. The final theme reflects the travellers’ nuances relating to internalised stereotypes of ‘White’ supremacy, which provide some insights into culturally specific elements, to be included in drug prevention guidelines.
CHAPTER FIVE

DISCUSSION OF RESEARCH FINDINGS: TRAVELLERS AND OBSERVERS’ SOCIO-CULTURAL MEANING CONSTRUCTION

5.1 INTRODUCTION

Research findings confirm that children who grow up in risk-producing environments (i.e. those characterised by poverty, emotionally distressed families and disorganised communities) are more prone to risk from drug abuse, such as poor scholastic progress and behavioural challenges (Myers et al., 2008; Brook et al., 2006; Fitzpatrick & LaGory, 2000). However, despite these risks, the number of children who present with negative health and behavioural outcomes is still in the minority, when compared to their prosocial counterparts (Elliott et al., 2006). The question that arose during the conceptualisation of the present study was: How do the non-users manage to short-circuit the seemingly normative construction of drug use, growing up in historically marginalised, underresourced neighbourhoods, where the easy access to drugs and more permissive parental attitudes (Smokowski et al., 2000) facilitate the onset of drug use? This research question culminated in the development of objective number 1 for the study, which was as follows:

- To explore adolescent narratives regarding the constructs ‘Coloured’, drug use, non-use and drug prevention programmes by three distinct groups of adolescents (drug users, non-users, and TADA peer mentors) from the Northern Areas communities.

In order to meet the objective of the study, a group of 29 adolescent non-users (hereafter referred to as observers, in keeping with the journey metaphor introduced in Chapter One) and ten users/travellers were invited to participate in the study (the recruitment and data generation process were detailed in Chapter One and Three).
The preceding chapter, which focused on the narratives of the travellers (those adolescents who ventured onto the drug use journey), provided the social-cultural context in which the present study was conducted; and concluded with the travellers’ recommendations regarding how other adolescents could avoid becoming travellers on the drug use journey. Their inputs provide useful insights and recommendations for universal and targeted preventive interventions. Although the presentation of the travellers’ narratives was not complemented with a literature control in Chapter Four, the core categories were illuminated in bold throughout the chapter. Both the travellers and observers’ narratives were analysed according to the analytical frameworks discussed in detail in Chapter Three.

This chapter will present the discussion of the analysed data generated from the travellers and observers’ narratives, complemented by a literature control.

5.2 OVERVIEW OF RESEARCH PARTICIPANTS

The adolescent participants were all between the ages of 16-18 years and were predominantly Afrikaans speaking. The observers were all in Grades 11 and 12, whilst seven travellers were in Grades 8 to 12, and three were not at school any longer. The total sample of adolescent participants consisted of 13 males (seven travellers and six observers) and 26 females (three travellers and 23 observers).

Table 5.1 below depicts the gender distribution of the two adolescent sample groups.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample group 1</td>
<td>6 (21%)</td>
<td>23 (79%)</td>
<td>29</td>
</tr>
<tr>
<td>(Observers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample group 2</td>
<td>7 (70%)</td>
<td>3 (30%)</td>
<td>10</td>
</tr>
<tr>
<td>(Travellers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total sample of</td>
<td>13</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>adolescents</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 5.1: Gender distribution of the two adolescent sample groups
The gender distribution is suggestive of a male dominated sample of drug users, with 70% of the travellers being male, compared to 30% female. Conversely, the female non-users (79%) were significantly more than the male non-users (21%). This sample constitution is consistent with prevailing statistics, which confirm a higher prevalence of drug use amongst males in comparison to females (SACENDU, 2007-2012) (Dada et al., 2012). The Health Society Guide (Addictions, 2012), however, cautions about the rapid increase in female drug use, highlighting that methamphetamine is especially popular amongst adolescent girls for its weight loss effects (Amaro et al., 2001).

5.3 THEMATIC DISCUSSION OF TRAVELLERS AND OBSERVERS' SOCIOCULTURAL MEANING CONSTRUCTION OF 'COLOURED' IDENTITY, DRUG USE AND NON-USE AMONGST ADOLESCENTS FROM THE NORTHERN AREAS OF PORT ELIZABETH

The data generated from the 10 biographical narrative interviews with the travellers and the 29 written narratives by the observers were analysed based on the narrative analysis framework provided by Lieblich et al. (1998:73). In analysing the participants' narratives, I focused firstly on the content in their narratives (i.e. categorising the topics according to the risk/protective resilience framework described in Chapters One and Two of this thesis). Secondly, I focused on the context of the narratives, as I wished to arrive at the participants' personal and collective meaning constructions of 'Coloured' identity; drug use; non-use; and drug prevention. The travellers' context was one of personal experience, whilst the observers' context ranged from living with parents who used drugs to observing drug use in their schools and communities. As the co-constructor of these stories, I was listening to the travellers' interpretations of their experiences, rather than directly accessing their experiences (Riessman, 1993:8).

Lieblich et al. (1998:12) suggest that meaning in a story refers to the implicit content, and advises that one listens for the traits or motives of the individual being displayed, or what a certain image used by the narrator symbolises. Meaning construction can also manifest in the narrator's silence on a particular aspect, and the avoidance of certain topics or non-elaboration in a narrative. By identifying the travellers by pseudonyms and the observers by numerical code, the reader can track my interpretation of the
participants’ narratives. An independent coder analysed the data and a consensus
discussion confirmed that our interpretations of the participants’ narratives were
essentially similar.

Furthermore, their narratives represented interpretative repertoires, i.e. a coherent
system of meanings that has developed over time and is used to evaluate actions or
events from a cultural context rather than an individual perspective. According to
McIntosh (1998), ‘opinions invite argumentation and defensiveness whilst experiences
invite listening without resisting’. I therefore interpreted the observers’ dominant use of
the second person as an indication, firstly, that they were expressing opinions rather
than relaying experiences; secondly, that they were possibly employing dissociation as
a defence mechanism. Presenting the discussion of the findings from the narratives of
travellers and observers findings in one chapter represents a triangulation of the data
(Denzin & Lincoln, 2003), which has the benefit of observing similarities and differences
in the narratives of the two sample groups. Since two different methods of data
generation were used with the two sample groups, the concurrent discussion of the
findings also allows for the evaluation of the data generation methods.

Two themes with accompanying sub-themes and categories emerged from the data
gathered from participants and the processes of data analysis, followed by consensus-
reaching with the independent coder. An overview of the themes, sub-themes,
categories and sub-categories is presented in Table 5.2 below.

<table>
<thead>
<tr>
<th>Theme 1: The travellers and observers’ construction of ‘Coloured’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-themes</td>
</tr>
<tr>
<td>1.1 Constructing drug use as a ‘Coloured’ phenomenon</td>
</tr>
<tr>
<td>1.2 Reconstruction of ‘Coloured’ identity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2: Risk and protective factors associated with drug use and non-use</th>
</tr>
</thead>
</table>
| 2.1 Risk and protective factors located in the individual domain         | 2.1.1 Individual risk factors | i) Personality factors  
                                                                             ii) Moral development  
                                                                             iii) Negative life events  
                                                                             iv) A pro-drug attitude |
| 2.2 Risk and protective factors located in the family domain             | 2.1.2 Individual protective factors | i) Personality factors  
                                                                             ii) Anti-drug attitudes  
                                                                             iii) Religious beliefs and  
                                                                             spirituality             |
| 2.2.1 Family risk factors                                               | i) Parenting factors  
                                                                             ii) Relationship discord and |
Each of these themes is discussed below and juxtaposed with quotations from the verbal narratives by the travellers and the written narratives of the observers. These quotations are verbatim representations of the observers’ written narratives and are therefore not always grammatically correct. The observers are furthermore identified by

### TABLE: 5.2: Overview of themes, sub-themes, categories and sub-categories (refer to Appendix G for schematic presentation of the table)
means of participant numbers and the travellers by means of pseudonyms in order to protect the identity of the adolescent participants.

5.3.1 THEME 1: The travellers and observers’ construction of the meaning ‘Coloured’

The first theme emanated from the first question in the written essay guide, where the observers were asked: ‘What does the word ‘Coloured’ mean to you?’ The rationale for including this question in the data generation guide was twofold; viz. firstly, to explore whether the adolescents’ narratives reinforced the stereotypical and historical association of drug use with ‘Coloured’ identity (London, 1999); secondly, to invite a deconstruction of this stereotypical association, as well as an interrogation and reconstruction of the ‘provocative’ implicit categorisation. The adolescent participants’ construction of the word ‘Coloured’ was located predominantly in a negative light, with a clear association between drug use and ‘Coloured’ identity emanating from the observers’ narratives. Their narratives included numerous other negative descriptions of ‘Coloured’ identity, most of which have been omitted from the discussion in this chapter, as they fall outside the narrative segment boundaries of the focus of the present study. The two sub-themes that are discussed under Theme 1 include the adolescent participants’ construction of drug use as a ‘Coloured’ phenomenon, followed by a reconstruction of ‘Coloured’ identity.

5.3.1.1 Sub-theme 1.1: Constructing drug use as a ‘Coloured’ phenomenon

The narrations by the majority of observers and travellers reinforced the stereotypical, historical association of drug use with ‘Coloured’ identity (London, 1999), as is evident from the quotes below:

“Baie rasse kyk neer op Kleurlinge omdat die meerderheid van ons verslaaf is aan dwelms. Hulle gooi ons sommer in een bootjie.” [Observer 16]

“Dan sal ek ook sé dit is van die vroeër generasie. Kinders drink omdat hulle glo dat hulle ouers en voorouer het ook die goedere gebruik, nou doen hulle die gevaar waaraan hulle nie weet in watter rigting hulle geleidelik kan word nie.” [Observer 4]
“We were also largely affected by Apartheid and our “standards” were lower than the Whites, who were said to be superior, according to them. Coloureds have that in mind I will be a nothing, that is why there is only a few Coloureds on top. You’ll see more Whites and Blacks on top than Coloureds.” [Observer 28]

“The norm… they would run to substances or to weed… Or to becoming alcoholics… Whereas as you would find people in the White area, they’re hardly out of their houses, when they’re not, they’re out socializing… About proper things… I mean speaking about maybe businesses or, or positive thing.” [Traveller – Ralton]

The participants’ views suggest that the stereotypical association is embedded in a **debilitating generational script**, which reflects the historical link between race and drug use. London (1999:1408) describes how the ‘dop’ system was utilised by ‘White’ agricultural employers in the 19th century as a remuneration system among mostly ‘Coloured’ farm labourers. This became a powerful oppressive practice through which farmers secured cheap labour and the labourers secured a job and their daily dop. Mager (2010) cited in Herrick (2012) supports the view that the automatic association of Non-whites and drug use can be traced to the **Apartheid laws** that prohibited drinking amongst ‘Africans’. This did not prevent ‘Africans’ from drinking, but rather resulted in the emergence of ‘shebeens’ as a response. Similarly, Parry (2005:426) points out that Cape Town (which has a predominantly ‘Coloured’ population), became known as the Tavern of the Seas during the 1800’s, as the British settlers used it as their refreshment station. Gambling and indulgence in liquor characterised these respite gatherings – hence suggesting a **normalisation** thesis.

Adhikari (2005) attribute this normalisation thesis to the effect of Apartheid, which categorised people on the basis of race and racial hierarchies in terms of the Population Registration Act of 1950(South Africa, 1950b), resulting in the privileged treatment of so-called superior groups (i.e. ‘Whites’). Swanson *et al.* (2003:743) confirm that in American society, the mere categorisation of people based on their physical differences has contributed to this notion of the ‘White race’ being pure and the Non-whites being impure. The authors postulate that it is this notion that has fuelled racism and contributed to negative perceptions of Non-whites, characterised by pathological labels. A letter by a reader published in the *Rand Daily Mail* as far back as 1971 (p.4) objected to racism in the strongest terms, describing it as a ‘phenomenon of inferiority’, through which people allow themselves to be subjugated. It is in this context that the social
construction of ‘Coloured’ people being inherently alcoholic (Mayson in London, 1999) has been perpetuated by politicians such as Blackman Ngoro, who labelled ‘Coloureds’ as ‘drunkards’ (Hendricks, 2005:2).

The participants’ narratives illustrate how the racial categorisation not only contributed to harmful stereotyping, but also to an internalisation of this ascribed inferiority and associated underachievement. This prevalent racial stereotype that attributes harmful drinking patterns to the Non-white South African population has been challenged by Seekings and Nattrass (2002, cited in Herrick, 2012:1049), who claim post-Apartheid South Africa has more of a class inequality than race inequality these days, and that it would be more relevant to investigate how the current inequity now informs and maintains these drinking practices.

A second explanation for associating ‘Coloured’ identity with drug use is located in the supposed lower value attached to formal schooling, hence, lower intelligence; ‘Coloured’ adolescents being less ambitious and seeing trading in drugs as an easy way to make money, as narrated below:

“A Kleurlinge het ’n gewoonte om nie te leer en klaar skool te loop nie. Sonder matriek kom ’n persoon nêrens en op so manier is hulle ongeskoold of halfgeskoold, hulle kry nie werk nie en dwelms en alkohol is alle oplossing!” [Observer 9]

“Mense sê coloureds is dom – dit is so….dan los hulle skool.” [Observer 11]

“Ongeloerde mense – hulle weet nie wat rondom hulle aangaan nie.” [Observer 13]

“Weer in Graad 8? En ek is 17 jaar oud? Dis maar beter as ek ’n werk gaan kry, my ma het gesê ek moet hier onder gaan vra vir daai straat-joppies – R150 ’n dag ek gaan vra daar onder.” [Traveller – Gavin]

The narratives by five other travellers: Andrew, Tyler, Zoey, Waydin and Charles, confirm the prevalence of low educational aspirations (refer to Sub-theme 2.3 in Chapter Four), albeit as a direct effect of them being on the drug use journey. Whilst these utterances echoed the social perception of scholastic underachievement and a lack of ambition, the observers’ views were predominantly narrated in the second
person, suggesting that they have not internalised these negative stereotypes of educational inferiority.

The majority of the research participants described poverty as a serious risk factor contributing to the large prevalence of drug use among the ‘Coloured’ community. These sentiments resonate in the quotes that follow below:

“Coloureds do not get jobs easily. All over it is Black empowerment. This is a generation problem because of the high unemployment rate. Men usually feel they are the head of a household, and if they can’t provide for their family, they end up taking substances and abuse using the substances. People live in poverty. They steal, assault, breaking in houses, robbing just to get substances.” [Observer 19]

“I think the biggest reason for the high rate of substance is job opportunities. Some have the qualification for some job, but can’t find a job and then they have a problem and get part of drug abuse.” [Observer 18]

“Our Coloureds are the people’s who are poor and don’t want to be successful and are the most without job.” [Observer 14]

The narratives from the observers evidently pertain to reasons for drug use amongst an adult population. Whilst none of the travellers alluded to poverty as a direct risk factor for them venturing onto the drug use journey, it was apparent from the narratives of Gabby and Zoey that their parents’ emotional unavailability resulted from working long hours in low income jobs. Furthermore, most travellers grew up in neighbourhoods characterised by sub-economic conditions, where drug use had become a popular coping response.

Findings from the South African Community Capability Studies, undertaken by the Centre for Democratising Information (Altman, 2012), endorse the lower value attached to education, citing that 30.8% of ‘Coloured’ youth reported education as useless and less interesting, as opposed to 17% for ‘African’ youth and 0% for both ‘White’ and ‘Indian’ youth. Altman (2012) hypothesises that this attitude may be informed by the high unemployment rate amongst the ‘Coloured’ ethnic group and the perceived limited opportunities, with Employment Equity guiding recruitment in the South African Labour market. Reddy et al. (2010) proposes that the post-Apartheid government’s transformation and affirmative action policies (Employment Equity Act No. 55 of 1998 of
the Parliament of the Republic of South Africa) (South Africa, 1998), aimed at redressing past imbalances, has amounted to a racial classification identical to that of the previous Apartheid government. Adhikari (2005) and Alexander (2007) concur, explaining that South Africa’s affirmative action policies perpetuate racial identities and segregation in South Africa. This has resulted in the ‘Coloured’ group being classified as a minority group, categorised in the Labour Relations Act (as Black, but not African), which places them in a lower priority category for affirmative action. This resonates with the poignant description depicted by Adhikari (2005) in his book titled “Not White Enough, Not Black Enough”, which suggests that the ‘Coloured’ group has been marginalised by the South African democratic government’s economic transformation policies. The findings from several local and international studies strengthen the view that unemployment, poverty and dilapidated socio-economic circumstances, prevalent amongst ethnic groups historically with minority status, are inextricably linked to adolescents’ involvement with drug use (Swahn, 2012; Potgieter et al., 2010; Brook et al., 2006; Botvin et al., 2001; Fitzpatrick & LaGory, 2000).

Oppelt (2012:15), agreeing with the views expressed above, has coined the phrase to describe the ‘Coloured’ ethnic group as the ‘nowhere people’ who, she warns, will find ways to subvert their continued marginality in South African society. According to Kinnes (2011), it is in this context that gangs are formed, especially to assert themselves against the unequal distribution of power, and hence promote advancement opportunities for marginalised groups. This sentiment resonates in the narrative of traveller Andrew who justified robbing ‘White’ people and distributing the proceeds of his crime to ‘African’ and ‘Coloured’ people (refer to sub-theme 2.3 in Chapter Four).

A traveller, Clarissa, whose parents had been compelled (due to financial constraints) to move her from a former Model C school to a public school in the ‘Coloured’ community, claimed that the lower quality of education and absence of sport and cultural programmes at the public school contributed to her emotional and cognitive disengagement from school, and eventual venturing onto the drug use journey. The strong link between school disengagement and adolescent substance involvement (Kliewer & Murrelle, 2007); the subsequent downward spiral in self-esteem; and
engagement in deviant behaviour as a way of salvaging a fragile image (Carroll, Houghton, Wood, Unsworth, Hattie & Gordon, 2009; McWhirter et al., 2007:113), were apparent from the narratives of the majority of travellers in the present study.

Loxley et al. (2003) caution that ethnic minority groups who have experienced social and economic exclusion, characterised by limited access to resources and quality education, often produce young people who are poorly equipped for the labour market. This has serious implications for South Africa, where the ‘youth bulge’ constitutes the largest portion of the population, with also the highest rate of unemployment (Altman, 2012).

Several observers equated ‘Coloured’ ethnicity with inferiority, which they attributed to the historical racial hierarchies in Apartheid South Africa and associated negative stereotypes, expressed as follows:

“People always measure Coloureds lowest; they think it is White, Black and then Coloureds. We are often looked down on. When people speak about Coloureds, they often use words like lazy, good for nothing.” [Observer 12]

“Some Coloureds are known as very untidy people who don’t care about others and the reason why I say so is that when I ask some of my friends what does it mean to be a Coloured they’ll always give me that answers and now you will think that we as Coloureds think nothing about ourself, but I can’t say I agree with my friends.” [Observer 17]

The participants’ views were predominatly narrated in the second person, which could suggest that they have not internalised these negative stereotypes of inferiority. However, Retief (2012), a journalist, reporting in a national Sunday newspaper on a rugby test between South Africa and New Zealand, commented how the mostly ‘Coloured’ (coined “disenfranchised and victimised”) rugby supporters utilised the rugby test as a platform to stage a public protest against the injustices suffered during the Apartheid years, by chanting against their countrymen. In the words of Retief (2012:13):

“One could understand the Coloured crowd’s allegiance to the All Blacks. Apart from an innate resonance with the name, there was also the very natural reaction
of people relating to players who had the same skin tone as they, who resembled them and who were excellent rugby players sticking it to the whitey!”

The picture that emerges above suggests that of a marginalised ethnic identity (McIntosh & McKeganey, 2000), which seems convincing when considered against the number of school drop-outs, teenage pregnancies and crime statistics for adolescents from this ethnic group (Statistics South Africa, 2008). However, this ‘deficit-orientated perspective’ (Swanson et al., 2003:745) is not only in stark contrast with the numerous stories of resilience amongst youth from historically marginalised communities (Korth, 2009), but also misconstrues the youth’s own construction of their experiences. The challenges as depicted above are also not unique to the ‘Coloured’ ethnic group, as several South African studies point towards a steady increase in a range of social problems across racial groups (Richter, 2010).

Several observers and travellers attributed the increased susceptibility to drug use to the high **accessibility and normative use of drugs in their schools and community**, which they described as follows:

“We have also decided that the schools should ask for the parents’ approval to do substance test regularly at school, because that is where the use of substances start in most Coloured areas and schools.” [Observer 26]

“Hier in die plek. Waar jy kom is dwelms, as jy daar kom, is dwelms. All over is dwelms, dwelms.” [Traveller – Gavin]

Two travellers (Andrew and Charles) shared how their parents had withdrawn them from the public schools in their community and enrolled them at former Model C schools (refer to Theme Three in Chapter Four), on the assumption that this would reduce the accessibility of drugs. The participants’ portrayal of their communities coheres with the manner in which numerous newspaper articles published over the last two years depicted the type of neighbourhoods in which most of the adolescent research participants resided (Butler, 2011; Luthuli, 2011). A study conducted by Brook, et al. (2005) echoes the concern about the relative ease with which South African youth can access both licit and illicit drugs. The authors observe that as accessibility increases, so the use of drugs increases, especially in communities characterised by a pro-drug use
attitude (National Institute on Drug Abuse (NIDA), 2003; Hawkins et al., 1992); exposure to such use; limited discrimination against it; and unavailable or non-supervising parents (Peltzer et al., 2010; Medina-Mora, 2005:28).

Whilst the narrations clearly confirm schools and high-risk communities as important domains in which to locate drug prevention programmes, it is important to note that this problem is not unique to the so-called ‘Coloured’ communities, as drug peddling has been reported to be rife at most schools. The common denominator is economically deprived communities, where children are recruited as drug peddlers by druglords (Gernetzky, 2012). Regardless, these findings clearly indicate a need for the community to mobilise against these identified negative factors, with the view to initiate the implementation of safer, drug-free neighbourhoods. It also suggests the need for the more stringent policing of the licensing and operation of taverns/drug outlets (Herrick, 2012).

The concern about reduced social cohesion in previously close-knit communities was echoed by several of the participants, illustrated in the narratives of two observers, quoted below:

“*They would always try to bring each other down, rather than supporting each other. They are not a unified group – there are always a few traitors. Coloureds are also easily influenced.*” [Observer 27]

“*The area where you live in, if you live in an area where people just don’t care about one another and where violence occur very often…. it difficult for that child to live in such an environment that’s when they feel that substances is the best option and even turn to gangsters for help or money and in order to get that money, they have to sell substances and later they even here to use it themselves.*” [Observer 12]

The views expressed by the observers and imbedded in the narratives of Liezle and Clarissa (refer to Theme 2.3 in Chapter Four) resonate with findings by Peltzer et al. (2010). These authors propose that communities marred by high drug availability and use rapidly contribute to a decline in traditional social relationships and weakened family bonds. These conditions, they argue, ‘resulted from decades of apartheid policies that have created an environment in which temporary escape from the harsh reality of
everyday life is often sought through the consumption of psychoactive substances (p.7).

5.3.1.2 Sub-theme 1.2: Reconstruction of ‘Coloured’ identity

This sub-theme emanated from a second round of data generation that was undertaken with the group of observers, prompted by the narrow descriptions that emerged from the first round of data generation. I decided to advance the co-construction of the observers’ narratives by affording them the opportunity to access their own agency and claim achievements in their written narratives (Bruce, 2007). This decision was consistent with the goal of the narrative strategy of inquiry, which promotes the emancipatory potential embedded in research. The observers were subsequently invited to respond to the following: “What do you enjoy about ‘Coloured’ identity and living in the Northern Areas?”

The subsequent narratives contradicted the largely debilitating social constructions, depicted in the first theme. In addition, a minority voice emerged from a few participants, who either challenged the negative construction, or presented a positive construction of ethnic and community identity, which ironically has the potential to reinforce further stereotyping, as is evident from the quotes below:

“People like to focus on the negative things – they don’t look at the positive thing that you are doing. I believe that for one negative thing in life there is a thousand things that can cancel that negative out. But for me when I hear the word coloured I think honest, kind, grateful, successful, achievers and a very colourful and unique race.” [Observer 12]

“Om ’n Kleurling te wees, is lekker, om die volgende redes: ons manier van leefwyse, die manier hoe ons aantrek, want kleurlinge hou van duur en name klere, nie almal nie, maar meeste van hulle.” [Observer 9]

“I mean you can go next door and ask for a cup of sugar…Or borrow something and they will come borrow from you.” [Traveller – Ralton]

The narratives by Observer 12 and Traveller Ralton, which could be descriptions of any person who upholds values of integrity and altruism, are associated with ‘Coloured’ identity – validating the caution by Alexander (2007) and Swartz (2010:7) that the
categorisation of people according to racial identities is not only incongruent with the ideals of a democratic South Africa, but also serves to reinforce unequal social relations, inequalities and racial prejudice.

One powerful oppositional voice, which unfortunately was a minority voice in the narratives of the adolescents, came from an observer, who challenged the relevance of the racial categorisation, and rejected the negative associations that accompany such categorisation as follows:

“Today the term ‘Coloured’ is outdated and archaic, and today it is considered an offensive term. When you get down to it, we are all Coloured, be it black, brown, white, red or yellow. I personally don't like the term ‘Coloured’. ‘Coloured’ used to be a perfectly acceptable term. I feel it is offensive to me, because people will always look down on you. People call you low class.”[Observer 19]

The participant’s ability to ‘scrutinize’ and ultimately challenge a societal narrative incoherent with the personal narrative she wishes to adopt, and the identity she wishes to develop, should form an essential part of culturally sensitive prevention interventions. Swartz (2010) similarly calls for ‘active inter-cultural social communication and education, to build an active understanding and hopefully, sensitivity and respect for other cultures’ (p.7). However, this should be preceded by an interrogation of our own cultural narratives and meaning constructions. Martin (2011) challenges the perception of marginality and places responsibility squarely on the shoulders of the community, arguing that their own passivity contributes to a feeling of exclusion.

In direct opposition to the views expressed above, Smokowski et al. (2000:436), who conducted research about resilience in minority adolescents in America, advocate for the relevance of racial identification and socialisation. These authors found in their study that ‘Black’ adolescents were particularly adamant to prove that they could surpass the small milestones that are usually expected of their ethnic group – an achievement that boosted their self-worth. Similar studies by Brody et al. (2004:903) and Belgrave, Chase-Vaughn, Gray, Addison and Cherry (2000) among African-American pre-adolescents found that the youth who held a positive view of themselves, their culture and their ethnic group, had a higher propensity for positive behaviour and a reduction in risky behaviour (compare also Clauss-Ehlers, Yang & Chen, 2006; Cabrera
 Whilst I agree that racial categorisation reinforces prejudices and negative stereotypes, the value of cultivating a collective pride in ethnic and community identity becomes apparent when reviewing the apathy and resignation evident in the narrations below:

“Dit is ook lekker vir my omdat ek was grootgemaak met die kennis om nie neer te kyk op die wat armoede ervaar nie, om die wat ryk is te aanbid nie. Ons is net hier waar ons in die middel is om net genoeg te het om te oorleef) te aanvaar en dankbaar vir dit te wees. Tye mag soms swaar is, maar vat elke dag soos dit kom.” [Observer 8]

“But the norm, they [referring to “Coloureds”] would run to drugs or to weed… Or to becoming alcoholics… Whereas as you would find people in the White area, they’re hardly out of their houses. When they’re there they’re in the house, when they’re not, they’re out socializing… about proper things… I mean speaking about maybe businesses or, or positive things… In such a way, that’s why I don’t like people saying jy hou jou Wit.” [Traveller – Ralton]

Several participants disagreed with the earlier construction of a non-cohesive community, and instead reconstructed an image of a community in which a collectivist culture of sharing and reciprocal support prevailed. The predominant use of their mother tongue (evident from the number of Afrikaans quotations), in a context where everyone knows each other and feels free to converse, was narrated as an element that enhanced community cohesion. The observers’ views are reflected in the quotes below:

“Om in die Noordelike Areas te bly is vir my lekker, omdat ek naby mense bly en kan baie van hulle af leer. Ek kan vrylik gesels en sê wat ek wil sê vir wie ek dit wil sê. Ek kan meng met mense wat ek ken.” [Observer 5]

“Die Noordelike Area is liefdevol! Jy sal nooit in ‘n Wit gebied dieselfde mense kry wat in die Noordelike Areas bly nie. Mense sal uit hul pad uit gaan om seker te maak jy is veilig en alles gaan goed met jou.” [Observer 15]

“Mense verstaan mekaar en ken mekaar vir jare. In ander areas ken die mense mekaar glad nie en maak ook nie ‘n poging om uit te vind nie. Hulle ken nie hulle bure nie.” [Observer 2]

Travellers like Zoey, Gavin, Andrew, Waydin and Clarissa relayed how they formed cohesive relations in different types of communities, as a substitute to travelling in the fast lane. Some travellers found this cohesion in their school community; whilst others located it in their community of peers and addiction support group (refer to Theme 4.3 in Chapter Four).
Several of the participants deconstructed the association of ‘Coloured’ identity with drug use, pointing out that **drug use is determined more by socio-economic status than by ethnicity** – a view that coheres with research findings (compare Herrick, 2012; Reddy *et al.*, 2010; Brook *et al.*, 2006). These participants chose to re-phrase their experiences of growing up in lower socio-economic conditions, where drug use is normalised, as observational learning opportunities, that motivated them to strive to be different. Their views in this regard are evident from the quotes below:

“Ek sien baie van die voorbeelde in my gemeenskap en wil nie daar opeindig waar hulle is nie.” [Observer 14]

“Wat daagliks gebeur in ons omgewing en enige plek met alkohol en dwelms is nie ’n mooi prentjie om te sien nie. Omdat ’n mens sien hoe baie mense hulle salarisse gebruik vir alkohol terwyl die kinders sonder kos in die huis is en die moeder moet gelde leen en swaarkry/ly daaronder. Maar wat hulle nie weet nie, is dat dit mors hulle op. Vir hulle mag dit lekker voel, maar hulle benadeel hulleself. Ek ken mense wat dit elke dag gebruik, byvoorbeeld Tik en dagga.” [Observer 8]

Despite the community challenges described earlier in this paper, the number of adolescents who present with negative health and behavioural outcomes is still in the minority, when compared with their pro-social counterparts. This underscores the numerous stories of resilience amongst adolescents from historically marginalised groups (Elliott *et al.*, 2006), hence prompting the contestation of debilitating normative beliefs and shifting towards hopeful constructions of community and cultural resilience.

The discussion in Theme 1, which illustrates that the deeply entrenched social construction of drug use being a ‘Coloured’ phenomenon, emanates from a collective meaning making of people living in predominantly historically marginalised communities in South Africa, characterised by high levels of poverty, low levels of opportunity, poor education, limited employment opportunities and other manifestations of social marginalisation, effected through deliberate social engineering by both the Apartheid government, and the failures of the present post-Apartheid government.
5.3.2 THEME 2: Risk and protective factors associated with drug use and non-use

The second theme emanated from two questions in the written essay guide to the observers. During the first round of data generation with the observers, the question: ‘What do you think is the reason for alcohol and drug use amongst adolescents from your community?’ resulted in narratives that were analysed and interpreted as ‘risk factors associated with drug use.’ During the second round of data generation, the observers were asked to respond to the following question: ‘What has enabled you to not become involved in alcohol and drug use?’ The observers’ responses to the question were analysed, resulting in the theme ‘protective factors associated with non-use’. The travellers’ biographical narratives generated during individual interviews were analysed and also categorised according to the risk/protective resilience framework to make sense of the meanings the adolescent participants attached to drug use, non-use and their recommendations for drug prevention. This collective framework also facilitated the triangulation of the data sources.

This ecological framework allowed for a contextual, multisystemic presentation of the adolescent narratives at individual, family, peer, school, community and societal levels, as explained in Section 2.4.2 of Chapter Two. This framework was particularly relevant for two reasons; firstly, evidence-based practice guidelines underscore the importance of reflecting on risk and protective factors in drafting a response to a social problem (SAMHSA, 2011; Myers et al., 2008; National Institute on Drug Abuse (NIDA), 2003); secondly, resilient outcomes emanate from the relationship between risk or adversity and protective factors (Garmezy, 1991; Masten, et al., 1990). Fagan, et al. (2011) refer to risk and protective factors presenting at either proximal, distal or distant level, highlighting that the distal factors represent the collective factors or, differently stated, the structural and environmental factors that have a direct effect on the individual’s propensity for drug use.

Aguirre-Molina and Gorman (1996:337) assert that people’s vulnerability to ATOD use increases significantly as the number of risk factors in their lives and surrounding community increases. This view concurs with research findings from international
studies (refer to Swahn, 2012; Feldtmann, 2010) and national studies (refer to Parry, Myers, Morojele, Flisher, Bhana, Donson & Pluddemann, 2004b). It furthermore concurs with findings from the present study, as the majority of travellers reported numerous concurrent risk factors prevalent at multisystemic levels.

The additional question that was posed to the observers during the second round of data collection was phrased as follows: ‘What has enabled you not to become involved in alcohol and drug use?’ The participants’ responses depict the protective factors that buffered their resistance to drug use. The concepts risk and protective factors were defined in Chapter One and further illuminated in Chapter Two of this research report. Theme 2 consists of six sub-themes, each representing the different levels in the multisystemic risk protective resilience framework. Each discussion of the sub-themes is in turn framed in terms of the two separate yet related categories of risk and protective factors.

### 5.3.2.1 Sub-theme 2.1 Risk and protective factors located in individual domain

As explained in Section 2.4.2.1 of Chapter Two, risk and protective factors in the individual domain refer to individual characteristics, character and dispositional traits (Kaplan & Sadock, 2007), strengths and weaknesses (McWhirter et al., 2007:108), and particular experiences that are developed and shaped in the context of family, school, peer, community and societal environments. The individual domain refers to the intrinsic factors over which a person has more independent control, compared to any of the other contextual domains. The two categories that pertain to the individual domain include the individual risk factors, followed by the individual protective factors emanating from the participants’ narratives.

### Category 2.1.1 Individual risk factors

It is noteworthy that the travellers and observers held very similar views on the individual risk and protective factors relevant to drug use, as will become evident from their narrations below. However, there is a discrepancy in HOW they describe these, as
well as the degree of emphasis some placed on risk and protective factors, while others regarded these as less prominent. The four subcategories that emerged from the analysis of the data were the following: i) Personality factors; ii) Moral development; iii) Negative life events; and iv) A pro-drug attitude. Each will be discussed in the ensuing section.

i) Personality factors

Five observers suggested that a lack of confidence was an individual risk factor that enhanced an adolescent’s vulnerability for drug use; however, only two provided a more detailed description of its meaning. Their narrations below suggest that drug use serves as a self-esteem and confidence booster to adolescents who wish to impress as socially competent when engaging with their peers. Their narrations in this regard follow below:

“Mense dink dit is cool om dit te doen omdat as jy “Tik” gebruik dan voel mense hulle het lus om enige ding te doen, bv. ‘n kar stoot of optel.” [Observer 13]

“Party glo ook dat alkohol hulle selfvertroue gee, wat nie waar is nie.” [Observer 27]

“Party kinders gebruik dwelms/alkohol om beter te kan sosialiseer met hul vriende en voel dat dit hulle ‘n boost gee, maar eintlik het hulle net ‘n swak selfbeeld en het geen selfvertroue nie.” [Observer 29]

The quotes above suggest that the uninhibiting effects produced by drugs provide people with a false sense of confidence and competence (McNeece & DiNitto, 2005; Gouws, Kruger & Burger, 2000:173-178). This serves as a serious risk factor when it compensates for an existing shortcoming in the person’s abilities. The following quote by traveller Charles illustrates this point:

“Now I always used to look up to people like QQQ and YYY, cause they always used to get girls and things and they’re well known people, so I also wanted to be like them, then I started smoking tik…..” [Charles]
Several other travellers made reference to the increased confidence they experienced in their interpersonal relationships as one of the derived benefits from being on the drug use journey (refer to Sub-theme 2.2 in Chapter Four).

The participants’ reports clearly illustrate the interdependence of low confidence, low self-esteem and drug use in adolescents. The participants’ narratives furthermore illustrate how drug-induced confidence results in a re-evaluation of the self-concept, and subsequent increase in self-esteem, especially when friends’ admiration and favourable response to this degree of confidence reinforce the behaviour. This association between the three variables emerged from the findings of other studies as well (compare Scheier et al., 1997; Brook et al., 1986). The important link with the present study is the multidimensional nature of self-concept (Carroll et al., 2007), as illustrated in the narratives of the travellers, whose self-concept increased as a result of the powerful leadership roles they assumed in their drug-using peer circle (compare Theme 2.2 in Chapter Four). Comparing this feeling to their earlier negative experiences of low academic achievement and other negative life events, it is comprehensible that the drug induced emotional boost served as a powerful reinforcement to continued drug use. Previous research reveals a definite link between low self-esteem and drug abuse amongst adolescents (compare Veselska, Geckova, Orosova, Gajdosova, Van Dijk & Reijneveld, 2009; Dakof, 2000; Best, Brown, Cameron, Manske & Santi, 1995); however, it is important to maintain the contextual, socio-cultural focus of the participants of the present study.

Other individual risk factors that often coincide with low confidence and low self-esteem is pessimism, a sense of hopelessness and a pervasive negative attitude. Two observers suggested a link between adolescent drug use and these risk factors as follows:

“Negatiwiteit van jouself en medemense; gemoed van hooplosheid [hopelessness].” [Observer 10]

“When youth are always negatiewe [negative] about themself [themselves].” [Observer 14]
These views seemed to resonate with a large proportion of the observers’ thinking, reflected in their overwhelmingly negative construction of ‘Coloured’ identity, as presented in the first theme of this chapter. This negative construction (refer to Theme 1 in this chapter) coheres with the assertion by Brody et al. (2004:902) assertion that adolescents who experience discrimination or marginalisation indirectly by observing it in their parents, may desert future expectations, and thus be more prone to succumb to drug use. McWhirter et al. (2007) confirm that consuming negative beliefs are prevalent in adolescents who have a pervasive view of problems as unsolvable and hold low expectations for a hopeful future. The latter was particularly evident in the biographical narratives of two travellers who were struggling to remain on the ‘straight and narrow’ road following their diversion from the fast lane (compare Theme 4.1 in Chapter Four).

Although only one observer identified impulsivity as an individual risk factor, several observers identified the converse of impulsivity, i.e. impulse control (National Institute on Drug Abuse (NIDA), 2003); self-regulation (Bower et al., 2012); being goal-oriented; and exercising careful planning as protective factors, which will be discussed later in this chapter. The observer expressed the risk associated with impulsivity as follows:

“Sommige van ons dink [nie] aan die nagevolge en andere gaan kop oorhels [halsoorkop] in ‘n situasie waar hul mettertyd nie meer kan hanteer nie.”[Observer 10]

This individual risk factor, which in effect manifests in poor decision making skills, was evident from the life stories of most travellers, and emerged mostly in interaction with drug-using peers. The personality characteristics associated with impulsivity include sensation-seeking and rebelliousness (McNeece & DiNitto, 2013), which resonate in the excerpts from the narratives of two travellers cited below:

“I was 9 years old. Me and my mother came to stay here, I was still young and I met a couple of friends. Most of the people always used to tell me, Gabby, you must get yourself out of that group, because they are not right for you. But I didn’t listen; I just wanted to do my own thing, because they were fun also for me. And I was doing all the wrong things with them…Walking out of the house, didn’t wanna go to school; 9 years…” [Gabby]

“Uhm I was dating this other guy, but he, he was already a drug user and I knew at the time, but I didn’t still take note.” [Clarissa]
These narratives concur with research evidence that associates pervasive drug use, rather than experimentation (McWhirter et al., 2007), with poor self-control (Griffin, Botvin, Epstein, Doyle & Diaz, 2000); sensation-seeking; impulsivity; and rebelliousness (Brook et al., 1986).

Four travellers ventured onto the drug use journey before the age of 10, and throughout their narratives suggested that they were never subjected to pressure by their older peers to use drugs, but admitted that their ignorance and impressionable young age prevented them from anticipating the consequences of their actions. One reflected in hindsight as follows:

“Ek sou gesê het, nee dankie, dis oraait; ek sal nie meer worry met dit nie, want ek weet mos nou wat gaan vorentoe gebeur.” [Gavin]

Two observers echoed the role of ignorance as a contributing factor to impulsive participation in risky behaviour as follows:

“Mense besef nie die nagevolge van hulle aksies nie.” [Observer 1]

“Mense besef nie wat drugs aan hulle kan doen nie.” [Observer 13]

These narratives concur with Gernetzky’s (2012) assertion that the high prevalence of adolescent drug use in Gauteng, South Africa is suggestive of learners’ ignorance of alcohol and drug related harm. Several studies concluded that whilst adolescents have a fairly good awareness of the types of drugs and their general consequences (Potgieter et al. 2010), they lack insight into the potential damage to their wellbeing and other long-term implications. Another explanation is that they may regard themselves as invincible and immune to the problems that others experience, which is consistent with their social and cognitive developmental phase (Louw & Louw, 2007; Santrock, 1999). These views were supported by several travelers, who confirmed that they had witnessed the negative outcomes of alcohol and drug use first hand in their communities, and were warned about the dangers of drugs by their parents. Similarly, the one traveler’s narration suggests that he was unable to apply hypothetical-deductive reasoning (Santrock, 1999), which would have enabled him to logically and
hypothetically consider the likelihood of his own susceptibility to addiction. This same traveller described how he only started to believe the reported negative effects of his methamphetamine addiction when he physically experienced some of these effects himself (refer to Theme 2.3 in Chapter Four).

**Poor self management and poor self-discipline are** individual risk factors, clustered as identity variables. The categories associated with these risk factors include **poor utilisation of resources (money) and time**, which surfaced in the experiences of four observers, whose assertions are cited below:

“Jy vind uit jy kry te veel sakgeld en begin dwelms misbruik.” [Observer 7]

“Some of them don’t have a head to work with money.” [Observer 14]

“When teenagers have money and have nothing to do with it, then they decide to use it on drugs and alcohol to impress friends.” [Observer 21]

“Spending time and money on unnecessary things.” [Observer 22]

Conversely, one observer suggested that the problem may be related to adolescents receiving **too much pocket money** – an assertion that resonated with the narratives of at least two travellers, and surfaced in the views expressed by practitioner navigators (refer to Theme 1 in Chapter Six).

The penultimate individual risk factor identified by the participants was **boredom** which, according to the observers, was especially applicable to adolescents presenting with multiple risk factors, such as **out of school or unemployed youth**. Their views on the matter were expressed as follows:

“Omdat mense sonder werk sit en hulle het niks om te doen nie. Dan deur die loop van die dag sit hulle op hoeke en bedel geld by mense vir hulle om vir hulle alkohol of dwelms te koop.” [Observer 8]

“When they are not working or attend school, they do this.” [Observer 14]

All the **travellers** described **boredom** as one of the most significant precipitating factors to drug use in the Northern Areas, especially against the background of the **limited**
recreational facilities available in the area. For the participants in the addiction stage of the drug use cycle, this factor seems to have been more prevalent during the recovery stage of addiction (refer to Theme 4.1 in Chapter Four). It is evident that such boredom and social isolation also give rise to negative thinking patterns which, according to one traveller, together with the physical proximity to the risk factors, exacerbated his susceptibility to drug use, as narrated below:

“I don’t know how, but when I’m alone or, or when I see someone that used to do it, that craving come back.” [Charles]

The individual factor identified by the participants as the most pronounced of the risk factors is the lack of coping skills. This is not surprising, given the numerous stressors that adolescents experience, ranging from schoolwork, relationships, peer pressure, and concerns about the future and their parents (Van Heerden, 2005:104). The responses from observers bear testimony to drug use as a coping response by both adults and adolescents, with most of them suggesting that drug use provides a numbing effect against and an escape from the difficult circumstances that characterise their lives. Their responses are cited below:

“Meeste jong mense kan nie die versoeking weerstaan nie, omdat julle dink die lewe is te swaar, dus hoekom hulle dwelms en alkohol misbruik, omdat hulle dink dus ‘n makliker manier om te lewe. Om onbewus te wees van al die dinge wat rondom jou gebeur, dalk het hulle huisprobleme of (geld) finansies in die huis is nie te wen nie.” [Observer 2]

“Baie jong mense gebruik alkohol of dwelms om die omstandighede waarin hulle self bevind te vergeet of selfs net weg te breek.” [Observer 5]

“Die effekte wat hierdie toxic middels op jou liggaam het, laat jou hoog voel, asof al jou probleme weg is. Met die gevoeling, gebruik jy dit sommer elke keer wanneer jy voel jy het ‘n probleem. Baie gebruikers het miskien iets gedoen wat hulle maak pla, ek ken iemand soos hierdie persoonlik. Dan is die gebruik van hierdie goedere net om die stress weg te vat. Soms net om hoog te voel, asof jy “langs Jesus sit”, soos die gebruikers sê.” [Observer 15]

“Baie van ons Kleurlinge ondervind alkohol en dwelms as ‘n goeie uitwerking om hulle probleme op te los, maar dit veroorsaak net meer van ‘n probleem as ‘n oplossing.” [Observer 25]

One observer hinted at socio-cultural stressors located in the apparent tendency of ‘Coloureds’ to undermine instead of supporting each other. Another labelled drug use
as a coping response particular to ‘Coloureds’; a view that resonated in how several observers constructed their view of ‘Coloured’. The view of Brody et al. (2004:902) is a useful reminder in this regard. The authors recommend that children from minority groups learn how to address direct and indirect experiences of being devalued in society, since the latter can contribute to a sense of futility about their future.

The responses from the travellers’ accord with views of the observers, as all confirmed that drug use served as a coping mechanism during their drug use journey. One traveller ascribed the onset of drug use as a coping response (i.e. dealing with a low self-worth and a lack of a sense of belonging, given the absence of both parents and emotional exclusion by her step-siblings). The other travellers all described drug use as generating self-medicating and tension relief benefits (McWhirter et al., 2007:149; Medina-Mora, 2005:27; Newcomb & Bentler, 1988) and as a coping response to their internal problems (e.g. frustration) and external problems.

Whilst there was no overt reference to gender differences in drug use, the sample composition in the present study alludes to adolescent drug use being more prominent amongst male adolescents. The disclosures by two of the female travellers about being introduced to drugs by their boyfriends (refer to Theme 1 in Chapter Four), suggest a potential gendered aspect of adolescent drug use. Amaro et al. (2001) as well as South African studies (Dada et al., 2012a; Reddy et al., 2010) warn that the gender discrepancy in drug use has changed drastically, with an increasing number of female adolescents initiating drug use, a view that was further confirmed in the individual interviews with the community representatives (compare Sharmar, 2012; Stanley, 2012).

ii) Moral development

Table 2.17 in Chapter Two provided an overview of adolescent developmental stages, including moral development. Excerpts from the narratives of two travellers illustrate moral reasoning that is characteristic of the pre-conventional stage of moral development. During this stage, moral reasoning is informed by the adolescents’ motivation to have their own needs met, as is apparent from the excerpts cited below:
“I was like worried about no-one man, I didn’t worry what people think of me, I did it for myself. It’s almost like it was meant for me, man, but afterwards I realized it’s not for me, because people used to speak bad about me and I used to do it just for… I don’t know why I used to do it, but it was always in me. Just to do stuff.” [Andrew]

“Sit sommer hier bo die juffrou se kop, daar is mos gate in die ceilings, dan spoeg ons op die juffrou se tafels….So stout gewees, maar ek worry nie meer met daai goed nie.” [Gavin]

The latter parts of the travellers’ quotes illustrate the conventional stage of moral development, where moral choices are guided by the adolescents’ need for approval from significant people in their lives, such as peers and family. These narratives further illustrate the interdependence between the travellers’ self-image and moral principles and behavior.

iii) Negative life events

The third individual risk factor highlighted by the participants relates to negative life events that could have an impact on an adolescent’s self-concept, self-worth and optimism about the future. The observers narrated negative life events, which included experiences of verbal, emotional and sexual abuse, as an individual risk factor that enhanced the individual’s susceptibility to drug use as follows:

“One of other reasons also is when people tell you you are worthless, no good, ugly, that hurts and feel unwelcomed, unsuccessful. That’s called emotionless [emotional] abuse and verbal [verbal] abuse.” [Observer 12]

“Allis begin dwelms en alkohol gebruik omdat hulle miskien by die skool of huis gemoleesteer word, nou gebruik hul hierdie goed omdat dit op hul gedagtes speel en hul dit wil maak dat dit verdwyn.” [Observer 3]

“Abuse is another reason for the abuse of drugs and alcohol amongst teenagers. They choose drugs to take their minds off things. They say it puts their mind at ease.” [Observer 21]

Two travellers who were in the addiction stage of drug use also shared particular episodes where they experienced physical and sexual abuse respectively (refer to theme 2.3 in Chapter Four). The narrations from both travellers illustrate how these experiences evoked negative impulsive decisions to continue on a path of self-destruction. Research confirms that children who have been victims of abuse are prone
to engage in substance abuse as an avenue of escaping the emotional turmoil that results from such abuse.

Several travellers described how negative life experiences and specific events evoked a general pessimistic outlook on life, which enhanced their receptiveness to venture on the drug use journey. The travellers narrated experiences that included (multiple) losses of attachment figures; the physical and emotional unavailability of attachment figures; relocation of the family, which culminated in the traveller being separated from close friends and a familiar school environment; and, lastly, low attachment to school (compare Theme 1 in Chapter Four). It is apparent from the discussion above that targeting pessimism and negative thinking patterns should form part of not only primary drug prevention interventions, but also relapse prevention.

iv) Pro-drug attitudes

The final cluster of individual risk factors is concerned with people’s pro-drug beliefs, which not only contribute to the acceptance of myths about the perceived benefits of drugs, but further reinforce drug use. The observers narrated these pro-drug beliefs as follows:

“Sommige glo dat hierdie middels hulle gesond hou soos bv dagga, wat kamstig goed vir die bors is, maar as jy weer kyk, is jou longe klaar gerook en sê die dokter vir jou jy sal in 3 maande se tyd sterwe.” [Observer 1]

“Som van ons Kleurlinge gebruik dwelms, want daar word gesê as jy dwelms bv, dagga gebruik laat dit jou beter konsentreer op skool en laat jou goed voel, maar die uitwerking daarop is geen waarborg nie. Dis eerder min konsentrasie.” [Observer 25]

Most travellers expressed positive attitudes towards drugs (refer to Theme 2.2 in Chapter Four), which later changed, when they experienced the consequences of travelling in the fast lane (refer to Theme 2.3 in Chapter Four). Several studies have documented the association between pro-drug attitudes and enhanced susceptibility for drug use (compare Patrick et al., 2010; Van Wormer & Davis, 2008; Mcneece & DiNitto, 2005).
The individual risk factors cited above are juxtaposed against the individual protective factors, discussed in the next section.

**Category 2.1.2: Individual protective factors**

Research has shown that individuals who succumb to the risk factors discussed above are in the minority when compared to others who, despite experiencing similar risk factors, exhibit strengths and assets that facilitate their adaptive functioning in the context of these risks (compare Stajduhar et al., 2009; Clauss-Ehlers, 2008). The individual protective factors enhance the propensity for positive development, which reduces the negative influence of challenges on their lives, or directly reduces the likelihood of their engagement in risky behaviour (Fagan et al., 2011:167).

The travellers and observers differed quite significantly in their narration of the protective factors, as the former group constructed protective factors as encompassing those factors that facilitated their recovery from on-going drug use, whilst the latter group’s construction depicted the characteristics enhanced their resistance to the onset of drug use. The list of protective factors that emanated from the analysis of the findings of both adolescent groups has been structured into three categories, viz, i) Personality variables (these include a vision and realistic goals for the future, self-control, and decision-making skills; ii) Anti-drug attitudes (which include sources of motivation and belief systems); and iii) Religious beliefs and spirituality. Each of these will be discussed below.

i) **Personality factors**

The first individual protective factor highlighted by observers involved having a **vision and a dream for the future**, juxtaposed against the sense of hopelessness and pessimism identified in the previous category as risk factors. The observers expressed the importance of having a vision and a dream for the future, as well as the required strategies needed in order to achieve these dreams:
The observers clearly narrated the importance of having a vision and dreams, emphasising the role of education as a prerequisite to being successful. Some asserted the importance of identifying an adult role model; prosocial goals; and a commitment to provide for their family. Some of the other strategies identified by the observers included dissociating from negative influences; identifying priorities; and visualising and believing in the positive future they could create for themselves (Potgieter et al., 2010). Some observers articulated the sentiment that goals were the stepping stones to dreams, and that these can be accomplished only through the avoidance of drug use, which has been proven to be a barrier to goal attainment; showing commitment and hard work. All these elements appear to be at the heart of self-control.

These findings concur with the outcomes of a study on non-offending Australian adolescents by Bower et al. (2012). In comparison to their peers (convicted of a range of criminal offenses), the non-offenders were more focused on their future and the impact that their present behaviour would have on their school achievement and goals in the long term. This is in sharp contrast to the narrations of the travellers who, during their travelling in the fast lane, appeared to be motivated by short-term outcomes (refer to Theme 2.3 in Chapter Four), (the immediate gratification of their needs for drugs; having fun; and avoiding the consequences of their actions (Bower et al., 2012:7). Whilst the observers’ narratives illustrate the importance of self-regulation.
(consisting of forethought, performance control and self-reflection) (Zimmerman, 2000 in Bower et al., 2012), the travellers operated on the premise of moral disengagement (Bower et al., 2012:7) to justify their antisocial behaviour. Whilst several of these were impulsive actions, the positive aspect emanating from their narratives is the suggestion that some were able to facilitate or participate in organised activities aimed at meeting the short-term gains referred to above (refer to Theme 2.3 in Chapter Four).

**Travellers** who were in the recovery stage expressed mostly idealistic hopes and dreams for their futures, with several of them aspiring towards careers in the helping professions aimed at offering the types of assistance that they themselves required at some point. Whilst their motivation appeared to be derived from an extrinsic source, their resilience in making a transition from their problem saturated identities is commendable. Several travellers on the straight and narrow road identified short-term goals that were more concrete and focused on detaching from their drug use identity. These involved staying sober; being able to exercise self-control; and resisting peer influence (refer to Theme 4.3 in Chapter Four), which Van der Westhuizen (2010) confirms as important goals for avoiding relapse.

Two travellers who were able to avoid entering the fast lane articulated goals that were seemingly more realistic and achievable, given their contextual realities. These goals included acquiring technical skills and focusing on sport, as opposed to aspiring towards passing Matric and tertiary studies. These aspirations matched the outcomes of a positive youth development approach and are consistent with the strategy to address unemployment in South Africa (Altman, 2012).

Lerner et al. (2003), propose that positive youth development enables young people to develop the 5C’s of competence, as proposed by McWhirter et al. (2007) (refer to Section 2.6 in Chapter Two). These characteristics contrast with those of adolescents who lack the necessary coping skills to address the adjustment challenges associated with their developmental life changes (Geldard & Geldard, 2004:43).
ii) Anti-drug attitudes

The second protective factor identified by observers included having strong anti-drug attitudes, as opposed to the pro-drug beliefs identified in the preceding sub-category under individual risk factors. The quotes by the observers below illustrate the reasons for their anti-drug attitudes, as well as the benefits of having an internal locus of control:

“Ek maak besluite oor my lewe en ek laat dit nie toe dat ander mense my druk om iets te doen nie.” [Observer 2]

“Ek dink alkohol en dwelms bring jou nêrens in die wereld nie. Jy verloor alles deur net jou cool wil hou en hierdie dinge gebruik. Ek sien nie myself daarin nie omdat ek lief is vir my lewe en dit goed wil leef.” [Observer 3]

“Want as ek alkohol of dwelms gebruik sal ek moet steel om aan dit te kom want ek’s ongeleer en het nie geld om dit self te koop nie. Ek sien ook nie hoe ‘n lewe waarin ek moet kinders grootmaak maar ek misbruik alkohol/dwelms nie. Ek sal dan nie voorbeeld vir die gemeenskap stel nie. Ek wil ook hê mense moet opkyk na my en nie my verstoot omdat ek met alkohol/dwelms betrokke is nie. Alkohol laat jy snaakse goed oorkom.” [Observer 13]

“Ek weet dis soms om lekker te voel, maar dis nie die moeite werd nie.” [Observer 15]

The narratives above suggest that the strong anti-drug attitudes were informed by a variety of factors, ranging from intrinsic sources of motivation evidenced by having a firm sense of self-control; a strong value and belief system; clearly delineated goals; and decision-making skills. One observer acknowledged the temporary positive effect of drugs, but argued that this was negated by the many harmful consequences witnessed, ranging from effects on one’s health, finances, relationships and future plans. The detailed descriptions of the potential drug-related harms they were protecting themselves against, mirrored several of the drug-related harms that the travellers suffered on their journey (refer to Sub-theme 2.3 in Chapter Four). These findings concur with an Eastern Cape provincial study by Potgieter et al. (2010), which found that disapproval of drug use could generally be attributed to youth witnessing the drug-related harm in their own communities. Similarly, Smokowski et al. (2000:438), confirm that resilient adolescents refuse to be enticed by the apparent exhilaration of the risk-taking behaviour of their peers, but instead learn from the consequences of others’ risk-taking behaviours. A striking quote by one traveller, in the recovery phase of
the drug use journey, confirmed the value of reflecting on and learning from one’s own mistakes and weighing up the options when making a decision:

“Honestly, I could say I’d just say they must be eager to learn from their mistakes, instead of repeating it all the time, I don’t think, I would think the reason why I think so, is because I went to the lowest of the low, so I had no other choice but to die, to go to prison, or I could just turn my life around there.” [Ralton]

The observers who used extrinsic sources of motivation as a deterrent against drug use, narrated their views as follows:

“Om eendag ‘n goeie voorbeeld vir jou kinders te wees.” [Observer 7]

“Omrede ek wil vir andere inspireer en ‘n rolmodel wees.” [Observer 10]

“Ek wil ‘n voorbeeld wees vir anders, ek wil die mense wat betrokke is met dit help om dit te bekamp. Ek wil ‘n goeie “role model” wees vir die mense in my gemeenskap. Ek wil ‘n rolmodel wees vir die mense in my gemeenskap sal nie weer dieselfde wees as ek saam hulle begin nie.” [Observer 17]

Whilst these extrinsic motivations demonstrate noble intentions and may serve as protective factors, Gouws et al. (2000:60) argue that such motivations are often associated with passive behaviour, which is dependent on the approval of others and social acceptance. This increases the potential for conforming to the standards of behaviour imposed by others who are regarded as more influential. Extrinsically motivated people usually demonstrate restricted consequential reasoning (Van der Westhuizen, 2010:191; Mentor UK, 2005), compared to intrinsically motivated people, who tend to be motivated by the need to achieve and learn (Falkowski, 2003:46). This therefore explains why intrinsically motivated people are more likely to present with cognitive flexibility, creativity, positive emotions, and high self-esteem (Sharland, 2006). In contrast, intrinsically motivated individuals use self-regulation instead of social acceptance as the route to social inclusion (Sharland, 2006:250). This was evident from the narrations of the observers who illustrate confidence in their ability to achieve their goals. Such narratives are furthermore devoid of the feelings of despair and pessimism that characterised earlier descriptions of ‘Coloured’ identity in the first theme. Reeve, as cited by Shamloo and Cox (2010), equates intrinsic motivation with the natural inclination of people to follow their own interests and to employ their capabilities to
overcome challenges in life – which view seems to be coherent with the observers’ optimism that they would achieve their goals.

When prompted to share how they would discourage drug use amongst their peers, three travellers suggested that it was every individual’s personal choice. However, the travellers’ biographies are testimony to the complexity of decisions regarding the non-use of drugs. This view is supported by Bower et al. (2012:10), who state that a person’s ability to exercise positive choices when confronted with a quandary requires three important skills, namely ‘self-regulation, social problem-solving and social skills’.

Several travellers relayed stories in which they constructed themselves as more socially competent when in a drug-induced state (refer to Theme 2.2 in Chapter Four). This paradox was also pointed out in studies by Carroll et al. (2009:799), who identified social competence as a protective factor, whilst Veselska et al. (2009:288) established that social competence increased the probability of drug use amongst adolescents. The explanation for how this usually positive element of resilience could now serves as a risk factor is located in the sociability and hence more frequent exposure to environments that cultivate risky behaviour.

iii) Religious beliefs and spirituality

The final individual protective factor that surfaced in the written narratives of several observers related to religious beliefs and spirituality, which was narrated as follows:

“Dit is teen my geloof en as ek teen my geloof iets moet doen, dan het ek nie geloof nie. Ek sal vir myself lieg en dan sal als wat ek in glo, deur my vervals word, want hoe ken ek sê ek is vol geloof as ek teen dit gaan?”[Observer 2]

“Ek was ook op die regte Christen-manier grootgemaak waar alkohol en dwelms streng verbode is in my geloof.”[Observer 9]

“Ek glo dat as drank en dwelms van God af was sou dit in Sy plan vir ons se lewe ingesluit het, dan sal jy nie so skuldig gevoel het nie.”[Observer 12]

“Eerstens is ek ‘n Christen en ek glo in God en ek probeer baie hard om die Tien Gebooie te gehoorsaam. Ek weet ek is nie volmaak nie, maar ek strewe na dit.”[Observer 17]
Similarly, several travellers constructed their narratives of recovery and prevention of a relapse around religious beliefs, underscoring the incorporation of such an element into a drug prevention programme in the Northern Areas. It is interesting to note how differently the travellers constructed the role of religion and spiritual resources. To Zoey, it served as a motivator for change, whilst to Waydin, Gabby, Clarissa and Ralton, it served as a source of support and impetus to desist from a life of drugs and negative peer involvement. Whilst the link between resilience, spirituality, Christian beliefs and actively practising a religion has been echoed in several international and local studies (Potgieter et al., 2010:65; Keegan & Moss, 2008:125; Falkowski, 2003:46; Pardini, Plante, Sherman & Stump, 2000), Erikkson et al. (2010:480) emphasise that religious beliefs may be more prominent in certain cultural contexts than in others. The prominence in the narratives of the travellers and observers in the present study confirms the importance of religious beliefs in the community in which the study was located.

5.3.2.2 Sub-theme 2.2: Risk and protective factors located in the family domain

The family is the cornerstone of society, as it serves as the primary socialisation agent and provider of care and nurturing, especially during early childhood. The family influences the structure of society, but is also shaped by the structural and socio-political changes in society, making it imperative to understand the context in which the family functions. The White Paper on Families (South Africa, 2012b) emerged out of government’s concern about the rapidly deteriorating circumstances of families in South Africa – a concern which was also evident from the participants’ construction of risk factors located in the family domain.

Category 2.2.1: Family risk factors

Both the travellers and the observers concurred that family risk factors constituted one of the most pronounced contributors to the onset of the drug use journey and/or changing the course of the journey. The family risk factors that emanated from the narratives of the travellers and the observers have been divided into three categories,
viz, i) Parenting factors; ii) Family relationships; and iii) Family environment. Each of these family risk factors is presented and discussed below according to the categories outlined above.

i) Parenting factors

The observers argued that parents who used drugs themselves, served as negative role models to their children, as the latter then assumed that drug use was normative and hence embraced favourable attitudes towards its use. Their views on this matter are evident from the quotes that follow:

“Mense glo ook dat die probleem is wanneer die ouers alkohol en dwelms gebruik dat die kinders voel hulle het ook die reg om dieselfde te doen. Kinders vat hul ouers as hul rolmodelle en dink as hulle dieselfde doen, sal dit ook hulle bevoordeel. Ek sien baie jong kinders, skaars op kleuterskool, wat speel-speel maak asof hulle alkohol drink of Tik. As hulle nou al so aangaan, wat gaan nie net gebeur as hulle ouer is nie?” [Observer 1]

“Ouers speel ook ’n belangrike rol. As ouers alkohol of dwelms gebruik, beteken dit dat kinders van kleins af blootgestel word aan dit. Hulle sal grootword met die gedagte dat dwelmmisbruik en alkoholmisbruik aanvaarbaar is.” [Observer 2]

“Ons ouers. Ouer mense gee nie meer om of hulle voor hul kinders dwelms gebruik of nie. Sommige van hulle gebruik ook saam hul kinders dwelms of ondersteun hulle addiction [dwelmafhanklikheid]. Hulle stel hulle eie kinders bloot aan die gevare van dwelmmisbruik.” [Observer 16]

Concurring with these views cited above, six travellers made reference to drug abuse by their parents. These six travellers were recovering from harmful involvement with drugs at the time of the interviews, supporting research evidence that children’s propensity for drug use is enhanced by parental drug use and parental favourable or ambivalent attitudes towards drug use (Miller & Plant, 2010; Kuntsche et al., 2005). Similar findings emanated from South African studies that confirmed a lower propensity for drug use amongst adolescents whose parents modelled anti-drug use attitudes and behaviour (Potgieter et al., 2010; Brook et al., 1991).

The quote by Observer 16 resonates with the narratives by travellers Gabby, Gavin and Tyler (refer to Theme 3 of Chapter Four), which highlight a seemingly prominent harm-
inducing practice amongst parents in the Northern Areas. This involves creating enabling environments in which children are permitted to use legal drugs at home, in what parents regard as a controlled environment. Several authors warn against parental approval of even moderate drinking by adolescents, claiming that even under parental supervision, this practice enhances the likelihood of progression to illegal drugs (Henry & Slater, 2005).

Excerpts from observers’ narratives quoted below, suggest a link between a lack of parental monitoring and supervision and adolescent risk behaviour:

“Baie ander ouers stel net nie belang aan wat hul kinders mee besig is nie. Hulle maak nie tyd om uit te kyk vir gevaartekens nie.” [Observer 16]

“Familie speel ook ‘n gedeelte in hierdie ‘probleem’. Eerste is wanneer ‘n kind te veel vryheid het en dink jy sal kan doen net wat hulle wil. Ook as daar nie ouers in die huis is nie, bv. die ouers is altyd in die werk en dan gebruik kinders dwelms/alkohol om die hol [leemte] te vul.” [Observer 29]

The narratives also allude to the possibility that low parental monitoring and supervision could be the result of (both) parents working long hours. Considering the socio-economic context of the community, it is assumed that parents work in low income jobs, which renders them unable to afford child care services (Vera & Shin, 2006:82). It is under these conditions that children may be exposed to undesirable socialisation agents, such as age inappropriate television programmes (Thornberry, Huizinga & Loeber, 2004), and drug-using peers and adults in a community in which drug use has been normalised.

Several travellers appeared to gloat about their ability to obscure their drug use from their unavailable and unobservant parents, who only realised this during the stage of problematic drug use (refer to Zoey’s narrative in Sub-theme 2.3 in Chapter Four).

Observer 26 further pointed to the negative consequences emanating from parents trying to overcompensate for their physical absence by giving their children large sums of pocket money. The excerpt from the narrative of Observer 26 cited below concurs with the individual risk factor discussed earlier, namely that children who
struggle with self-management and self-discipline are more inclined to spend these large allowances on drugs:

“Parents overcompensate (by giving more, more, freedom because of hectic lifestyles) — because both parents are working and don’t always spend enough time with their kids, they start to overcompensate. Overcompensating leads to the kids having too much spending monies and they start drinking over weekends and after a few years they drink heavier and later in their lives they become alcoholics.” [Observer 26]

Kerr et al. (2010) propose that competence in adolescence is characterised by a decrease in parental monitoring and an increase in adolescents’ autonomy, which was evidently not characteristic of the majority of travellers in the present study.

ii) Relationship discord and low family cohesion

The observers identified conflictual family relations and family disintegration as the second most prominent family risk factor for adolescent drug use. Their narratives suggest that adolescents engage in drug use as a way of communicating their emotional needs to their parents, retaliating against the absence of parental warmth or escaping to the solace offered by drug use, which frequently occurs in the context of an embracing peer group. These views resonate with the travellers’ stories, many of whom highlighted high tension levels in relationships between them and their parents/guardians, with some expressing a longing for a closer emotional bond with their parents. Whilst several of the narrated arguments were seemingly linked to drug-related incidents (refer to Theme 2.3 in Chapter Four), it is possible that they were also informed by the parent-adolescent dynamics that characterise the adolescent developmental stage (Bester, 2011:148; Gouws et al., 2000; Parry et al., 2004). The storylines of the observers cited below serve as evidence:

“Wanneer ouers ook skei, is ’n geval wanneer jongmense na dwelms of alkohol gedryf word.” [Observer 5]

“Sommige keer vind hulle nie liefde in die huis nie en verkies om saam vriende te wees wat bv. dwelms misbruik.” [Observer 7]

“Ek dink tieners begin dwelms en alkohol misbruik omdat hulle probleme het by die huis. Daar is ook tieners wat dit gebruik omdat hulle ’n stry gehet dit met hul ouers nou gebruik hul hierdie
“Also when they are being ignored at home they use drugs and get into trouble and think maybe now they’ll listen or care.” [Observer 21]

These findings concur with Brook et al. (2006), who assert, based on a study among a group of South African adolescents, that the quality and quantity of parental attention is a significant predictor of adolescent drug use, and that in the absence of such nurturance and emotional bonding, adolescents turn to their peers for a sense of belonging and affirmation. These findings point to the need for parental training on the changing needs of children, and how to respond to children’s needs for autonomy (Brody et al., 2004:913) in a developmentally appropriate way.

Only two travellers grew up in intact nuclear families. The other eight travellers were raised by grandparents, single-parent mothers or in reconstituted families. Trojanowicz, Morash & Schram (2001:144) assert that reconstituted families experience numerous challenges, such as disagreement about the disciplinary styles used by step-parents, which often fuels disagreements between parents and hostility between child and step-parent, which unsettles the entire family system. These findings underscore the experience narrated by traveller Charles (refer to Theme 2.1 in Chapter Four).

Young and Long (2007) make reference to grandparents being more permissive and indulgent than parents in general, as they view their grandparenthood as a time to rectify all the mistakes they made with their own children. This assertion may resonate with the observation about the high number of children being raised by grandparents (due to teenage parents relinquishing their responsibility to their parents) in the Northern Areas, where the present study was conducted.

It is evident from the discussion above and the literature cited that relationship discord in families, and low family cohesion, detract from positive adolescent development and enhance the risk for drug use (Carroll et al., 2009), as well as negative behaviour across multiple domains of the adolescents’ functioning (Youngblade et al., 2007:S52).
iii) Family Environment

A few observers referred to *unemployment and financial stressors* as significant family problems that contributed to adolescents’ susceptibility to negative environmental and peer influences. A selection of their narratives is cited below, whilst the rest will be discussed under the community risk factors according to how the particular observers constructed their narratives:

“Parents don’t have enough money to put their children in school or to continue their studies. As a result of that, teenagers sit around on corners of streets, and that’s when they start adapting to life on the streets.” [Observers 21]

“Dit kan ook wees dat daar finansiële probleme in die huise is en party ouers kan dit nie hanteer – veral nie mans nie. Vrouens kan dit nog hanteer, maar dan kry jy van daardie moeders wat niks omgee vir niemand of niks nie en min wetend sy het miskien ‘n baba om te versorg nie.” [Observer 8]

“Family financial problems, family that’s not so rich, who can’t afford to give their children the best that they so much want to; now the child feel inferior and poor, because they can’t afford what their friends can.” [Observer 12]

These narrations resonate with the views expressed in the White Paper on Families (South Africa, 2012b), namely that family functioning is influenced by one’s social context. Similarly, Thornberry *et al.* (2004) suggest that families with few resources, who live in underprivileged areas, experience more difficulty in providing their children with an upbringing that will keep them away from deviant and at-risk behaviour.

**Single parenthood and reconstituted families** emerged as significant risk factors for adolescent drug use. Whilst the dynamics in these family environments were discussed under the category pertaining to family relationships above, it is important to illuminate this particular family structure under the current heading, due to its prominent influence in adolescent risk behaviour. One proposition offered by McWhirter *et al.* (2007) is that single mothers who have low income jobs seem to adopt a more permissive parenting style. Furthermore, mothers in reconstituted families often feel torn between their husbands and their own children, and vacillate between permissive and authoritarian parenting styles.
The preceding discussion highlights the importance of enhancing family protective factors as a means of strengthening families’ resilience. The next sub-theme examines the participants’ constructions around family protective factors, in relation to a literature control.

Category 2.2.2: Family protective factors

The family protective factors that emanated from the narratives of the observers and travellers have been grouped under two categorie. These are: i) Parenting factors; and ii) Nurturing family relationships and high family cohesion. Each of the two categories of family protective factors is presented below:

i) Parenting factors

The travellers and observers were in agreement that the family's values, rules, non-approval or disavowal of drug use, prosocial attitudes and positive family role models served as important family protective factors against drug use. The observers articulated their views on the aforementioned as follows:

"Daar is baie mense wat voorbeelde vir my gestel het. Dit was deur my ouma en oupa in my gestel dat dit onaanvaarbaar is." [Observer 2]

"Ek is goed opgevoed deur 'n enkelma, dus sien ek nie die nodigheid om my lewe en my geld wat vir beter dinge kan gaan; te mors op alkohol en dwelms nie." [Observer 9]

"Die familie wat ek het. Hulle help my en vertel my daagliks van die gevare wat daarmee gaan." [Observer 15]

The narrative of Observer 15 illustrates the importance of parents educating their children about the dangers and consequences of drug use (Miller & Plant, 2010; Molgaard & Spoth, 2001). The three travellers who did not progress beyond the recreational use of drugs (refer to Theme 1 in Chapter Four), portrayed their parents (and primary caregivers) as strict disciplinarians who articulated their non-approval of and rules relating to drug use clearly (Molgaard & Spoth, 2001), and monitored them closely (Eriksson et al., 2010). These narrated experiences concur with the sentiments that parents who are actively engaged in their children's lives serve as powerful
deterrents to peer and media influences to use drugs (CASA, 2001b, as cited in McNeece & DiNitto, 2005:217). This stance is further strengthened when families reinforce environmental support that enhances responsible behaviour (Houghton & Roche, 2001 cited in Carroll et al., 2009) (compare Theme 4.3 in Chapter Four) which depicts the travellers’ narrations of how being entrusted with responsibilities at home enhanced their resistance to drug use.

The converse of parental modelling and drug norms is also true, as several travellers who were in active recovery from drug addiction reported how the drug related harm they experienced and witnessed in their own families served as active motivation to remain drug free (refer to Theme 4.3 in Chapter Four). Smokowski et al. (2000:438) suggest that two children exposed to the same role model may often manifest their learning in totally different ways; speculating that this may be influenced by the person’s relationship with the role model, or simply by biological factors. The essence of this stance is that resilient individuals derive learnings from a role model’s behaviour, rather than replicating similar behaviour patterns – a process described by Van Wormer and Davids (2008:388) as family adaptation.

ii) Family Relationships

Many of the adolescent participants in the present study were raised in economically deprived neighbourhoods by single parents, whose sacrifices they now wished to reward. Excerpts from the narratives of observers, cited below, seem to suggest the presence of nurturing relationships with their parents, which serve as the trigger for their commitment, sense of indebtedness and motivation to follow their parents’ positive example. The quotes below capture their sentiments in this regard:

“Nog ’n rede is dat ek my ouers, veral my ma, wil trots maak en laat sy sien dat al haar moeite en harde werk nie verniet is nie.” [Observer 5]

“Wat word van my as ek moet dit gebruik en elke dag vra ek myself, is dit die manier hoe ek vir my ouers dankie wil sê eendag… as ek dwelms moet gebruik?” [Observer 8]

“Vandat ek ‘n jong dogtertjie was het ek my ma belowe dat ek haar uit die gemeenskap sal kry in ’n plek waar sy vry sal wees om te gaan waar sy wil sonder om haar kop te breek oor wie
haar sal roof of aanrand, want dis wat ons mense aan mekaar doen om geld vir dwelms en alkohol in die hande te kry. My ma is vandag nie meer hier nie, maar ek gaan my belofte aan haar hou dat ek myself dan uit die gemeenskap sal kry. Die enigste manier hoe ek dit gaan regkry, is om nie by dwelms en alkohol betrokke te raak nie.” [Observer 16]

These experiences cited above, resonate with the travellers in the present study, whose loyalty to their parents served as the turning point in their drug use journey (compare Theme 4 in Chapter Four). In addition, several travellers reflected on the nurturance they received from guardians and significant others, which facilitated their ability to select an exit route from the fast lane (refer to Theme 4 in Chapter Four). These findings confirm the views that higher family cohesion and nurturing parent-child relationships are associated with lower risk of drug use (McWhirter et al., 2007), the belief to uphold family pride (Kim et al., 2002:577), and enhanced resilience in adolescents (Veselska et al., 2009:290). Smokowski et al. (2000) further emphasise the value of strong family relations and social support (Ledoux et al. 2002; Miller, 1997), reporting that children from underprivileged communities who benefit from firm, instructive parenting, balanced with high levels of warmth, have proven to present with high levels of academic resilience (Smokowski et al., 2000:427). This observation held true for at least two travellers who were pursuing their final year at high school at the time of the study. The much thinner narratives relating to family protective factors in comparison to the risk factors illustrate the need to strengthen family protective processes.

5.3.2.3 Sub-theme 2.3: Risk and protective factors located in the peer domain

Adolescence is presented in the literature as a vulnerable developmental period, since it characterises the intersection between childhood and adulthood (Louw & Louw, 2007; Gosin et al. 2003:122). Accordingly, adolescents need to spend more time with peers and reduce the influence of their parents (Bezuidenhout & Joubert, 2003), and yet still rely on their parents’ influence and guidance. This paradox often results in increasing tension between parents and adolescents, which Bester (2011) attributes to the adolescents’ overestimation of responsibilities, which often coincides with normative developmental changes in their parents (Louw & Louw, 2007; Santrock, 1999). It is these constructions that give rise to adolescents frequently being described as an
‘endangered and dangerous group at risk from others, to themselves, and to the fabric of communities’ (Kim et al., 2002:566).

The peer group becomes the primary source of socialisation during the adolescent period (Kliewer & Murrelle, 2007; Kim et al., 2002:568; Oetting, 1992), especially with regard to the learning of social norms. It is therefore not surprising that peer drug use has been confirmed as the dominant influence in adolescent drug use (Brook et al., 2006; Kim et al., 2002). The fact that twenty-five of the twenty-nine observers made reference to peer influences as risk factors for drug use, compared to only six of them referring to protective factors, confirms that they were equally more inclined to subject their peers to a ‘sorting process’ (Hanson, Miller & Diamond, 2011:16). This has several implications for adolescents’ perceptions of their own identity and that of their peers. Their suggestions to actively avoid negative peers, in order to reduce susceptibility to substance use and increase association with positive peers for the inverse effect, resonate with the tendency to categorise and uphold the description by Kim et al. (2002:566). Their apparent silence on the protective role the peer group could fulfil, suggests a gap in the identification of peer factors and processes that could be to their benefit. The respective peer risk and protective factors constructed by the observers and travellers are subsequently discussed in the ensuing section.

Category 2.3.1: Peer risk factors

There was strong agreement between the travellers and the observers that negative peer association, the nature of peer influence and the factors impelling submission to peer influence interact to compound the adolescents’ susceptibility to depart on the drug use journey. Each of these risk factors will subsequently be discussed, albeit in an integrated manner, due to their interrelatedness.

The quotes below portray the construction that association with non-conforming peers enhances the adolescents’ exposure and susceptibility to peer pressure, and subsequent alienation by prosocial peers – sentiments that have been endorsed by previous studies (compare National Institute on Drug Abuse (NIDA), 2003; Hawkins et
The views of the observers were expressed as follows:

“Vriende het ‘n baie groot invloed. Wat jou vriende doen ken jou beinvloed, omdat meeste van ons vriende wil beindruk. Mense wat vriende is met mense wat dwelms gebruik of alkohol, gaan poog om hulle vriende te beindruk deur ook dit te gebruik.” [Observer 2]

“Ander tieners gebruik weer alkohol en dwelms omdat hul vriende dit doen en hulle nie wil uit voel nie. Tieners begin dwelms te gebruik sodat hulle kan famous is by die skool en ook aan ‘n soort groep te kan behoort.”[Observer 3]

“Kleurling tieners dink dit is “cool” om alkohol te gebruik. Hulle doen dit om vriende te beindruk dit noem hulle “‘n coloured” ding. Eers is dit net vir die pret en hoe ouer hulle word hoe verslawer raak hulle.”[Observer 9]

“Dit begin altyd op ‘n jong ouderdom waar jy gesê word om die tipe dwelm of drankie te toets. Om nie ‘n spoilsport te wees voor die res van jou vriende sal jy dit maar vat en uittoets. Maar in woonbuurt waar’ ek woon, gebruik mens hierdie middels om populêr te wees”. [Observer 15]

The narratives by both the observers and travellers illustrate that peers, being the primary socialising agents in adolescence, are influential mediators of the choices adolescents make about risks. Sharland (2006:257) therefore argues that adolescents’ normalisation of risk behaviour (such as drug use) is motivated more by their need to blend in with their peers, rather than by a desire to defy adult authority. Mazzardis, Vieno, Kuntsche and Santinello (2010) term this external motive to blend in with peers, the conformity motive, which is closely associated with adolescents’ internal enhancement motive to have fun and experience excitement (Kuntsche et al., 2005). Louw and Louw (2007) reiterate that the enhancement motive is a normal need in adolescence, since this developmental stage is characterised by curiosity and excitement seeking – therefore, suggesting that experimenting with drugs is normative behaviour for adolescents (McWhirter et al., 2007:149).

The narratives of the travellers reveal that they were attracted to non-conforming peers by a number of factors, cited below, and supported by direct quotes:

- The need to have fun with their friends: “and I didn’t want to listen, I just wanted to do my own thing, because they were fun also for me.” [Gabby];
The need to be associated with the popular peers at school: “I was hanging out with them and stuff, because they are the cool guys on the school.” [Waydin];

The need for assimilation with their friends: “All my friends was there and then they also tried it and then I didn’t want to be left out.” [Liezle]

The need for a sense of belonging derived from older peers, in the absence of parental warmth and support (refer to narratives of travellers Gavin, Andrew, and Zoey in Theme 1 of Chapter Four).

The following narrative by Observer 16: “Tieners voel soms dat hulle te veel verantwoordelikhede het, veral as daar geen ouers by hulle bly nie en hulle moet al die verantwoordelikhed van die ouer oorneem. Hulle voel hulle wil wegbreek en dan draai hulle na dwelms vir comfort”, suggests that association with non-conforming peers also serves as an avoidant coping response to being confronted with adult responsibilities. This assertion supports the views of the travellers Charles, Zoey, Gavin, Andrew, Gabby and Clarissa – all of whom described how drug use served as a coping response to the family-related stressors they were experiencing (refer to Theme 2 in Chapter Four).

The benefit of protection (against being bullied) afforded by these peers (refer to Theme 1 in Chapter Four).

Submitting to the influence and power of older boyfriends (refer to the storylines of Liezle and Clarissa in Theme 2 of Chapter Four).

The travellers’ experiences resonate with the sentiments of Falkowski (2003) and National Institute on Drug Abuse (NIDA) (2003) that negative peer association occurs mostly when supervising adult figures or nurturing parent-child relationships are absent. These negative peer associations result in the reinforcement of antisocial actions, since their friends’ responses provide them with the attention and status they often desire (McWhirter et al., 2007) and the opportunity to escape from the increasing demands placed on adolescents in the 21st century (Fatusi & Hindin, 2010:1; Kuntsche et al., 2005). Rayle, Kullis, Okamoto, Tann, LeCroy, Dustman & Burke, 2006) further propose that the longer time spent with friends, the greater the propensity to drug use. Several South African and international studies support findings from the present study, that
adolescents who have drug-using peers in their friendship circle (i.e. peer social influences) are more inclined to engage in drug use themselves (Potgieter et al., 2010; Brook et al., 2006).

It is evident from the narratives of the observers and travellers that the peer group fulfilled several functions during adolescence, ranging from launching from parental influence; identity development; serving as a social outlet; a source of feedback; learning the rules that govern social behaviour; serving as an active support and informational/consultancy network (Smetana, 2011; Gouws et al., 2000; Smokowski et al., 2000; Santrock, 1999). These findings attest to the importance of prioritising the peer group as influential change agents during drug prevention.

The literature makes reference to four mechanisms of peer influence: i) informed by group norms; ii) direct peer pressure; iii) peer influence through modeling; and, lastly; iv) by creating structured opportunities (McWhirter et al., 2013:179; Karcher et al., 2004:194-195; Griffin et al., 2003:3). These peer influences, which are of an interactive nature and can occur in isolation and in combination, were evident from the narratives of all the travellers. The narratives of travellers Charles, Waydin, Tyler and Clarissa illustrate how they experienced peer influence in specific social contexts, where loud mood-altering music and a festive atmosphere (refer to Theme 1 in Chapter Four) dulled their awareness of harm and reduced their inhibitions. The narratives of Andrew, Zoey and Charles alluded to their involvement in gangs (refer to Theme 2.3 in Chapter Four), where the group norms prescribed involvement in crime as a way of securing their access to their drug of choice. Similarly, the narratives of Tyler illustrate the degree of peer pressure that was exerted in the direct drug offers he received (refer to Theme 1 in Chapter Four). The peer influence mechanism of modelling emanates from the narratives of Liezle and Charles, who were both attracted to the carefree and confident personas they observed in their friends (refer to Theme 1 in Chapter Four). Brook et al. (2006) hold a view that differs slightly from the dominant view on peer influence, claiming that certain adolescents purposely select peers who use substances so that they can embark on the experimentation.
The narratives by both the observers and travellers suggest that the adolescents’ susceptibility to submit to peer influence was subject to the **consequences of resisting peer pressure**. The observers articulated the potential consequences as follows:

“*Kleurlinge doen dit ook as gevolg van ‘bad company’, omdat hulle doen wat anders doen net om in te pas, want sommige tye as hulle dit nie doen nie, word hulle gedreig om dood te maak of hulleself dood maak.*” [Observer 4]

“*Some are forced to use it and if you refuse, they will call you a loser and spread mean rumours about you even if you know what they say ain’t true. When you a teen all you can think of is popularity and your reputation at school. You will do anything to be that girl or that guy even if it means taking drugs, you will really be surprised how low people would go to be seen. Teen likes to experiment on drugs to impress their friends. Teens do drugs because they think it’s cool, they sell drugs to be seen, because they think they have power over learners or people who are not using it. They do it because they want to be respected by others.*” [Observers 17]

“*Another reason is peer pressure: teenagers tend to do anything for their friends, because they don’t want to be the odd one out. They’re afraid of being called a sissy or a loser. They, too, want to be classified as being cool and popular.*” [Observer 21]

These narratives suggest that the consequences range from being ostracised, excluded, blackmailed, having one’s reputation tarnished, having one’s life threatened, to the risk of suicide. The narratives of Observers 4 and 25 concur with Kim *et al.* (2002), namely that ethnicity determines the strength of socialisation sources. Smetana (2011:56) further purports that adolescents’ judgment on exclusion from their peer groups is multifaceted and informed by their moral views and social hierarchy, with those from low status school peer groups experiencing exclusion as marginalisation. This appears to be relevant to at least three travellers in this study, who persistently conformed to their drug-using peers, who were perceived to enjoy an elevated status. Similarly, Smetana (2011:57) proposes that adolescents’ position on what is right or wrong is also influenced by social, cultural, historical or personal circumstances. This held true also for the travellers in this study, who were offended by their parents’ mistrust and perceived lack of support, and their teachers’ lack of understanding. Yet, they seemed to regard their own violation of their families’ trust and possessions as acceptable, as they needed to feed their addiction. A discussion on peer protective factors follows below.
Category 2.3.2: Peer protective factors

The observers and travellers identified the following as protective factors on the level of peer relationships: i) associating with prosocial peers; ii) disengaging from negative peer influences; and iii) peer resistance skills. Due to their interconnectedness, these protective factors are discussed as a collective. Three of the 29 observers alluded to the association with prosocial peers (and positive adults) as a protective factor, which they articulated as follows:

“*My vriend en familielede speel ‘n baie belangrike rol in my lewe om nie betrokke te raak by alkohol- en dwelmmisbruik nie.***” [Observer 6]

“*Wel ek het vriende wat dit nie gebruik nie, so dit is ook maklik vir my om nie daar betrokke te raak nie.***” [Observer 11]

“*My vriende wat ek met is, doen dit nie.*” [Observer 14]

Traveller Gavin emphasised the importance of positive peer selection, in a community ravaged by drug use amongst adults and adolescents, as follows:

“*Hier in die plek. Waar jy kom, is dwelms, as jy daar kom, is dwelms. All over is dwelms, dwelms. As jy nie like; jy moet jou vriende kies. As jy verkeerde vriende kies, dan, dan moet jy maar… dis jou besluite wat jy neem.*” [Gavin]

Gavin’s caution resonates with both international and local studies, which have confirmed that an environment in which adolescents are surrounded by prosocial peers has a greater potential to facilitate the promotion of resilience, as opposed to disorganised communities, characterised by the presence of negative peer influence, negative adult role modelling, and the absence of positive social and recreational outlets (Eriksson et al., 2010:479; Van der Westhuizen, 2010:139-140; Kim et al., 2002:567-568). These research findings also concur with the findings of the present study, as the travellers who managed to disembark from the drug use journey formed relations with prosocial peers. For example, Zoey joined her church’s Brigade; Clarissa joined the FAD support group; Ralton was promoted to school leader and received continuous support from a prosocial girlfriend and a network of prosocial adults) (refer to Theme 4.3 in Chapter Four). Their decision to find an alternative social outlet, instead
of withdrawing into social isolation, attested to their need for social connectedness (Patrick et al., 2010:457). Smokowski et al. (2000:443) found in their study among disadvantaged youth, that positive relations occurred in clusters, and that the values of these were located in positive role modelling and continuous motivational messages. This implies that adolescents who maintain good relations with positive peers also enjoy positive relationships with their parents and/or siblings, as seem to have been the case for the travellers mentioned above (refer to Theme 4.2 in Chapter Four).

The travellers’ narratives detailed different mechanisms employed to distance themselves from their earlier drug using peer circles (refer to Theme 4 in Chapter Four). Two travellers disengaged systematically by initially remaining in the friendship circle, using a licit drug, whilst their peers used illicit drugs (refer to narratives by Gavin and Andrew in Theme 3 of Chapter Four). Others actively disengaged from their peer groups by altering their daily routines. For example, traveller Waydin avoided earlier meeting places, travelled a different route to school, and volunteered to remain in the classroom during school-breaks. Traveller Andrew reported how his grandparents moved him to a different school, whilst Zoey and Gavin were moved to different towns in their parents’ desperate attempts to create distance between them and the availability of drugs. Gabby’s parent also initiated admission to a Child and Youth Care Centre, as she (the mother) seemingly felt powerless against the peer and community risk factors to which her daughter was exposed, especially as her role as monitoring agent was diminished by her status as a single parent with long working hours.

Several travellers employed direct and subtle peer resistance skills, which could also be categorised as individual protective factors (refer to Category 2.1.2 in this Chapter). Waydin, who previously succumbed to the taunting of his peers, described how he chose to ignore the teasing – effectively applying the skills of emotional regulation (Bower et al., 2012; Karapetian & Grados 2005) as follows: “It’s still a problem, but I, I don’t take note of the people any more.” Charles, on the other hand, formed a different cognitive construction of the peer group, which he initially idolised. He articulated his reconstructed thinking as follows: “I don’t wanna be like them, I thought they were cool, but now they not cool anymore for me; they will go hit anyone in the street, just like that, for no reason.” Tyler was the only traveller who challenged his peers’ use of
drugs directly, as described below: “Yeah, I ask them, what is so nice about the drug? So they said, no, it's the feeling. They give me that answer the whole time….the feeling. I don't understand what they feel if they are so lam [inert] and lazy.” The narrative suggests that he questioned the dissonance between their subjective description of the effects of the drugs and his observations of these effects.

Another protective factor shared by four observers alludes to the techniques employed in terms of the Social Influencing Model (Cuijpers, 2002; Tobler et al., 2000). The narratives below suggest that the observers’ direct observation of drug related harm contributed to their critical evaluation of this behaviour against their goals for their own lives. They expressed their views as follows:

“Ek is nie beter as hulle nie, maar ek het drome en sal alles doen om my drome en doelwitte te bereik.” [Observer 3]

“Ek sien ook die negatiewe invloed wat dit op ander het en dit is baie teleurstellend en hartseer.” [Observer 18]

“Die dinge wat ek sien in die omgewing. Dis hard soms om te sien hoe lyk tieners met sulke tipe gebruik.” [Observer 15]

On a positive note, contesting the popular belief that adolescents are passive victims of peer pressure, the narratives of the travellers in particular suggest that adolescents are active participants in their respective peer circles, who respond to their own needs for belonging and acceptance, rather than submitting to coercion by their peers (refer to Theme 1 in Chapter Four). In addition, their submission to peer influences is also informed by other contextual factors, such as the strength of their relationships with parents, intrapersonal factors (such as high self-esteem and self-efficacy), and attachment to school.

The next sub-theme constitutes the presentation of the school domain as both a risk and a protective factor in relation to adolescent drug use.
5.3.2.4 Sub-theme 2.4: Risk and protective factors located in the school domain

School serves as a significant socialising agent for children from as early as their pre-school years. During the adolescent phase, it provides them with the knowledge and skills they will require to enhance their productive functioning in society (Luiselli, Putnam, Handler & Feinberg, 2005:188). Children could, however, also experience school as very stressful, as a result of learning problems or limited academic survival skills (McWhirter et al., 2007:126). In addition, a crowded and non-conducive school environment, cramped daily programmes, limited educational resources, the stress of certain school subjects, unrealistic demands and expectations, an excessively competitive culture, and ongoing violence, intimidation and/or teacher strikes all contribute to school-related challenges. Whilst the narratives of travellers and observers corroborated on most of the school specific risk factors, the narratives by the travellers facilitated a more detailed understanding of how distinct experiences at school and approaches to school culminated in either risk or protective factors for the participants. The school risk factors are discussed below, followed by the school protective factors.

Category 2.4.1: School risk factors

The following categories emerged for school related risk factors from the data analysis: i) Low attachment, low commitment to school and learning difficulties; ii) Teacher attitude; iii) School environment unsafe; iv) Absence of sport, cultural and extra-curricular activities. It is important to note that the travellers rated school risk factors as one of the three dominant risk factors (following family and community risk factors) that marked their venturing on the drug use journey. School risk factors often triggered the acceleration in speed, and hence dangerous encounters on their journey. These risk factors frequently prolonged their travels in the fast lane, which resulted in protracted negative consequences. Each of the three categories of school risk factors is subsequently discussed below:
i) Low attachment, low commitment to school and learning difficulties

Several observers suggested an association between low attachment to school whether children like going to school (Wong et al., 2010:277), low commitment to school “whether adolescents are willing to put effort in school” (compare Wong et al., 2010:277), low school achievement and venturing on the drug use journey, as an avoidant coping response. A selection of their narratives follows:

“Die tieners is stadig in hul skoolwerk nou is hulle skaam, dan los hulle skool en begin drink en alkohol te gebruik omdat hulle dink dit gaan hulle cool maak.” [Observer 3]

“Teenagers go through a lot of pain sometimes and even on school, if you failed you maybe go and use a substance without the intention to get hooked and just as you want to stop it — too late.” [Observer 12]

“Kleurlinge het ‘n gewoon te om nie te leer en klaar skool te loop nie. Sonder matriek kom ‘n persoon nêrens en op so manier is hulle ongeskoold of halfgeskoold, hulle kry nie werk nie en dwelms en alkohol is al oplossing! Wat hulle gouer tot sterwe laat kom.” [Observer 9]

“Mense sê Coloured is dom…..dit is so, dan los hulle skool.” [Observer 11]

These narratives illustrate how low school achievement affects adolescents’ views and feelings about themselves. This situation is aggravated by low school attachment, which can start as early as kindergarten, as illustrated in the narrative of traveller Tyler: “I never used to like crèche. I always used to cry when they took me. Actually I used to run back to the car when my grandfather dropped me in the mornings, then I used to run back to the car.” His biographical narrative illustrates how his dislike for school persisted throughout primary and secondary school, contributing to low school commitment, low school achievement, and his repeated suspension from school. Research findings concur that low school achievement can activate the downward spiral of low self-esteem (Bower et al., 2012:1-2; Bonell et al., 2010:2), and engagement in deviant behaviours as a way of salvaging a fragile image (Carroll et al., 2009; McWhirter et al., 2007:113; Luiselli et al., 2005).

Five travellers from the present study were suspended from school for initially presenting with behavioural problems, and later drug-related offences at school (refer to Theme 2.3 in Chapter Four). One of these travellers was eventually expelled from
school, and one dropped out of school. The strong link between school disengagement and adolescent drug involvement has been noted by several authors (Kliwer & Murrelle, 2007; Grunbaum et al., 2000:145-149). In concurring, Bower et al. (2012:10) refer to expulsion and suspension from school as punitive measures that are embedded in deficit-based perspectives that have proven to have adverse effects on young people, as was the case for all the five travellers in the present study. The authors claim that disengagement (which can also be self-initiated) could “result in embarrassment, fear, boredom, powerlessness, or a lack of social and self-regulatory skills typically associated with anti-social behaviour and serious conduct disorders’.

The narratives by observers 9 and 11, cited above, reiterate the self-depreciating construction (referred to in Theme 1 of this Chapter) of ‘Coloured’ identity being synonymous with low academic aspirations and low school commitment, which are then offered as explanations for the propensity for drug use. This view was corroborated by at least four travellers in the study, as illustrated by the narrative of traveller Gavin, who was expelled from school and was recovering from a “Tik” addiction: “Weer in Graad 8? En ek is 17 jaar oud? Dis maar beter as ek ‘n werk gaan kry, my ma het gesê ek moet hier onder gaan vra vir daai straatjoppies… R150 ‘n dag ek gaan vra daar onder.” The view of ‘Coloureds’ having low academic aspirations was echoed by the practitioner navigators who participated in this study (refer to Theme 1 in Chapter Six), as well as in an interview with members of the Bethelsdorp SAPS Youth Forum (Minnie & Muller, 2012). This view, sadly, concurs with national university graduation figures, as well as with findings from the South African Community Capability Studies, undertaken by the Centre for Democratising Information (Altman, 2012). The findings from the latter study indicate that 30.8% of ‘Coloured’ youth described education as useless and less interesting, as opposed to 17% of ‘African’ youth and 0% of both ‘White’ and ‘Indian’ youth respectively. Altman (2012) hypothesises that this attitude may be informed by the high unemployment rate amongst this group and the perceived limited opportunities, with employment equity currently guiding recruitment in the South African labour market (Employment Equity Act No. 55 of 1998) (South Africa, 1998).

Notwithstanding the association with ‘Coloured’ identity, several researchers have confirmed the relationship between low academic aspiration, poor school performance
and adolescent drug use (Morojele, Rich, Flisher & Myers, 2012; Johnston et al. cited in McNeece & DiNitto, 2013), implying that the inverse should serve as school protective factors. An encouraging observation was that two travellers in the present study who have been more optimistic about their recovery (i.e. Ralton and Clarissa), attended school diligently and started exploring post-school studies. This endorses the proposed focus on school attachment, school commitment and scholastic achievement as important for drug prevention interventions, which will be discussed further under the theme on preventive interventions.

ii) Teacher attitude

One observer alluded to the impact the attitudes of teachers and fellow learners could have on adolescents’ commitment to school, by stating: “In school they are also discouraged by pupils and teachers” (Observer 19). In contrast, the majority of the travellers expressed the effect brought about by what they perceived as negative attitudes and behaviour by teachers. The existence of tension in the learner-teacher relationship is evident from the narratives that follow:

“There was times that I wanted to jump, because of teachers I never liked. Now my class teacher is one of the Sirs.” [Waydin]

“Once I was naughty, one night and then the one teacher she hit me, but not with fists and not her hands, like with a belt, and she also hit my one friend.” [Gabby]

“Die juffrou, miskien sy slaan my onnodig, dan stry ons, dan jaag hulle my weg van daai skool af.” [Gavin]

One of the travellers, Waydin, appealed for a change in teachers’ attitudes towards learners, suggesting that certain teachers were prone to perpetuate negative labelling and ostracise learners who had previously presented with drug related conduct problems. Waydin narrated his own experience as follows: “But the teachers still labeled me as that boy now whenever I tried to do something”. Another traveller, Tyler, who always requested help (with academic tasks) from his peers, rather than his teachers, shared his interpretation of his teachers’ attitudes as follows: “Some of the
teachers don’t take note. Like we’re there to just give you work and write down….like we come here to get paid. This is my job. That’s their attitude."

Traveller Clarissa, who transferred from a private school to a public school, implied that there was a strong enforcement of and adherence to discipline by teachers at the private school she attended. In the narrative that follows, she articulated how she adopted a more assertive attitude to protect herself at the public school, upon realising that teachers had a different approach to enforcing discipline. She articulated it as follows:

“When you’re in a private school, you do certain things and there is a certain discipline. So then through that years of moving there, I had to change my attitude, my, myself to adjust to my surroundings. I had to you know, you can’t be quiet anymore, you have to be that person that can defend yourself.”[Clarissa]

These narrations point to a need for increased emotional control in teachers; effective management of learners with challenging behaviour; and a revision of the schools’ disciplinary sanctions for drug-related offences.

iii) School environment unsafe

It was interesting that none of the observers identified the access to drugs on the school premises as a risk factor, whilst nine of the 10 travellers in the present study alluded to the prevalence of drug use and drug sales on school grounds. These reports corroborate with a newspaper article about the influx in adolescent drug use and sales in Northern Areas schools (De Jager, 2011:4), as well as reports by a community volunteer and a drug prevention practitioner rendering services to the Northern Areas community (Stanley, 2012; Perreira, 2012). The second South African National Youth Risk Behaviour Survey by Reddy et al. (2010) highlight the use of alcohol on school property (15.1%); the use of cannabis on school property (11.5%); and accessing drugs at school (10.8%), as more prevalent amongst the ‘Coloured’ learners nationally. Comparative figures for ‘Black’ learners are 12.5%; 7.5%; and 8.8% respectively. This problem, however, is not unique to so-called ‘Coloured communities’, as drug peddling has been confirmed as rife at most schools, especially in economically deprived
communities, where children are recruited as drug peddlers by drug dealers (Daniels, 2007).

Two travellers in the experimental phase highlighted the need for enhanced and trustworthy security measures at school, narrating how the drug suppliers bribed the security guards at schools in order to gain access to the learners. They also expressed fears about the compromised security measures at their schools, which become paramount to adolescents who need protection when they wish to disengage from their former drug-using peer circle. Youngblade et al. (2007) reiterate that school safety enhances learners’ social competence and reduces the potential for externalised behaviour, as will become evident in the discussion under school protective factors.

iv) Absence of sport, cultural and extra-curricular activities

Several of the observers referred to the absence of extramural/ sport or recreational programmes as a community-based risk factor. It is mentioned under school risk factors, because of its relevance to the non-utilisation of the school facilities to occupy learners after school. One traveller, Clarissa, pointed out how her transfer from a former Model C school to a public school resulted in reduced enthusiasm about school, mainly because the quality of education was different, and there were fewer opportunities to engage in the sport of her choice.

The travellers and observers’ school experiences were located in schools where the learner and teacher motivation had been seriously compromised by resource challenges (documented in Section 2.4.2.4 of Chapter Two). The inequality in the education system and its consequences are reiterated by UNODCCP (in Peltzer et al., 2010:6). However, it is also these factors that have resulted in the emergence of parental advocacy and more parental involvement at some Northern Areas schools (to be discussed under school protective factors below). The discussion of the risk factors above illustrates the interaction between adolescent drug use, low school attachment, commitment, low school achievement, learner conduct problems and poor teacher-learner relationships.
Category 2.4.2: School protective factors

The three school protective factors emerging from the analysis of the observers and travellers’ narratives will be presented in an integrated format, based on their interrelatedness. There was only one protective factor connected to school that emanated from the narratives of the observers, articulated as follows: “Ek leer baie van die soort goete op skool en dit is ‘n spieël vir my.” (Observer 14). This can be interpreted as either observational learning or receiving education through drug awareness programmes at school. The silence by the other 28 observers could suggest that there is no drug awareness taking place at schools or that it is not having a significant enough impact on them to have been mentioned.

Several of the travellers acknowledged how the validation, offers of assistance and positive reinforcement they received from teachers, evoked a reciprocal positive change in their attitude towards school (refer to Sub-theme 4.2 in Chapter Four). In the case of Ralton (refer to Sub-theme 4.2 in Chapter Four), his newly acquired responsibility facilitated a detachment from his earlier problem saturated identity as the class joker – an identity that previously brought him a lot of popularity, as opposed to the new more respected identity of student leader. These findings concur with earlier studies that confirmed how positive learner-teacher relationships (Smokowski et al., 2000:442), and academic support (National Institute on Drug Abuse (NIDA), 2003) help learners feel empowered in their learning (McWhirter et al., 2007), enhance positive school adjustment, and buffer negative interaction with peers (Resnicow, Reddy, James, Omardien, Kambaran & Langner, 2008; Howell, 2003).

Additional protective factors that emerged from the narratives of the travellers related to them having an enhanced connectedness to their school environment. Waydin, for example, experienced a positive connection to the school’s Christian Youth group. This initiative was suggested by a teacher, and resulted in closer integration with the school as a community institution – an important contributing factor to positive youth development enhances social assets (Gomez & Ang, 2007:97-98). For some of the other travellers, school protective factors included having a dedicated teacher at school, whom they could talk to, without feeling judged; also having positive peer
connections at school and having positive peer role models (refer to Sub-theme 4.2 in Chapter Four).

Another intended protective factor was the presence of security guards at school, but this has served more as a risk (refer to the discussion under Sub-category 2.4.1 in the present chapter).

Traveller Waydin remarked how a consultation between his parent and a teacher resulted in a more empathic approach from the teacher, pointing towards the benefit of closer collaboration between parents and teachers. The same traveller also commended the collaboration between the school and a community-based support group (FAD), which involved the video recording of learners as monitoring of their discipline and adherence to school rules. Gomez and Ang (2007:97-98) confirm that positive youth development in schools can be achieved by collaborative partnerships with community stakeholders that share the same vision.

Two travellers also expressed regret at the school not offering sport which could keep them constructively occupied. This missed opportunity to enhance protective structures for adolescents from the Northern Areas communities was also noted by a practitioner navigator, who listed the benefits of physical activity as a healthy alternative to drug use.

The discussion of the protective factors concurs with what Eriksson et al. (2010:480) termed the ‘cascade effect’ where a positive engagement with teachers elicits a positive outlook on school work and promotes connections to prosocial peers.

5.3.2.5 Sub-theme 2.5: Risk and protective factors located in the community domain

The reciprocal influence that neighbourhoods and communities have on child and youth development was illustrated in detail in Section 2.4.2.5 in Chapter Two. The community risk and protective factors are discussed in the ensuing sections.
Category 2.5.1: Community risk factors

The following three community risk factors emanated from the analysis of the travellers’ and observers’ narratives: i) easy access of drugs; ii) normalisation of drug use in the community; and iii) low social cohesion in the community. Embedded in the last risk factor are self-deprecating generational scripts associated with the ‘Coloured’ identity. Each of these is discussed in the ensuing section.

i) Easy access of drugs

The observers articulated how the prevalence of taverns in the Northern Areas neighbourhoods enhanced the easy access of drugs by children and adults alike. Their narratives suggest that people are more prone to drug use because of such accessibility, emphasising that the owners of these outlets flout regulatory legislations, i.e., the Drugs and Drug Trafficking Act No. 140 of 1992 (South Africa, 1992), and Tobacco Control Act No. 12 of 1999 (South Africa, 1999), which prohibits the sale of tobacco and other legal drugs to children under the age of 18 years. They expressed their concerns about the easy access to drugs as follows:

“We as teenagers has easy access to drugs in our community. I can’t even count on my fingers all the drug lords in my area.” [Observer 21]

“Taverns” is ook waarom mense drink en “drug dealers” is ook een van die dinge….. Taverns wat soms nie ver is om vir mense om alkohol te gebruik is ook ‘n oorsaak van die misbruik van alkohol onder ons kleurlinge. Mense wat dwelms verkoop bly net af of langs ons kleurlingmense, maar maak gebruik van hulle dwelms al weet hulle dis vergeet.” [Observer 25]

“The second reason that stands out to me is the fact that drugs are widely available and kids can easily get them even from the age of 13 if not younger because those selling these drugs are just worried about getting their profit, they don’t care who they sell it to in the end.” [Observer 28]

The participants’ portrayals of their community concur with newspaper articles highlighting the scourge and normative trend of drug use (De Jager, 2011; Williams, 2011:7; Luthuli, 2011:1). A study conducted by Brook et al. (2005) echoes the concern about the relative ease with which South African youth can access both licit and illicit drugs. The authors observe that as accessibility increases, so the use of drugs
increases, especially in communities characterised by a pro-drug use attitude (National Institute on Drug Abuse (NIDA), 2003; Hawkins et al., 1992); and unavailable or non-supervising parents. Similarly, the majority of travellers in the present study reported on the availability of drugs in their neighbourhoods, frequent drug use in their own homes, and subsequent negative consequences, which they continue to witness on a daily basis (refer to sub-theme 4.1 in Chapter Four).

ii) Normalisation of drug use in the community

Whilst the observers did not explicitly identify the normalisation of drug use under the question pertaining to risk factors, these can be inferred from their recommendations for community-based drug prevention interventions (which are discussed in Chapter Seven). However, the narratives cited by the travellers clearly depict the normalisation of drug use in the community. Theme 1 in Chapter Four presented a detailed depiction of how the majority of travellers in the addiction phase began their drug use journey, under the ‘mentorship’ of older peers in their community and accessed their supplies from a number of sources in their own community. The narratives below also depict the normalisation of drug use by the parents of Gavin and Andrew, who in their desperation to reduce the “tik” related harm, have allowed their children to use alcohol as a substitute drug:

“Maar my ma worry nie as ek drink nie, sy is net geworry ek moenie rook [referring to Tik use] nie soos daai. Want die rook maak my mal.” [Gavin]

“My ma used to allow drinking. When we drink on the streets, there’s always like arguments.” [Andrew]

In the narrative by Zoey below, she described how she cleverly capitalised on the perception of normative alcohol abuse amongst adults in her neighbourhood, managing to convince the principal that the inebriated adult accompanying her to school was her mother:

“Baie keer dan skors hulle my, dan vat ek sommer ’n ander auntie in die straat in, om maar nou net my ma te speel. ’n Auntie wat drink en so. Sy moet maar nou net my ma is… ek het haar altyd gaan haal.” [Zoey]
The fact that she succeeded in upholding this perception at school, illustrates how these problem-saturated constructions of the individual and the communities are accepted unopposed, effectively reducing the construction of an alternative story of hope and potential (Morgan, 2000). This has implications for the role of the school in subverting these dominantly negative perceptions of the learners of their school and the communities that they come from. Herrick (2012) warns that the normalisation of alcoholism in South African culture, coupled with the reduction in life expectancy, following the inception of democratic government, has also contributed to ambivalent attitudes towards risk-taking behaviour – so, in essence, the risk factors are constructed as less significant as, in the words of one of the travellers in this study:

“As much as I smoke, or they say I’m smoking, I mean not that I’m being negative but everybody’s gonna die, you just choosing the form or whatever in which you want to.” [Ralton]

The normative acceptance that people venture onto a drug use journey during holiday periods (SACENDU, 2012) reverberates in the following narrative by traveller Gabby:

“Was just thinking I am; I’m just gonna try it once again and see and so, and it’s mos holiday and so and then I ma [will] try it out again. And when the school, when it’s back to school it’s gonna be normal again.” [Gabby]

These findings resonate with the contention by Sharland (2006:257) that the physical location, cultural influences and community values play a significant role in how adolescents perceive, and hence engage with, risk behaviour.

iii) Low community cohesion

Two observers described the debilitating effect that low community cohesion had on personal and community development. Excerpts from their narratives follow below:

“The area where you live in…if you live in an area where people just don’t care about one another and where violence occur very often…. it [is] difficult for that child to live in such an environment. That’s when they feel that drugs is the best option and even turn to gangsters for help or money and in order to get that money they have to sell drugs and later they even here to use it themselves.” [Observer 12]

“We as Coloureds think too much of themselves trying to be what they not supposed to be, but after a while when they realise what they busy doing is way wrong and when it’s time to open
your eyes it’s too late; As a Coloured we wouldn’t rather help each other up. They break each other down by backstabbing you.” [Observer 20]

These written narratives resonate with the overwhelmingly negative construction of ‘Coloured’ identity presented in Theme 1 of this chapter. Their narrations of a self deprecating generational script, associating drug use with ‘Coloured’ identity, was expressed as follows:

“Dan sal ek ook sê dit is van die vroëer generasie. Kinders drink omdat hulle glo dat hulle ouers en voorouer het ook die goedere gebruik, nou doen hulle die gevaar waaraan hulle nie weet in watter rigting hulle geleë kan word nie.” [Observer Four]

“Coloured people are stupid, especially the youth. This is not me being rude. I’m being honest, because we are using drugs and alcohol but we see what negative effects it had on the lives of other drug and alcohol travellers. We suppose to be the more educated generation.” [Observer 26]

“Dit is ’n populêre ding onder die kleurling-jeug. Jongelinge sien by die ouer mense, want hulle stel nie ’n voorbeeld vir hulle nie.” [Observer 27]

The picture that emerges from the discussion of these two preceding sub-themes suggests elements of what Vera and Shin (2006:82) describe as socially toxic environments. These are predominantly low income neighbourhoods, characterised by low social cohesion and low community pride, inadequate recreational facilities for young people, and limited social support. Garbarino (1999) asserts that these neighbourhoods offer limited opportunity for community building, further exacerbated by the internalised racial stereotypes emanating from the narratives of the four sample groups in this study (refer to Theme 6 in Chapter Four; Theme 1 in Chapter Five and Theme 1 in Chapter Six).

Category 2.5.2: Community protective factors

The community protective factors are, to a large extent, the inverse of the community-based risk factors and are presented here in an integrated discussion. The travellers highlighted the support they received from members of the community as a protective factor, whilst the observers instead cited how they were deterred from drug use as a
result of witnessing the drug related harm in their community. They describe the benefit of observational learning as a community protective factor as follows:

“Omdat ek in my omgewing sien hierdie dinge verwoes kinders se lewens. En ek wil nie op eindig waar hulle is nie.” [Observer 3]

“Ek het gesien wat drank en dwelms aan die mense in my gemeenskap en selfs familie lede doen….dit veroorsaak onnodige probleme vir jou en jou huisgesin.” [Observer 12]

“Ek sien dag in en dag uit hoe mense hulle lewe weggooi deur hierdie drank en dwelms wat hulle gebruik en dit is hartseer om mense so te sien, onskuldige kinders wat daaronder moet ly; dis nie lekker om dit te sien nie.” [Observer 17]

“Ek sien ook die negatiewe invloed wat dit op ander het en dit is baie teleurstellend en hartseer.”[Observer 18]

The narratives above suggest that participants were motivated to avoid the drug-related harm and consequences that they witnessed in their communities. These consequences ranged from the abuse of the family income, the neglect of children, relationship difficulties, physical neglect, to emotional hardship. This implies that observers perceived themselves as susceptible to the onset of drug use, and therefore acquired adaptive mechanisms to subvert their vulnerability to this risk.

The travellers in the present study identified the cohesion in their respective communities and acceptance by community members as protective factors. The travellers who experienced unconditional acceptance from members in their community also narrated this as a protective factor, as is evident below:

“En daai selfde dag wat ek kom sing het, toe voel ek hier is, hier is mense wat vir my omgee hier. Dis maar die dinge wat ek doen moet ek afskryf.”[Zoey]

“A few months, few months, because I've been moving up and down and you know in the time that I've been moving I haven't been to FAD [Families against Drug Abuse] and that's when I relapsed…… [Being removed] from my source of hope ya, it's like you crash.”

The travellers’ narratives depict the meaning that adolescents derive from receiving continuous support and affirmation. Elliott et al. (2006:275) confirms that primary strengths in communities are: that they have strong interpersonal connections; shared
socialisation values and processes; that community resources are allocated and utilised equally and effectively; that the neighbourhood shapes the family and peer activities; and that the neighbourhood shapes individual developmental outcomes.

The societal risk and protective factors discussed in the ensuing section overlap significantly with the community factors and will be noted accordingly.

5.3.2.6 Sub-theme 2.6: Societal domain

The risks that adolescents are exposed to are heightened by the structural challenges that characterise the community and society in which they grow up. These include unemployment and underemployment, poverty, and disparity at socio-economic and educational levels (Harker Burnhams et al., 2012:19-20; Zucker et al., 2009; Reddy et al., 2010; Brook et al., 2006); all of which are particularly relevant to South Africa with its unique socio-political history of racial oppression (Chopra et al., in Burnhams, 2010). Similarly, the individual’s health is embedded in the health of its wider context (United States, 2010), and therefore a change at the macro level of society is likely to have positive effects at micro level as well.

Category 2.6.1: Societal risk factors

Three societal risk factors emerged from the analysis of the findings, which are: i) unemployment; ii) unequal opportunities; and iii) media influences, each of which is discussed below.

i) Unemployment

The observers and travellers were in agreement that unemployment was the primary societal risk factor contributing to drug use amongst adolescents from economically deprived communities. The narratives that follow below, imply that drug use plays one of two roles in these economically deprived communities, i.e. (a) it becomes a coping mechanism, numbing the frustration resulting from economic deprivation; (b)
unemployed individuals utilise the opportunity to create an income through the legal or illegal trade in alcohol and other drugs. The narratives below further illustrate how these two factors interact to perpetuate a vicious cycle of poverty, drug abuse and gangsterism in disadvantaged communities:

“Werkgeleenthede wat skaars is, mense dink om dwelms te verkoop is ‘n makliker manier om geld te maak en dus word dit meer beskikbaar.” [Observer 2]

“Die Kleurling-populasie is die grootste mate in dwelmmisbruik omdat Kleurlinge self hierdie tipe dwelms maak, want hulle wil geld maak om aan die lewe te bly of om ryk te raak.” [Observer Four]

“Dit kan ook wees dat daar finansiële probleme in die huise is en party ouers kan dit nie hanteer, veral nie mans nie. Vrouens kan dit nog hanteer, maar dan kry jy van daardie moeders wat niks omgee vir niemand of niks nie en min wetend sy het miskien ‘n baba om te versorg nie.” [Observer 8]

“Poverty always plays a big role in drug and alcohol abuse amongst Coloured people. Because kids grow up in poverty and they see people/their parents and family members using drugs and alcohol from a very young age: they grow up with the idea that using drugs and abusing alcohol is right. Many youngsters growing up in these “poverty areas” are attracted to the lifestyles of the gang members in their neighbourhoods. They try to escape their conditions at home by using drugs and by becoming part of these gangs. In these gangs they commit crimes and that start abusing drugs and alcohol.” [Observer 26]

“Some are very poor and they join gangs to earn some money; They often join gangs because of the circumstances they live in. They use drugs so that they can’t go hungry, and I know this, because I had a family member who was very, very poor.” [Observer 17]

The narratives by the observers are consistent with those of the peer and practitioner navigators, who mentioned that adolescents living in economically deprived environments were particularly susceptible to drug use (refer to Section 2.4.1 in Chapter Six). Concurring with this view, Loxley et al. (2003) suggest that this applies mainly to ethnic minority groups, as they have historically experienced social and economic exclusion, characterised by limited access to resources and quality education. These experiences not only contribute to young people being poorly equipped for the labour market, but also serve as a catalyst to young people joining gangs (Kinnes, 2011), where they assert themselves against the unequal distribution of power. The assertion is therefore that adolescents from these ‘socially toxic’ environments (Vera & Shin, 2006:82) will find ways of challenging dominant society,
whilst actively creating opportunities to ensure their economic and social livelihood (Siegel, 2001:211).

ii) Unequal opportunities

Two observers expressed the view that social and economic exclusion was particular to the ‘Coloured’ ethnic group, who had fewer employment and advancement opportunities, because of affirmative action policies. Their sentiments are captured in the excerpts that follow below:

“I think the biggest reason for the high rate of substance is job opportunities. Some have the qualification for some job, but can’t find a job, and then they have a problem and get part of drug abuse. Coloured adolescents gets a some lazy ethic [ethnic] and don’t feel to get them further educated, then it leads to getting involved in drug dealing and pursue the youth in it because it is much easier to buy it in area.” [Observer 18]

“Coloureds do not get jobs easily. All over it is Black empowerment. This is a generation problem, because of the high unemployment rate. Man usually feel they are the head of a household, and if they can’t provide for their family, they end up taking substances and abuse using the drugs. People live in poverty. They steal, assault, breaking in houses, robbing, just to get drugs.” [Observer 19]

This picture of inequality, poverty and unemployment constructed above, is one that persists in post-apartheid South Africa, with 30% of young people living in households without a single person employed (Magongo, 2011). Peltzer et al. (2010) assert the view that: ‘social injustice and the weakened family bonds which resulted from decades of apartheid policies have created an environment in which temporary escape from the harsh reality of everyday life is often sought through the consumption of psychoactive substances’ (Peltzer et al., 2010:7).

Aggravating this scenario, South Africa has a youth bulge – with youth constituting the largest proportion of the population, with also the highest rate of unemployment (Altman, 2012). This scenario implies that the South African economy would need to grow by at least twice its current rate and would require special interventions to address the unemployment issue. However, what is encouraging about the participants’ constructions above, is that both the adolescents and adults in these communities had actively embarked on actions to become self-supporting. Whilst the nature of these
income-generating ventures might be harmful to communities and society at large, this initiative suggests that there is potential for prosocial economic empowerment in these communities, with the necessary guidance. Parry (2005:426) alludes to the double bind that the liquor trade presents in South Africa, stating that the Liquor Act of 2003 contributes to the country’s objectives in terms of black economic empowerment, whilst at the same time specifying the need for the industry to be regulated in order to reduce the alcohol-related harm at social and economic levels. It is evident that legislation could serve as both a risk and protective factor, subject to how and by whom it is regulated.

iii) Media influences

Another societal risk factor is the role of the media, which was narrated very differently by the two groups of adolescent participants. It was peculiar that only one observer and five travellers made reference to the media’s role, both as a risk factor and as a role-player in drug prevention. By contrast, the peer and practitioner navigators were more articulate about the overt and covert influences of the media in shaping the perceived meaning of drug use, non-use and prevention amongst adolescents from the Northern Areas, and this will be discussed in more detail in Chapter Six. The five travellers alluded to the role of the media in enticing adolescents to venture on the drug use journey. Liezle reflected on the role of loud music as an inducing factor, combined with several other factors, in inducing her to accept her first drug offer at a party (refer to Theme 1 in Chapter Four).

Similarly, the narratives from the other travellers illustrate the association between the gangster image portrayed by popstars and actors in American rap music videos and movies respectively. The influence of these role models is apparent from the value that many adolescents from the Northern Areas attach to branded clothing, gold teeth and jewellery (refer to Theme 1 in Chapter Five and Theme 1 in Chapter Six).

Furthermore, the participants’ narrations demonstrate the challenges that they experienced in a society in which drug enticing advertisements target young people and societal norms appear to be pro-drug in nature (Fagan et al., 2011; Snyder, Milici,
Slater, Sun & Strizhakova, 2006). Such sentiments confirm that structural and environmental influences cannot be overlooked in drug prevention interventions (Rayle et al., 2006). The narratives by the peer and practitioner navigators (see Section 2.5.1 in Chapter Six), also concur with the construction of the media as a significant risk factor in marketing alcohol and drug use as socially desirable. The implication for drug prevention would, therefore, be to deconstruct these images so that the adolescents’ reconstructed images more closely resemble prosocial youth portrayal.

Category 2.6.2: Societal protective factors

The narrative by the observer below depicts the media’s role as that of shaping an anti-drug use attitude, as it portrays the negative consequences of drug use:

“Die televisie sowel as koerante leer ‘n mens baie oor wat met mense gebeur wie alkohol en dwelms misbruik. Vir my is dit ‘n “eye opener”, dit vertel my al klaar watter tipe lewe ek sal het as ek by hierdie gebeurtenis betrokke raak. Die alledaagse lewe leer mens ook baie.” [Observer 6]

It is evident from this narrative that the individual regarded himself as susceptible to drug-related harm, which resonates with the basic assumption of the Health Belief Model that people will take the necessary steps to avoid risky behaviour if they deem themselves susceptible to the harmful condition (Rice, 1998:96). In addition, the observer above also alluded to his observational learning from everyday life, which resonates with the Social Learning Theory (Bandura in Hill, 2008:453). According to this theory, behaviour is learnt through social modelling, and hence can be unlearnt. The observer’s decision not to mimic the social models in his environment was informed by his anticipation of the consequences of drug use, as evidenced from his narration. This reasoning is also coherent with the Theory of Reasoned Action (Azjen & Fishbein, in Hill, 2008:453) (discussed in Section 2.4.2.3 in Chapter Two).

It is evident from the narratives of travellers Liezle, Gabby and Ralton that the presence and selection of music type constituted a significant role in their construction of their drug use journey, suggesting that drug prevention interventions can incorporate the creative use of music that contests normative drug use messages. The social
service practitioners (refer to Section 2.3.1 in Chapter Six) also made reference to the extent of musical talent they encountered amongst the youth from the Northern Areas communities; these may be useful avenues to explore, especially given the assertion that youth-driven programmes enhance a sense of ownership amongst youth presenters and facilitate community capacity building (Ager et al., 2008:315).

5.4 CHAPTER SUMMARY

In this chapter, the research findings emanating from the analysis of the travellers and observers’ narratives were presented. A brief biographical description was provided of the adolescent research participants. An overview of the two themes, sub-themes, categories and sub-categories was provided, followed by a literature verification and supporting excerpts from the participants’ narratives.

The first theme presented the participants’ socio-cultural meaning construction of ‘Coloured’ identity, which revealed debilitating stereotypes of normalised drug use, inferior intelligence, low socio-economic status and marginalisation. These negative social constructions were juxtaposed against a minority voice from a few participants, who either challenged the negative construction or presented a positive construction of ethnic and community identity which ironically has incited further stereotyping.

The second theme presented the participants’ socio-cultural meaning construction of drug use and non-use, which present a dynamic interplay between each layer of the ecological systems framework. At the individual level, it was associated with personality factors, pre-conventional moral reasoning, negative life events, and pro-drug use attitudes. Non-use was associated with personality variables and anti-drug attitudes, rooted in religious beliefs and spirituality. At family level, drug use was associated with parenting factors, relationship discord and low family cohesion, and a compromised family environment. Similarly, non-use was attributed to protective parenting factors, nurturing family relationships, and high family cohesion. Negative peer association, alienation by pro-social peers and the consequences of resisting peer pressure emerged as peer-related risk factors. Association with pro-social peers, disengaging from negative peer associations and peer resistance mechanisms emerged as peer
protective factors. Low attachment and low commitment to school, learning difficulties, teachers’ attitudes, an unsafe school environment and the absence of sport, cultural and extra-curricular activities emerged as school-based risk factors. Protective school processes entailed learning about drug-related consequences, teacher support, and a safer school environment. The easy access of drugs, normalisation of drug use and low community cohesion emerged as community-based risk factors, juxtaposed against benefiting from witnessing drug-related harm in the community and drawing on support from members of the community. Societal risk factors encompassed structural factors of unemployment, inequality and media influences. In contrast, the prosocial learning opportunities presented by the media emerged as a societal protective factor.

The next chapter will focus on the peer and practitioner navigators’ social-cultural meaning construction of ‘Coloured’ identity, drug use, non-use and drug prevention, and their reflection on their own preventive interventions.
CHAPTER SIX

DISCUSSION OF RESEARCH FINDINGS:
PEER AND PRACTITIONER NAVIGATORS’ SOCIO-CULTURAL MEANING CONSTRUCTION

6.1 INTRODUCTION

The present chapter has two purposes; firstly, to present a discussion of the practitioner and peer navigators’ socio-cultural meaning constructions of the terms ‘Coloured’ identity, drug use and non-use; and, secondly, to present a discussion of their reflections on their own drug prevention interventions.

The envisaged outcome of the present study is an enhanced understanding of the socio-cultural meaning attributed to cultural identity; drug use; non-use; and drug prevention in the Northern Areas community, with a view to develop guidelines for drug prevention interventions that are culturally sensitive and contextually relevant. Implicit in the goal of the present study is the claim that current drug prevention programmes are seemingly failing to yield significant changes in drug abuse patterns amongst adolescents from the Northern Areas, since they are incongruent with the meaning and belief systems these young people attach to drug use in their communities. The two previous chapters of this thesis provided support for this postulation, especially since the analysis of the narratives of both the travellers and observers featured risk and protective factors that appeared to be prevalent in the cultural and socio-economic contexts of the target population.

The goals of drug prevention were discussed in detail in Sections 2.2 and 2.3 of Chapter Two. There has been an increasing call for drug prevention programmes to be grounded in best practice methods, i.e. guided by research or evidence of their effectiveness (United Nations Office on Drugs and Crime (UNODC, 2004) and adapted to the specific needs and context of target populations (Prevention of and Treatment for Drug Dependency, Act 70 of 2008 (South Africa, 2008b); Foxcroft et al., 2003, cited in Myers et al., 2008:19). Drug prevention and treatment has been recognised as a
specialist field (NDMP, 2012-2016); Harker et al., 2008; Atkinson, cited in Myers et al., 2008:18) that requires programme implementers who are adequately trained (Ennett, cited in Myers et al., 2008:18). To this extent, the NDMP (2012-2016) proposes the establishment of a Professional Licensing or Qualifications Board to formulate norms for skills training and monitoring in the areas of drug prevention and addiction management. In the absence of such a National Accreditation and Monitoring Board in South Africa, as well as the infrequent evaluation of drug prevention programmes in South Africa, it was imperative to learn from the experiences of peer and practitioner navigator, who had been rendering drug prevention services. The insights gained from the navigators’ reflections enabled me to guard against reinventing the wheel (Rothman & Thomas, 1994:31-33), and also provided valuable insights (Fawcett, in Rothman & Thomas, 1994:32-33) that were triangulated with the narratives of the travellers and observers (as depicted in Chapters Three and Four of this study).

The National Drug Master Plan (2012-2016) (South Africa, 2012a) stipulates the role that each government department and different role players should assume in enhancing the effectiveness of drug prevention in South Africa, highlighting the Department of Social Development as occupying the primary role in this regard. The two core departments with which the Department of Social Development should collaborate in enhancing awareness regarding drugs are the Departments of Education and Health respectively. Furthermore, the Department of Social Development forms part of the Local Drug Action Committee (LDAC), which coordinates cooperation and collaboration amongst Non-government Organisations (NGOs), Faith-based Organisations (FBOs), Community-based Organisations (CBOs), civil society organisations (CSOs) and Business Against Crime (BAC). BAC renders drug prevention services, embedded in a social development approach. The White Paper on Families (South Africa, 2012b:65) emphasises the central role of social service professionals in ensuring that the vision of the policy is effected. These roles, which include psychosocial and emotional support to families and providing child protection services, coincide with the protective processes that many adolescents require from their parents and community members (refer to Chapters Four and Five).
The study was located in the Northern Areas of Port Elizabeth, where drug prevention interventions are primarily offered by social workers and social auxiliary workers from the Department of Social Development, a NGO rendering specialist services in the field of chemical addiction treatment and prevention, volunteers (i.e. former drug users or their family members) from CBOs affiliated to the LDAC, and the Police. Furthermore, the specialist NGO offers training to several of the stakeholders mentioned above, to capacitate adolescent peer mentors and practitioners (Perreira, 2012).

TADA is a school-based peer-led drug prevention programme that was initiated in 1986 by Adele Searll, the mother of an adolescent drug user (Searll, 1989). TADA culminated in a peer-led prevention programme, under the auspices of an NGO, which provides training and supervision for the TADA members. In order for a school to have a TADA group, it has to make available a committed teacher to serve as the on-site supervisor and coordinator of all the peer drug prevention activities at the school. Learners volunteer their services, and a final selection is made by the school leadership of 10 to 15 learners, who are then trained and supervised by a social worker or social auxiliary worker from an NGO and/or the Department of Social Development. TADA members are equipped with training in life skills that facilitate personal development, planning, organisational and decision-making skills, knowledge about drugs, peer pressure resistance and basic communication and helping skills (SANCA TADA Manual, 2008).

The present chapter comprises a discussion of the narratives that were generated during three separate focus group interviews with social service professionals (i.e. social workers and social auxiliary workers—hereafter referred to as practitioner navigators), and school pupils involved in a TADA group (hereafter referred to as peer navigators), from a school in Port Elizabeth. The term navigators is consistent with the journey metaphor that was chosen to discuss the findings as outlined in Chapter One.

A sample of social workers and social auxiliary workers were recruited by means of the purposive sampling method, stipulating the following sampling criteria: i) Practitioners had to be in the employ of a government department or an NGO; and ii) they had to be rendering drug prevention services to adolescents from the Northern Areas of Port Elizabeth. The TADA peer mentors were recruited by means of a purposive sampling
method, and had to be actively involved in peer-led drug prevention services at their school. Data generation took the form of qualitative focus group interviewing, which was supplemented by participant observation of two drug awareness programmes. Three separate focus group interviews were conducted. The first focus group interview comprised four practitioner navigators from an NGO; the second focus group comprised five practitioner navigators from a government department, and the last focus group comprised 10 peer navigators from one school.

The focus group interviews were audio-recorded and field notes were recorded manually. The data was transcribed and analysed according to the content and thematic narrative analysis methods of Lieblich et al., (1998:73) and Riessman (2003) (refer to Chapter Three). The analysis method made provision for scrutinising how the participants’ stories were told, and will be illustrated in this chapter, concurrent to the discussion of the themes that emerged from the data analysis. An independent coder assisted in verifying the consistency of the researcher’s analysis of participants’ stories emanating from the data analysis process (Babbie et al. 2011:278; Alston & Bowles, 2003:48). The iterative process of moving between the data generation and the literature review (Creswell, 2013) also assisted with the verification of the findings, which will be discussed in this chapter. Below follows a brief biographical description of the peer and practitioner navigators respectively.

6.2 BIOGRAPHICAL DESCRIPTION OF NAVIGATORS

The TADA peer navigators were members of a peer drug prevention intervention group at their school. The former Model C school was not situated in the Northern Areas, but its learners were predominantly from the Northern and Township areas in Port Elizabeth. The 10 peer navigators were between the ages of 14-18 years and in Grades 9-12. The TADA group was identified as the most effective and efficiently functioning one that was trained and monitored by the gatekeeper (a social worker who coordinates peer drug prevention services in the schools). The practitioner navigators were social workers and social auxiliary workers, from two different organisations. The one group represented an NGO that renders specialist services in the field of the treatment and prevention of chemical addictions, whilst the group from the second organisation
provided a generic social work service, with drug prevention located in one of their special programmes. The biographical information of the practitioner navigators is summarised in the table below.

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<thead>
<tr>
<th></th>
<th>Social workers</th>
<th>Social auxiliary workers</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Number of participants</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Qualification</td>
<td>Degree in Social Work</td>
<td>Diploma in Social Auxiliary Work = 3</td>
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</tr>
<tr>
<td>Age group</td>
<td>Ranging between 26 and 45</td>
<td>Ranging between 26 and 36</td>
<td></td>
</tr>
<tr>
<td>Number of years practical experience</td>
<td>Ranging between 1 and 15 years</td>
<td>Ranging between 2 and 5 years</td>
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<td>Ethnic group</td>
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<td>Black Coloured White</td>
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<td>4 0 1 4 0 0</td>
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**TABLE 6.1: Biographical detail of the practitioner navigators**

Eight of the practitioner navigators were female, while only one was male. In comparison, six of the peer navigators were females, while four were males. Six of the practitioner navigators were from the ‘Coloured’ ethnic group, two from the ‘White’ ethnic group and only one from the ‘Black’ ethnic group. The practitioners’ practice experience ranged between 1 and 15 years.

**6.3. THEMATIC DISCUSSION OF PEER AND PRACTITIONER NAVIGATORS’ SOCIO-CULTURAL MEANING CONSTRUCTION OF ‘COLOURED’ IDENTITY, DRUG USE AND NON-USE AMONGST ADOLESCENTS FROM THE NORTHERN AREAS OF PORT ELIZABETH**

The data generated from the focus group interviews with the 9 practitioner navigators and 10 peer navigators, were analysed based on the narrative analysis framework provided by Lieblich *et al.* (1998:73). The content of the navigators narratives was categorised according to the risk/protective resilience framework described in Chapters
One and Two. Specific attention was devoted to the context of the navigators’ narratives, as it was important to explore how their socio-cultural meaning constructions influenced their drug prevention interventions in Northern Areas communities, as well as their reflections on those interventions. Four themes, several sub-themes, categories and sub-categories emerged from the process of data analysis and comparison with the independent coder, as presented in Table 6.2 as an overview.

**Theme 1: The peer and practitioner navigators’ construction of ‘Coloured’**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Categories</th>
<th>Sub-categories</th>
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<td>1.1 Co-constructed view of ‘Coloured’</td>
<td>1.1.1 Associated with race group and geographical area</td>
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</tr>
<tr>
<td></td>
<td>1.1.2 Association with historical stereotypes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.1.3 Permissive parenting</td>
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</tr>
<tr>
<td></td>
<td>1.1.4 Teenage/Adolescent parents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.1.5 Constructing and deconstructing drug use as a ‘Coloured’ phenomenon</td>
<td></td>
</tr>
<tr>
<td>1.2 Challenging the negative construction of ‘Coloured’ identity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Theme 2: Thematic discussion of navigators’ socio-cultural meaning construction about the reasons for drug use amongst adolescents from the Northern Areas of Port Elizabeth**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Categories</th>
<th>Sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Risk factors located in the individual domain</td>
<td>2.1.1 Individual risk factors</td>
<td>i Personality factors</td>
</tr>
<tr>
<td>2.2 Risk factors located in the family domain</td>
<td>2.2.1 Family risk factors</td>
<td>i Parenting factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii Family environment</td>
</tr>
<tr>
<td>2.3 Risk factors located in the peer domain</td>
<td>2.3.1 Peer risk factors</td>
<td>i Experimentation developmentally appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii Value derived from peer association</td>
</tr>
<tr>
<td>2.4 Risk factors located in the community domain</td>
<td>2.4.1 Community risk factors</td>
<td>i Easy access to drugs and normalised occurrence of drug use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii Changing trends in drug use in Northern Areas communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii Community apathy and lack of ownership by community members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iv Poor relationship between community and police</td>
</tr>
<tr>
<td></td>
<td></td>
<td>v Absence of prosocial community role models</td>
</tr>
<tr>
<td>2.5 Risk factors located in the societal domain</td>
<td>2.5.1 Societal risk factors</td>
<td>i Poor socio-economic circumstances, perceived marginalisation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii Media glamourise drug use</td>
</tr>
</tbody>
</table>

**Theme 3: Peer and practitioner navigators’ description of drug prevention services rendered in Northern Areas communities**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Target audiences for drug prevention programmes</td>
<td></td>
</tr>
<tr>
<td>3.2 Content and format of drug prevention services</td>
<td></td>
</tr>
<tr>
<td>3.3 Responses of the audience to drug prevention programmes</td>
<td></td>
</tr>
<tr>
<td>3.4 Navigators’ monitoring and evaluation of prevention programmes</td>
<td></td>
</tr>
</tbody>
</table>

**Theme 4: Navigators’ reflection of barriers to rendering drug prevention interventions**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Limitation related to resources</td>
<td></td>
</tr>
</tbody>
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TABLE 6.2: Overview of themes, sub-themes, categories and sub-categories

Each of these themes is discussed below, and the overlap with the findings from the travellers and observers’ narratives is clearly indicated. The triangulation of the narratives from the four participant groups transcends the limitations of one source of data generation (Denzin & Lincoln, 2003), and enables the identification of similarities and differences in the meaning constructions. These insights proved invaluable in the formulation of the drug prevention guidelines. Each of the themes will now be discussed in the following sections.

6.3.1 Theme 1: The peer and practitioner navigators’ construction of ‘Coloured’

6.3.1.1 Sub-theme 1.1: Co-constructed view of ‘Coloured’

In keeping with the primary goal of the study, namely to develop drug prevention guidelines that are culturally sensitive, the first question in the focus group interview, to both the practitioner and the peer navigators, was: “What comes to mind when you hear the word ‘Coloured’? Whilst I wished to probe particular cultural narratives, the opening question in the focus group interview implicitly proposed a stereotypical racial categorisation of the target audience, with the hope that the navigators would challenge the use of the concept and, secondly, that they would deconstruct the historical stereotypes associated with the construct ‘Coloured’.

Category 1.1.1 Association with race group and geographical locations

The practitioner navigators in both focus groups agreed that the meaning they attached to ‘Coloured’ was that of a race group, associated with particular geographical locations, populated by people from this race group. The co-constructed story by the practitioner navigators follows below:

“Race group”
“And to me you are always attached to the area you stay in, like ‘van Gelvan se mense’, ‘Schauder se mense’, and then there is a certain way people see people from Gelvan or Schauder or Salsoneville.” [Neighbourhoods listed in the excerpt are all situated in the Northern Areas of Port Elizabeth]

Category 1.1.2: Associations with historical stereotypes

The majority of both the practitioner and peer navigators, however, proceeded to construct associations with ‘Coloured’ that resonated with historical stereotypes of the ethnic group. The group dynamics in the one practitioner focus group (consisting of one ‘White’ and three ‘Coloured’ participants) presented a startling reproduction of ‘Coloured’ submission to ‘White domination (Adhikari, 2005:9). The practitioner from the ‘White’ ethnic group largely steered the conversation, which was met by supporting co-constructions of her colleagues. They thickened the plot of the problem saturated story, which depicted ‘Coloured’ identity as synonymous with stereotypical labels, including valuing a glamorous exterior appearance, marked by branded clothing, gold teeth and shiny jewellery, which was expressed as follows:

“Name kleure is baie belangrik vir ‘n Kleurling.”

“Baie belangrik.”

“Bling-bling” goue tande, ringe, chains.”

These views echoed those of a practitioner navigator, who mimicked the vernacular of the ethnic group in the following articulation:

“The boikies with the hats and/or the coloured hair, you know the green, white or red coloured hair or sometimes it’s shaven but they always have like a bit of a cap or a hat with a quite a bit of earrings and some “bling-bling.”

“Coin, chain, goue tand.”

Her decision to express herself in this manner, concurred with what Adhikari (2005:16) would describe as the tendency of other ethnic groups to denigrate and stigmatise the ‘Coloured’ dialect as socially inferior (Wicomb, 2012). The content and form of this
narrative was, however, co-constructed by the other practitioner navigators (who all identified themselves as ‘Coloured’), in a linguistic style that Adhikari (2005:12) would describe as historical ‘assimilationism’. The following excerpts from the narratives of the practitioner navigators illustrate this point:

“Funky.”

“Ja, ja…. I just see them, you know. The walking… type of walking they’ve got.”

“And the slang.” [dialect]

“En die broeke wat hang.”

“Ja, ja, jail style, with the underwear that’s hanging out and they will always look at you – ‘yo bru’."

These depictions of ‘Coloured’ identity relate with how youth from an economically deprived city in Russia were depicted. Pilkington (2007:221) however, deconstructs what may otherwise appear as a need to be viewed as exceptional and oppositional by suggesting that the ‘gangster jacket and swaggering walk of the region’s youth are symbolic displays of a shared understanding of what it means to live on the margins’. The participants’ observations, which formed part of the present study, as well as my experience from social work practice in the Northern Areas communities coincide with Pilkington’s sentiments cited above.

In accordance with the negative depictions above, the following co-constructions by three practitioner navigators not only illustrate internalised stereotypes, but also how the dominant problem saturated story regarding ‘Coloured’ identity continued:

“I was also thinking in terms of, gangsterism, lazy people just want to stand ‘bakhand’ [begging for hand-outs], you know.”

“And sometimes if I think of adult adolescents/youth, coloured, I see a group of people; they either don’t know how to work or they don’t want to work, you know, they are much more laid back, I don’t care, my parents will look after me, type of attitude.”

“Doing drugs.”
“Strong willed.”

These unflattering stereotypical descriptions of ‘Coloureds’, as being lazy and expecting hand-outs instead of earning their keep, resemble the narratives of the observers (refer to Theme 1 in Chapter Five), and were also expressed by two of the community volunteers interviewed for this study (Minnie & Muller, 2012; Stanley, 2012).

The parallel between ‘Coloured’ identity and gangsterism was reiterated by two of the peer navigators, as follows:

“Gangsters”

“Gangsterism”

The aforementioned negative descriptions resonate strongly with those views depicted by the observers (refer to Theme 1 in Chapter Five), as well as the findings that emanated from the interviews with the community members, confirming the dominant space such sentiments occupy in the community. I was intrigued by the similarities in the two separate focus groups, where the conversation, initiated by members from a non-‘Coloured’ ethnic group, was reinforced by the initial silence of navigators from the ‘Coloured’ ethnic group (Adhikari, 2005), resulting in a very narrow description (Morgan, 2000:12) of ‘Coloured’ identity. This resulted in the adoption of the dominant negative story by the practitioner navigators in both focus groups, obscuring all other possible positive meanings of ‘Coloured’ identity or alternative interpretations of specific behaviours. Kinnes (2011) offers one alternative interpretation by suggesting that the prevalence of gangsterism in particular neighbourhoods can be traced back to the unequal distribution of social power and resources, resulting in marginalised groups claiming what they regard as their rightful share. These findings underscore the recommendation by Herrick (2012) for macro interventions focused on addressing the growing socio-economic disparities in South Africa, as part of a comprehensive drug prevention approach.

There was also consensus amongst the peer navigators that the particular characteristics relating to dress style and gold jewellery served to mask the
inadequacies and insecurities of the people who sported them. This also resonates with earlier constructions by the navigators of social service professionals, who equated ‘Coloured’ identity with uncertainty and insecurities. The peer navigators’ expressions to this effect follow below:

“Dit heg, vir ‘n persoon so te sé waarde aan himself, wie hy is en wat hy het.”

“Jy kan hoe [emphasising] buite blink, jy blink nie van binne nie.”

“Dis vir hulle ‘n masker om alles weg te steek agter die label wat hulle dra.”

“Onthou julle in Afrikaans het Juff. __________ gesê dit skep amper jou identiteit.”

“Dit is die waarheid, want once hulle daai klere het, dan is dit net brille… dis net “fine’geid.” [referring to wanting to be smart]

“Hulle wil net different wees.”

“Deftig. Hulle hou hulle bo-oor almal. Superior.”

The narratives above confirm the navigators’ construction that a shiny glamorous exterior hides internal uncertainties and is used to project a false sense of security and confidence. It was interesting to note how many peer navigators participated in the construction around the purpose that branded clothing and gold jewellery serve for ‘Coloured’ adolescents. It was also apparent that the construct of race and its associated stereotypes featured during classroom discussions, as the navigators made reference to two separate lessons where teachers initiated discussions to this effect. Oppelt (2012:15), a journalist, who hails from the Cape Flats, a ‘Coloured’ neighbourhood in Cape Town, South Africa, poignantly termed the above, expressions by the ‘nowhere people’, who find ways to subvert their continued marginality in South African society – in essence then, a counter-narrative (Daiute & Lightfoot, 2004:183) to contest the predominant notion of not being good enough.
**Category 1.1.3: Permissive parenting**

The role of the mother and parenting practices also received particular prominence in the construction of ‘Coloured’ identity. The majority of the practitioner navigators described the child rearing practice by ‘Coloured’ mothers as one of permissiveness, indulgence and emotional over-involvement. The excerpts from their narratives serve as illustration:

“The main thing for the youth is consequences, they don’t care about consequences. Because let’s face it in the coloured community, the mothers pick up the consequences. The mother is the sonde-deksel [cause of trouble]; the mother is the one who will go all-out to protect that child. And I know, you know, whoever is mothers here, we feel we have to protect our children. But in the case where it is a youth that’s involved with certain things, the mother goes to the extremes to protect these children. And they are so much in denial.”

“The mothers“ Because they want to give their kids the things that they don’t have, lots of the times. Its, uhm, “I didn’t have this freedom;” “I didn’t have….; I couldn’t just be; I had to work when I was 14 or 15 or 16”. And now I have to protect my child, even if he is 25, he still needs to be enjoying his youth, because I couldn’t – I had to work like a slave when I was that young.”

“And then that also gives the youth the view that I am still a child and I still need my mother to do certain things for me. So even if I do something wrong in the street or no matter what I do, I know that there’s always gonna be a safety net.”

“And somewhere that child learns the art of manipulation very well, and they know if I do this then my mother… or if I say so… my mother is going to feel bad. They study you; they know already if they are gonna do this, then they you are going to say that, it is like a pattern.”

The consensus view from the practitioner navigators was that parents were overcompensating for what they did not have, whilst others suggested that the permissive parenting style compensated for letting their children grow up in a blended family or in a single-parent household. The excerpts from their narratives accentuate this view:

“I think you get the overprotective ones, then you get the ones that feel guilty when they can’t provide for the children, even if they…. especially if the woman raised the child all alone.”

“And then you find that they want to compensate, especially with the guys that – I didn’t actually provide a proper male role model to him.”
The narratives highlight the practitioner navigators’ perception that the parenting style of ‘Coloured’ mothers inhibited the development of a sense of accountability and responsibility, culminating in further consequences, as illuminated in the excerpt below:

“No I was just thinking what _____ [name of colleague] was saying about responsibility, I was thinking on another level now, like let’s say the parent, like the mother, falls away, That child doesn’t know what it’s like to be on his own, he doesn’t know how to take responsibility, and that is where everything goes wrong, he goes into using dagga now, he’s never-minded now, mixed up with all the wrong friends, especially if it a sudden death. If it is a sudden death, like maybe the mother wasn’t sick, it just happened suddenly or maybe she had cancer and she hid it and nobody knew that she had cancer and just suddenly it took her and then she died.”

The irony illustrated in the narratives above, is that children raised in these dependency producing environments, might be prone to rely on dependency – enhancing aids – reinforcing a vicious cycle, which ultimately keeps the dominant story of addiction alive. Whilst this phenomenon transcends racial, ethnic and class boundaries (Liddle & Rowe, 2006), the dominant discourse locating it in the ‘Coloured’ identity arena has kept the societal stereotype alive (Young & Fitzgerald, 2006).

Category 1.1.4: Teenage/Adolescent parents

Several practitioner navigators were of the opinion that indulgent and punitive parenting styles also emanated from inexperienced teenage parents and grandparents assuming child-rearing responsibility for their teenage children’s children, evident from Section 2.2.1 in Chapter Six and in the practitioner’s comments below:

“Because, when you look in the community, because we have teenage mothers, their children grow up by themselves. I see a lot of that, because the teenagers are so frustrated now, they have to look after a person. They didn’t really plan for this person. Although some of them do plan, because they think of that grant-in-aid. So now, if they want to go out, they have this baggage. That is how they see it. They have this baggage, they can’t now enjoy their life, because they have this child, and then they start beating this child up. So those kids raise themselves. From the age of two years old, I see them walking in the streets asking someone for a 50c. [pause] That poor child is growing up so fast. It is the truth.”
Category 1.1.5: Constructing and deconstructing drug use as a ‘Coloured’ phenomenon

The presence of a pro-drug attitude featured as a significant risk factor, articulated by both the peer and practitioner navigators. They proposed that this normative occurrence of drug use amongst the ‘Coloured’ ethnic group could result from genetic make-up (Ross & Deverell, 2010) or conditioning – the product of observational learning (Bandura, cited in McNeece & DiNitto, 2005:26-38). A practitioner navigator argued as follows:

“What I am saying, is based on research that was done previously by SACENDU people. We attended the training…You may correct me but I think the Coloured race was the worst amongst all the other races and with my experience as well. I came here [Port Elizabeth] two years back and it is the first time I am seeing this kind of drug use, as compared to where I am coming from. And with me, besides the economic thing, I think it is a genetic thing as well……. When it comes to smoking, you associate it with a Coloured person and White. No, I was just saying the way I see it, doesn't look funny when you can put a black person and an old woman, you won't see it as funny with a Coloured person as opposed to a Black person. It runs through the family. The parents allow their children to smoke.”

This stereotypical view of drug use being normative amongst the ‘Coloured’ ethnic group only was deconstructed by practitioner navigators, who had observations to the contrary, which they shared as follows:

“I think in the olden days you wouldn't see an African Mamma smoking, but now it's common you see them everywhere. And I went to varsity for the first time and I was in shock, because I've never seen African ladies smoke, because you don't see it anywhere, and there they were walking around with their bottles of water and cigarettes. It was a culture shock for me.”

“The other day, as well, I was waiting outside for my lift one. Of the African Security guards, she came out and she looked up and down and then she took out a cigarette and she started smoking. I was like staring at her, because it's uncommon. You can't get used to it because you never used to see it, but it's happening now.”

Several practitioner navigators suggested that drug use is motivated by a lack of coping resources amongst the ‘Coloured’ ethnic group. These views are supported by findings from other studies, which drew parallels between low socio-economic status (as opposed to ethnicity) and drug use as a coping resource (Patrick et al., 2010; Potgieter et al., 2010; Lidia et al., 2006; National Institute on Drug Abuse (NIDA), 2003).
Several of the navigators agreed that family communication and utilisation of counselling were not accessed as coping resources as open and direct communication of feelings was incongruent with the ‘Coloured’ culture. This view was, however, deconstructed by one of the navigators, who cited the increase in the number of counselling requests from this ethnic group as evidence to the contrary. These constructions are cited below:

“And another thing, I also discovered is that there is little happiness in their lives. Obviously, when you’re high, you forget about all your stress and your dramas and everything. So I think that’s a way for them to escape their daily ‘depressing’ (If I can put it that way) lives.”

“And also our Coloured people never-ever want to be counselled. They don’t like to talk about their feelings.”

“They haven’t grown up with doing that.”

“Whether it’s the church leader or a counselor or a social worker that counsels them, they don’t want to open up.”

“They don’t even wanna say I love you to family members.”

“Then, on the other hand, looking at the statistics, the Coloured people coming for counseling has increased. So maybe there is something happening.”

Further evidence to receptiveness for counselling is found in Section 2.1.2 of Chapter Five, and in findings from a study conducted by the Medical Research Council among adolescents from the Western Cape (Alcohol and Drug Research Unit, 2012).

6.3.1.2 Sub-theme 1.2: Challenging the negative construction of ‘Coloured’ identity

The dominant negative story was finally contested in the one practitioner focus group by the youngest navigator, albeit towards the end of the interview. Similarly, only one peer navigator refuted the inherent proposed categorisation (imbedded in the question that I posed to them) asserting himself as follows:
The peer navigator’s articulation proposed that the similarities in people exceeded the differences and that difference in skin colour was the only thing that set them apart. The navigator issued a brief invitation for an alternative story to be explored or at least for the dominant story to be deconstructed, arguing that this ‘taken for granted’ truth about ‘Coloured’ identity should be challenged; instead, people’s individuality should be recognised (Morgan, 2000:46). His assertion: ‘Don’t judge a book by its cover,’ represents an explicit request for people to be separated from their historical categorisation (White & Epston, 1990).

This peer navigator later invited the remaining nine peers in the focus group to co-author his story of unique outcomes (White & Epston, 1990). One navigator jokingly suggested that it was an impossible task, and in his assertion, reinforced the dominant plot depicting ‘Coloured’ identity as synonymous with violence and gangsterism, which he expressed as follows:

“Jy kan dit nie verander nie, [laughing] hulle gaan jou skiet.” [laughing]

This response elicited an assertion that the dominant meta-narrative of marginality and inferiority can be discontinued only by its authors, and not by the subject of the negative labelling, illustrated by the excerpt from the navigator’s narrative below:

“Ek dink net dat die meeste van die mense sê nou dis Kleurlinge, Kleurlinge dit, Kleurlinge dat ….die [feit] is as mense minder gaan sê dat dit Kleurlinge is, dan gaan die kleurlinge ook begin terug rek.”

This external locus of control was also evident from the assertion by a practitioner navigator who abdicated responsibility to researchers to find a solution to the problems of the youth in the Northern Areas communities, as reflected in the excerpt from the narrative below:

“I’m just thinking with all these studies and things. The people need to speed up what they are doing. The children are just going from bad to worse.”
One practitioner navigator projected her own ambiguity when she criticised the sanctimonious approach by some ‘White’ people to have pity for ‘Coloured’ people, only to demonstrate an identical approach in her statement, which follows below:

“I always knew that, I look at my friends sitting around the table and that I used to have in Coloured communities and then I think if you grow up there and some people come in and give you gifts and things, why are they doing that? Sort of, ‘Oh shame, you’re Coloured and I am White, so I need to give you something. But then I am taking away from who you are, because I don’t see you for who you are. And for me, sitting here and looking at my [emphasis] Coloured community, which I love dearly and love to work in it, I think it must be very complicated. Because they don’t have the opportunities, the mothers and fathers that are 40, 50 and 60, they don’t have the same opportunities that I have. Very few of them have the same opportunities.”

As co-constructor of the narrative in the focus group interview, I challenged the practitioner navigator with the following question: “How do you know that they don’t have the same opportunities, and what does ‘same opportunities’ mean to you?”, resulting in the response that follows:

“How many Coloured lecturers do you have at the NMMU? Not a lot. I don’t think you have the same opportunities to study, to go further than Matric, or even to get to Matric. So for me, if I had to go back and turn back time, I would change a lot of things. I think the Black kids; they really do get a lot of opportunities than Coloured kids. I know that other Whites say oh but my kids are White they can’t get work. No, it’s not true. If you look at schools, there are not a lot of Coloured kids in White schools or in previous Model C schools. Why not? So for me, I think to be Coloured is difficult, and I think the amount of prevention if we have to move into that communities we have to target parents so that parents can equip kids. Because youth are still young. And now the parents themselves are unequipped to be parents.”

This evoked a vigorous counter-narrative from the youngest practitioner navigator in the focus group, who took exception to the assertion that ‘to be Coloured is difficult’. She berated the ‘Coloured’ ethnic group for being the primary authors of these debilitating stories, resulting in self-inflicted views of marginality, reinforced by harm-inducing behaviours, such as drug use (Pilkington, 2007:219). She proceeded with a challenge to the ethnic group to become the authors of the alternative story of positive self-esteem, self-acceptance, ethnic pride and boundless opportunities, which she passionately articulated as follows:

“What came to mind for me during this focus group was that, Coloureds are always so focused on wanting to fit in either with the Black side or the White side. That they have no real self-
esteem of being who they are, of being Coloured. Why do I need to want to be White? Why do I need to want to be Black? This is who I am, and if they can be taught to be proud of themselves, from a very young age, then I think that would eradicate a lot of issues, like the fact that we have such a high rate of substance abuse amongst our youth. Because their need for acceptance is so great that they are willing to sacrifice themselves and their future, just to have that little bit of acceptance with a group at that point in time. And I always try and make it a point that do you know why your friend is using [drugs]? Have you ever asked him? That friend is just as broken, lost and confused as you are. So I think if you really, it’s maybe not impossible, but if you really try and teach them to accept who they are and teach the parent to actually encourage your child to be proud of who you are. Then they will, because there are opportunities, and then they will take the opportunities. Then they will have the guts to actually want to be something more. Because it is like, oh, we’re Coloured, you actually go and work in a department store; you do this, unless you’re very, very intelligent you go to university. It doesn’t work like that, there’s a lack of motivation, and I think [what is needed is] some education with the parents, as well as to what other resources are available.”

“That’s why I don’t feel being Coloured is difficult, I am very sorry [addressing her colleague], in no way is it difficult to be Coloured! I love it!”

Ironically, the navigator’s reconstruction of ‘Coloured’ as a unique privilege, characterised by a collectivist culture offering social and material support to one’s neighbour reinforces a different set of stereotypical views, confirming Alexander’s (2007) contention that the use of racial identities only serves to reinforce unequal social relations, inequalities and racial prejudice. The practitioners’ narratives are cited below:

“It’s so very nice, living in a community, knowing everybody’s business.”

“It’s nice when you go down the street and the auntie ask you, Listen, have you seen that on? My mother can walk down the street and she can ask, do you know… I saw [name of person] there. It’s very nice, you know…”

“So it is quite nice. You know that you can borrow a cup of sugar next door. You know your neighbours. You won’t lay in your house three days, dead. Your furniture being picked up, no, they are not moving, I would have known if they’d moved. That’s what nice about being Coloured. It can work on your nerves at times, but it’s nice.”

The navigator further proposed two resolutions to bring about a change in the internalised negative stereotypical constructions of ‘Coloured’ ethnicity viz, i) to nurture the development of ethnic pride, and ii) to promote ethnic pride. These were expressed as follows:

“That’s why I’m saying, teach them to be proud of themselves.”
“And I think Coloured people, they don’t really promote who they are... this is what we do, and we are proud of the things that we do.”

These findings suggest a need for ethnic identity exploration amongst not only the adolescent participants in drug prevention interventions, but also the practitioners, if they are to embark on evidence-based drug prevention interventions that are culturally sensitive. It furthermore emphasises the need for social service practitioners to be cognisant of their professional mandate as change agents (Potgieter, 1998) which, ultimately, can contribute to the enhancement of people’s social functioning and their quality of life. Alternatively, stated by Solis in Daiute and Lightfoot (2004:183), people should be empowered to ‘scrutinize’ and, ultimately, challenge societal narratives that are incoherent with the personal narratives they wish to adopt and the identity they wish to develop (Burkitt, 2008).

6.3.2 Theme 2: Navigators’ socio-cultural meaning constructions about reasons for drug use (and non-use) amongst adolescents from the Northern Areas of Port Elizabeth

The navigators’ socio-cultural meaning construction about drug use amongst adolescents from the Northern Areas has been divided into risk factors located in the individual, family, peer, community and societal domain. The exception is that none of the peer or practitioner navigators’ narratives alluded to risk factors located in the school domain, which was peculiar, considering that the peer navigators’ interventions were based within schools. Another distinction is the navigators’ silence (with the exception of a few spontaneous reflections) on protective factors, as these did not form part of the data generation questions, and has been noted as a limitation of the study. The navigators were, however, prompted to offer recommendations for drug prevention interventions, which allowed me to draw inferences about protective factors. These recommendations are discussed in Chapter Seven as a precursor to the presentation of the drug prevention guidelines. Similar to the thematic analysis of the travellers and observers’ narratives, the risk/protective resilience analysis framework was applied to analyse the findings that emanated from the data generation with the peer and
practitioner navigators. These are subsequently presented and discussed, informed by a literature control.

6.3.2.1 Sub-theme 2.1: Risk factors located in individual domain

The factors located in the individual domain of the multisystemic risk/protective resilience framework were described in Chapters One, Two and Five of this study, as character or dispositional traits (McWhirter et al., 2007:108), as well as how the individual responds to experiences in the different contexts of his life. **Personality factors** were the only individual risk factors that emanated from the narratives of the peer and practitioner navigators.

The peer and practitioner navigators were in agreement that the **absence of a vision** and **long-term goal** was a significant limitation amongst adolescents from the Northern Areas. This was confirmed by the observers and travellers, discussed in category 2.1.1 of Chapter Five. One practitioner navigator’s extended narrative, which she expressed very passionately, suggests that teenage pregnancies (and their associated risk-enhancing behaviour) were a manifestation of **a lack of vision** – a sentiment echoed in the interviews with community volunteers (refer to Minnie & Muller, 2012; Sharmar, 2012 and Stanley, 2012). An excerpt from the practitioner’s narrative follows below:

“I wanna say the route to all evil is All Pay [child support grant], because really, that has become the goal of many young girls… that independence. That is the first taste of independence they can get and I don’t know if they willingly go into it or if it falls into their laps and they take it as it goes. But then they have that and now a lot of the times the father will see the mother is getting an income… I also want a part of that. So you will have many times; you can go any time on pay-day, you can go to Pick and Pay. You can just sit there outside Mr Price and see who goes into Pick and Pay liquors and it will be the young father and the young mother and the child walking with a chomp or one chocolate in his hands. And they will be going in and you know now, you can stand by the till and see how much money they are withdrawing. To the T [precise amount] that R280. So that is…. the standard has been raised… it’s so low that that is the goal and it stops there. Whereas I think in African communities, you have your babies then you go on with life; you go to study; there’s opportunities for you. That’s what I always tell my clients …that it’s a lifetime commitment, but it’s not a life sentence when you have a child. It’s not the end; it’s not a death sentence.”

It is evident from the narrative that the navigator associated the adolescents’ lack of vision with their focus on the **immediate gratification of needs**. She furthermore cast
doubt on the effectiveness of the child support grant as a poverty alleviation strategy, claiming that this grant (referred to as AllPay and amounting to R280 per month), provides teenage mothers with an independence, which unfortunately is not utilised adequately towards improving their future. The practitioner navigator furthermore stopped short of justifying the lack of vision against the limited opportunities available to ‘Coloured’ adolescents when compared to ‘Black’ adolescents, who have a stronger commitment to furthering their education, with the knowledge that they will have access to post-school advancement opportunities. The view that ‘Coloured’ adolescents demonstrate lower school commitment is coherent with the assertion by observers and travellers (refer to the category 2.4.1 in Chapter Five).

Another practitioner navigator shared her observation of how the focus on short-term goals and extrinsic rewards had become the dominant focus of adolescents (and their parents), who expanded their energy on planning for the Matric farewell, as opposed to preparing for the examination and planning for studies upon the completion of Matric. She described her frustrations as follows:

“And then once again December, it’s the social worker — no in January when the child has passed. Because now I feel and I think this is a new evil that it’s raising its head in the ‘Coloured’ community. Daai matriektafel [referring to the pre-farewell party at home]. And I want to klap [smack] the person that started that, because now that is the academic goal of that child; daai tafel [this home party]. All the planning goes into that. They don’t plan for the exams.... they don’t plan for next year. And it’s really like the lotto; people are fancy. I know people that had a fundraiser vir die tafel. And now the child’s school fees wasn’t paid yet, but the shoes of R300 was paid. Two months in advance already. The dressmaker was paid; the deposit was paid; but the school fees wasn’t paid yet. And then they... I don’t know if people... I don’t have the guts yet to ask people, ‘do you think this child will pass Matric?’ Because it’s really let’s do the tafel and then it’s like the lotto you’re putting your numbers in there. Then you wait, ma, if the child’s name appears then you start planning what are you going to do; what are you going to study.”

Similarly, one peer navigator shared the view about ‘Coloured’ adolescents being motivated by short-term goals and acquiring an easy income, instead of expending energy on long-term goals and hard work. He articulated his opinion as follows:

“En van hulle wat Graad 12 het, wil nie werk nie. Hulle dink dis [referring to the selling of drugs] gou geld maak... En hulle gaan studeer nie verder nie, of hulle doen dit nie self nie; hulle kry mense om dit te verkoop vir hulle.”
The social construction of the ‘Coloured’ ethnic group lacking vision and long-term goals appeared to be a dominant narrative spanning across the narratives of all the participant groups in the present study and featured prominently in their recommendations for drug prevention interventions (refer to Chapter Seven).

6.3.2.2 Sub-theme 2.2: Risk factors located in the family domain

The importance of the family as a socialisation agent was argued in Chapters One, Two and Five of this thesis, and its long-term effects is supported by the findings of Frank and Fisher in Peltzer et al. (2010:6). The authors point out that “epidemiological surveys in South Africa suggest that high proportions of drug consumers experienced especially difficult family circumstances as children”. As children’s experiences in families are shaped by parenting practices and the type of family environment, these two categories guide the discussion of risk factors located in the family domain. The aspect of family relationships will be integrated in the discussion of these two categories, as a result of the integrated manner in which the navigators generated their narratives.

i) Parenting

Several practitioner navigators endorsed observational learning (Louw & Louw, 2007), informed by poor child-rearing practices, as a key explanation for children’s susceptibility to drug use. Permissive parenting, underpinned by ignorance (about the effects of so-called safe drugs) and misguided (unsupervised) child protection methods in a socially toxic environment (Vera & Shin, 2006) reverberated as the dominant family risk factor through the narratives of all four groups of navigators, as illustrated in the quotes:

“And also with this new ‘in thing’, the hookah pipe, which makes it almost alright to use drugs. Because some parents even buy the hookah pipe for their children, saying that it is safe to use, but they don’t know that it’s the gateway [interrupted by colleague].”

“And it becomes like a babysitter, the hookah pipe. Because people buy the hookah pipe so the children can be at their house and not in the street.”
“But it is also because parents want to be in fashion, because if we look at the hubbly bubbly, it’s a fashion statement, and people wanna be in fashion so I will buy it for my child. The pipe and everything that goes with it, because I don’t want my child to be behind. Must be in fashion, and I as a mother must be in fashion.”

“That’s what I experienced, yes, in assessment and lots of the times you will find those are the kids that when they are 17, 18, 19, the parents allow them to drop out of school. Because, shame, they need to have a life.”

The practitioner narratives furthermore imply that the child-rearing methods endorse a value system that validates the importance of short-term goals and gratification derived from exterior rewards. Bower et al. (2012:7) warn that this approach not only deprives children from cultivating a dream and vision for their future, it also makes them more susceptible to participate in high-risk behaviour, such as drug use. Several community volunteers consulted during the conceptualisation of the study confirmed from their observations in their community engagements how parents who entrenched the importance of a goal-driven future-focused perspective were more likely to disapprove of the use of drugs and monitor their children closely (Minnie & Muller, 2012; Stanley, 2012). The assertion about permissive parenting surfaced in the navigators’ narratives (in both focus groups) of ‘Coloured’ identity (refer to category 1.1.3 in Chapter Six and category 2.2.1 in Chapter Five), as well as illustrating the entrenchment of this social construction amongst practitioners who participated in the study.

Henry and Slater (2005) warn about how inconsistency in parental role modelling and attitudes about drugs communicates ambivalence about drug use to children. The following narratives by a peer and practitioner navigator respectively (supported by the travellers’ experiences reflected in Theme 1 of Chapter Four), underscore the authors’ warning:

“Maar byvoorbeeld, my ma het nie vir my gestuur om vir haar ‘n drink te gaan koop nie. Jy begin by die ouerhuis. Want as jy jou kind gaan leer wat is reg en verkeerd, dan gaan jou kind na jou luister. Maar jy kan nie jou kind gaan stuur gaan koop vir jou ma ‘n dop nie.” [Peer navigator]

“So now the kids must have it, ya, that’s true, oh goodness me. Drink with the father…. the mother actually allows them, I think the parents nowadays think that drinking is not as bad as using dagga or tik, so it is okay if he drinks himself into oblivion, as long as he’s not smoking dagga or using tik.” [Practitioner navigator]
During this construction of parenting practices and their contribution to drug use, the navigators disputed the notion that there is a ‘correct way’ of parenting. They reached consensus that, whilst parenting practices are also socially constructed in terms of what parents in different contexts and cultures have found or observed to be effective, the barometer of ineffective parenting is informed by behaviour that is incongruent with the developmental stage of the child.

A pertinent notion that emerged from the focus groups with the navigators is that parents do not encourage independence and autonomy in their children, but instead allow their adult children to live with them (a sentiment articulated in Theme 1 as well). The following excerpts from the navigators’ narratives illustrate the differing views on the matter, concluded by the stereotype that ‘Coloured’ parents are more prone to nurture dependence:

“In every culture, there is a midway. The group that’s in the middle, too, you know, if I observe her [referring to her colleague], her and her family, she has found I think ‘a midway’, because the kids need to take responsibility at home, they need to do certain things even if they are 14 or 15 years old, and she can provide them with everything.”

“But what is right? I may be looking from my culture to what is right. So maybe that is why I think ‘oh, what ____[referring to a colleague] does, is right’ but then I look at ____[referring to a different colleague] family then I think but there’s nothing… Ya maybe the mother taking care of the child, but hello I am also still taking care of my 21 yr child, and not letting her go that much, so what is then right? All I’m saying is that there is that extremes when parents say ‘ag let them be’ they are 30 they don’t have to work, because I have struggled so hard and I didn’t have a youth and they must have a youth now. Then on the other side, it is the parents that say ‘listen, no, I still need to be responsible for this child’.”

“And also if we come back to the different races; Africans, whites, indians and coloureds. There is a significant difference. In the African culture where you get to a certain age you have to be out of the house. Start with your own life. Preparing yourself for the future. With the whites; certain age you need to start preparing your life. Our coloureds we stay in the house until we are forty and we don’t work and we still rely on our parents.”

It is significant that the debate around parenting practices in different cultural groups emerged in both focus groups. The practitioner navigators in the second focus group highlighted parenting practices in the respective cultural groups changed over time – a view supported by Smetana (2011). The initial perspective that ‘African’ children
treat their elders with more respect and that the latter enforce stricter discipline, was disputed by practitioner navigators, who commented that the **shift in societal and community values** has contributed to a shift in parenting practices. The debate as it unfolded is cited below:

"With me, I think with African… I think Africans are more strict as compared to Coloureds when it comes to disciplining our children."

"I beg to differ; they are much stricter, it’s just that it comes down to choices and I think somehow you just have to make the right choice. I also don’t think there is much difference, because in the past like [referring to colleague] said the Ubuntu; that was part of the African culture, but if you now think in terms of today’s world, many African people are very westernized also using and abusing drugs and it’s not more under the table, they doing it now in the open. I don’t think nowadays there’s much difference."

"And I also think it is also dependent on your community, and this social advancement of your community, the people’s thinking in that community. That is maybe more conservative or more less conservative and traditionalist."

The conclusion to be drawn from this debate is that the emergence of a more individualistic, westernised culture has contributed to parents adopting more liberal parenting approaches, which allows for greater autonomy in children at a much younger age. The narrative of the practitioner navigator quoted earlier in category 1.1.3 in this chapter further also illustrates that some parents reinforce commercialised values in their children by providing them with items that allow them to be on a par with their peers. So, in effect, the parents are yielding to their own need to assimilate within dominant society. These findings emphasise to the need for a different approach, in terms of the more active involvement of parents in drug education. The preceding discussion resonates with findings from literature, that the many changes in South Africa post democracy have resulted in acculturation and changes in many cultural values and norms (The White Paper on Families, 2012b; Peltzer et al., 2010:6) which have enhanced children’s susceptibility to high risk behaviour, such as drug use.
ii) Family environment

The three types of family environments that are highlighted as family-bound risk factors are single parenthood, reconstituted families and teenage pregnancies in families. These are discussed in fewer details below, and have already surfaced in Theme 1.

Single parenthood and reconstituted families (characterised by the presence of a step-parent or non-biological parent), emerged from the narratives of all four participant groups as a prominent contributing factor to drug use in the Northern Areas communities. The following excerpts from the practitioner navigators illustrate how children’s need for parental guidance and nurturance may be compromised by their single parents’ preoccupation with their multiple roles or their parents’ overcompensation for their inability to spend enough time with their children:

“Like in the case of children; they experience a lot of things at home, like there’s poverty, single-parent households where there is only the mother working; there’s absence; houses where the father is absent. How do children cope with those things in life? They just try to find the easy way out, that is why.”

“Because I can assure you that three out of five assessments I do with youth, male youth, who were raised by single mothers and the mothers married when they were older; those boys make their mother’s feel so guilty about marrying another man, that they get away with murder.”

The practitioner navigators reflected on the potential losses children from single-parent families’ experience, and how the absence of a sense of belonging is transposed into anger. The following excerpts from the practitioner navigators’ further suggest that children may find acceptance in their peer groups particularly appealing, amidst their sense of abandonment in the family context (refer to 2.3.1 in Chapter Five), attest to their views in this regard:

“And also a lot of children grow up with anger. They grow up with that anger in them. Where parents get divorced as we said earlier, the new parent moves in, they can’t handle that. So they are angry at that new parent for moving in. They think now that parent is taking on the role of their father/mother that is not there and they don’t know how to deal with it.”

The strong consensus amongst all four sample groups, about the association between single parenthood and adolescents’ susceptibility for drug use, points to two
conclusions, i.e. that the quality of parents’ relationship with their children, and parents’ access to environmental support (Brook et al., 2006), serve as significant protective factors.

Practitioner navigators also alluded to the increase in teenage pregnancies (also referred to in theme 1 of this chapter), resulting in ill-prepared parents, and grandparents having to shoulder the responsibilities for childcare. They co-constructed the views as follows:

“And I also want to add to what __________ [referring to colleague] said about single-parent families and the father being absent. Our parents are getting younger, children 16 and 13 and 12 are having babies. So what values can that child learn [teach] another child?”

“The mother is still young, she’s still looking for a possible husband, and she’s been a child herself so there was no childhood left. Sy het nie haar kinderjare geniet nie. En hier het sy nou hierdie kindjie, wat maak ek nou?…. So as hy onder my voete uit is, is dit beter.”

“Of gaan laai hom net af by ouma, dan kan ek my ding gaan doen. Of as sy ’n man het, ’n stiefpa, dan moet sy die man tevrede stel en die kinders ly daaronder.”

6.3.2.3 Sub-theme 2.3: Risk factors located in the peer domain

The dynamic role of the adolescents’ peer group was discussed comprehensively in Section 2.4.2.3 in Chapter Two and Category 2.3.2 in Chapter Five. Two sub-categories emerged from the analysis of navigators’ narratives which will guide the ensuing discussion.

i) Experimentation with drug use developmentally appropriate

Contrary to the observers, who problematised the adolescent life stage, the practitioner navigators normalised the experimentation with drugs during adolescence as developmentally appropriate. The following expression by a practitioner navigator: “They are young and they are living in the moment” suggests that adolescence is marked by a carefree attitude of focusing on the present only. The peer navigators echoed the sentiments that the adolescents’ motivation to assimilate within the peer culture is a normative, if not, automatic response during this phase (Smetana, 2011;
Ksir et al., 2008; Kim et al., 2002), especially as it secures peer acceptance. The peer navigators’ co-constructions were expressed as follows:

“Groepsdruk….Dis cool! Kom ons doen ook dit.”

“Dis die in-ding.”

“Dis soos ‘nike’-tekkies – “just do it!”

These views resonate with the following assertion by a practitioner navigator that drug use becomes a way of identifying with one’s environment in an attempt not to be perceived as the odd one out, who is trying to outsmart his/her peers (Louw & Louw, 2007):

“And those families in Bloemendal [neighbourhood in the Northern Areas]; those less advanced communities, besides the fact that they are unemployed and they don’t have money; I think it’s peer pressure. You don’t want your neighbours to think that you think better of yourself or you think you are cleverer. You can’t do your own thing, while other people are doing this.”

This narrative is contrary to the social construction presented by both the observer as well as some practitioner navigators who implied that the ‘Coloured’ ethnic group’s envy of each other’s achievements contributed to their competition with one another.

ii) Value derived from peer association

There was consensus about the value of the peer group in adolescence, and the particular needs they fulfil (refer to Category 2.3.2 in Chapter Five), which is interpreted as a risk rather than protective factor, based on the form and content of the navigators’ narratives. One such an excerpt, cited below, implies that adolescents derive primarily emotional as well as material gains from associations with older peers:

“And that’s where the false sense of security comes in, because usually the people that the group is with, is usually much older than the person going into the group. There is always an older one, so that one is seen like the father figure. That person is giving you the love, the comfort, buying you the takkies, because as much as you don’t wanna say it; that is what is happening. Buying takkies for them; these nice things; luring them into that, especially the children. The child wants to be accepted and loved; those two, so they go to other ways to get it; wrong ways.”
These constructions resonate with the voices of the travellers and the observers reflected in Sections 2.3.1 and 2.3.2 of Chapter Five, and are consistent with developmental theory explanation of normative changes associated with adolescence (Louw & Louw, 2007). It is therefore imperative that social service professionals are familiar with normative developmental changes, so that they can be alerted to atypical behavioural changes. Abbott-Chapman, Denholm and Wyld (2008:611-627) have explored the factors that inform Australian adolescents’ risk taking behaviour. Their study revealed that adolescents who enjoyed supportive relationships with their immediate and broader social systems (i.e. parents, family and friends) were less inclined to participate in risk taking behaviour, whilst those who depended only on peers for support, had an increased inclination to engage in high risk behaviour.

A very significant finding from the latter study, reiterated by all four sample groups in the current study, is that drug use in the peer group is often secondary to the benefit of attachment to the group. Drugs become a means to an end for many of the adolescents – either a means of passing one’s time, having fun, satisfying curiosity, or mainly receiving unconditional acceptance from peers. Unfortunately, the unifying factor in these peer groups is the narcotic, and when it dissipates, friendship follows suit. The findings from the practitioner navigators concurred with the travellers, whose narratives suggested that friendship bonds were superficial and therefore easily severed when drug use was removed from the equation. The excerpts from the practitioners’ narratives illustrate their views in this regard:

“En ledigheid is die duiwel se oorkussing…Also, it is a false sense of security that you get out of it in a sense, because where the drug is there is always friends. So you get that false sense of security. It’s not the drug, it’s actually the friends that is getting them together, because if the drug is taken away, there would be no reason for them to be friends. It’s a way of being accepted.”

“It collapses; you can almost say it collapses; the friendship collapses, because it wasn’t a real friendship.”

The next sub-theme deals with the community domain, which, ironically, is one of only two domains to which the navigators assigned protective factors.
6.3.2.4 Sub-theme 2.4: Risk and protective factors located in community domain

The community-based risk factors were a dominant theme that emerged from the analysis of the practitioner and peer navigators’ narratives. The analysis exposed in six sub-categories, each of which is discussed in the ensuing section.

i) Easy access to drugs and normalised occurrence in Northern Areas

The issue of the availability and accessibility of drugs in the ‘Coloured’ communities emerged as a sub-theme from the co-construction of three practitioner navigators’ narratives, which were expressed as follows:

“It is spreading, I must say it is spreading to the other areas, but it is mostly Coloured. They are selling it, they’re the merchants.’

“And I also think drugs, it is available these days, freely available, it’s not something you really have to go and search for; you just go down the road or two houses away there are people selling drugs… I think it’s accessible everywhere these days, but I think it might be more accessible in certain areas than in other areas.”

“I don’t know if they are making it yet. It comes from Johannesburg and Cape Town – I haven’t heard of anyone making it here yet. But it’s not your coloured people that are bringing it in. It’s other races, they’re not using it. Then they bring it into the Northern Areas.”

These views were supported by two peer navigators, who articulated the following:

“Is baie beskikbaar.”

“Dis meer beskikbaar as in die ander areas. Dis nie net Kleurlinge nie; dit is in die Kleurlinggemeenskappe word daar klomp, [pause] word dit verkoop.”

“Word dit verkoop, dan kom al die ander rassegroepe, kom na die Kleurlinggebiede toe om dit te koop.”

A practitioner navigator purported that the Northern Areas community was vulnerable to ‘other race groups’ that transported drugs into the community, which is in contrast to a peer navigator’s assertion that other race groups were lured to the Northern Areas by the availability of drugs. Nonetheless, their views of the Northern Areas as a high-risk
community (Elliott et al., 2006:2), were consistent with those of the community volunteers interviewed during the conceptualisation phase of the study (Minnie & Muller, 2012; Sharmar, 2012; Stanley, 2012). As indicated above, the navigators also disputed the notion that drug use was a normalised occurrence in the Northern Areas community only. Their responses indicated that they associated the prevalence of drug use with a lack of social order and poor socio-economic status rather than ethnicity, as is evident from the excerpts from the peer practitioners’ narratives:

“Dis nie altyd so nie, Tannie; baie keer in die Blanke woongebiede.”

“Soos by klubs, En met die Engelse mense.”

“Ja, in Central, daar is baie daar [pause] dwelmposte.”

“Jy word ooral aan dit blootgestel, maar meer in die [pause] in die deurmekaar areas.”

“Vir inkomste, seker maar.”

The general construction that the prevalence of drug use is informed by structural factors of poverty (Zucker et al., 2009; Reddy et al., 2010; Brook et al., 2006) was encapsulated in the excerpt below from a practitioner navigator’s narrative, which touched on the presence of a class differentiation in the choice of drugs:

“There are two categories of that. Whenever people say drug abuse they think of your hard things, like that for me is more for White people. They use the heroin, like the real drugs, like the heroin and cocaine and that things, but in terms of reality, your dagga and your alcohol is a daily thing which is different and that is another category for me [pause]. Ja, because soft drugs is really the biggest problem because it is everywhere and anywhere.”

The statement underscores the meta-narrative that emerged in from the present study, namely that South Africa is a polarised country where there is a privileged group (in this case “White”) (Adhikari, 2005), which has access to resources that enable them to obtain what they need – in this case, the ‘real’ drugs, whilst the cheaper, more accessible drugs are used by the ‘inferior groups’. Here, the latter represents the ‘Coloured’ population group, which has historically been classified as being of lower socio-economic status (London, 1999). Research findings from other South African
studies support the view that more expensive drugs are more readily found in higher income neighbourhoods (Potgieter et al., 2010; Reddy et al., 2010).

ii) Changing trends in drug use in Northern Areas

Furthering this thinking pattern, two practitioner navigators reflected on the changing trends in drug use in the Northern Areas communities, which have-far reaching implications for prevention in these communities. Their narratives suggest that poly substance use has escalated amongst adolescents, who either just use any drug that they can find, or alternate their drugs of preference in accordance with their needs or their means. In the excerpts below, the two practitioner navigators cited statistics and comments from an adolescent relative, as further evidence in support of their view:

“What I see in Gelvandale, Helenvale, Bloemendal [neighbourhoods in the Northern Areas], in those areas, it’s not just one drug. You’d find one youth, using three drugs. They don’t have anything of preference, whatever comes their way they, will use. As long as they can get high.”

“Strangely enough, a lot more youth has come in [for treatment] for using dagga so maybe the message is getting out there. And then they are only using dagga. Maybe they are not telling if they are using anything else, but there is a lot of them now realizing ‘okay, but dagga isn’t good for me’.

“You see in the Western Cape its quiet down now. Because every single organization in the Western Cape working with substance abuse, even other NGOs have jumped onto the wagon to assist. They’ve put measures in place and they’ve come up with prevention techniques. Whereas in the Eastern Cape it’s still new. Because October last year when the stats were read out it was 7% of our clients that was on tik. May this year, it was 57%. So it shot up by 50.”

“To share with you, this is something that I find very interesting, I know this is happening, but my cousin came from Johannesburg, and he is also still very young. He left early this year, and he came to me and he said ‘you know, it is so disturbing.’ Because when he left, his friends were drinking; now he’s come back 8 months later and they are all tikking. And he says to me, ‘you know, all my friends they are big-sized, you must see them now.’ He says they look like skeletons, in 8 months.”

The overarching perception held by all the sample groups in this study, that the accessibility of drugs in a community enhances adolescents’ susceptibility to drug use (Vera & Shin, 2006; National Institute on Drug Abuse (NIDA), 2003), was contested by Pilkington (2007). The author, who conducted a study in a poor neighbourhood in Russia, suggests that drugs are easily accessible, because there is a demand, and
not the other way around. This view was supported in part by narratives of five travellers in the present study, who detailed the plans they would construct to access drugs in order to feed their addiction. The assumption that emanates from these views is that drug prevention interventions should focus on both supply and demand reduction interventions, and that the comprehensive collaborative approach, adopted in the Western Cape, should be considered.

iii) Community apathy and lack of ownership by community members

The practitioner navigators from both focus groups were in agreement that community apathy, and lack of ownership by community members, were two significant contributing factors to drug use amongst adolescents from these communities. Their co-construction of this narrative was shaped around comparing a ‘Black’ community, in which they rendered services, to several ‘Coloured’ communities. They expressed their experiences of working in these different contexts as follows:

“But now, let’s look at our areas that we work in. We work in Motherwell, and things are happening there. Things are really happening in Motherwell. Mothers getting involved, parents getting involved, the Police getting involved. It’s a community that is starting to build itself, from where I sit. But then I go to places like Jacksonville or the Extensions, and nothing is happening there. I mean how many people have tried to come into Helenvale, and tried to lift up Helenvale? Now again the Mayor has said let’s now focus on Helenvale. We have to, but we have to educate the three-year olds, to have a different outlook.”

“In my opinion, and it’s my opinion only, Motherwell area is really moving along, because the community is abiding of the Police. The Police in Motherwell have been trained on various programmes that our organisation renders. And they make use of those programmes as crime prevention programmes. So they are very visible. The sector police in Motherwell go to the schools.

“The community leaders have bought into this whole growing thing.”

“If I look at Gelvandale Police station and your Bloemendal police station: Bloemendal police station is still trying, they’re trying. Because they would have like awareness campaigns in the schools and they will involve us.”

As the focus group interview progressed, a practitioner navigator contested the construction of community apathy as a barrier to drug prevention services and instead
proposed a counter-narrative of ignorance by the community (refer to Sub-theme 4.1 in this chapter).

iv) Poor relationship between community and Police and absence of community mentors

The practitioner navigators attributed the perceived apathy amongst the Northern Areas community members to the lack of interest, initiative and involvement by the Police and politicians, which in turn results in the community disrespecting the Police and the community leaders. The excerpts below illustrate their views in this regard:

“A lot of the times, the leaders are there for their own reasons and not the communities. They are there to enrich themselves out of the community and stuff the community. That’s how I see it, when I look at the Councillors in Gelvandale [Coloured community], they are not buying into change. As long as Gelvandale can look like a problem, they can look good, because they can say that they are doing something, but the community does not want to buy into it. And that is only my own opinion from where I sit.”

“To get back to the Police officers in Gelvandale, we have sector police there as well. I speak to the Captain regularly, because he comes from Motherwell, but he always tells me, ‘my hands are chopped off’, ‘because I know what I’ve achieved in Motherwell [‘Black’ township area].’ He was the one that was requesting training for his sector police. And now he is in Gelvandale and he is under total different management. Where their sector police have to be chasing criminals. Whereas the Motherwell sector police, they also do that, they also go and apprehend suspects, but they also focus on the community. Where Gelvandale is totally different, they can’t go and do schools. They will go and have the once-off talk, but they don’t run programmes like Motherwell.”

Swisher and Whitlock (2004) describe neighbourhood social capital as the social relationships that exist amongst the actors in the neighbourhood, which they can draw upon to meet both their own and the neighbourhood’s needs. Coleman (cited in Swisher and Whitlock, 2004:223) suggests that social relationships offer three types of resources, i.e. a) the belief that the offers of support and resources to others will be reciprocal; b) access to information, and c) the effective endorsing of norms. The narratives by the practitioner navigators above suggest that they considered the neighbourhood social capital in the Northern Areas to be rather low, in comparison to what they observed in a comparative ‘Black’ neighbourhood. This perception resonates with the first round of data generated with the observers, who gave an equally negative
assessment of the social capital in their neighbourhood (refer to Sub-theme 1.1 in Chapter Four).

v) Absence of prosocial community role models

The low neighbourhood social capital was further attributed to three factors, i.e. the absence of positive role models; the absence of informal social controls in the neighbourhoods; and the presence of negative role models. The excerpts below illustrate the two practitioner navigators’ views in this regard:

“*There is no role model… there aren’t people who see and identify this problem and people should come up with ideas and maybe they… it’s just a way of reaching, telling, someone that I have a problem, I’m looking for this attention…*”

“There’s a wrong role model for the coloured youth.”

The need for prosocial role models has been recognised and incorporated in several youth development programmes. Evidence to this effect is found in the UK Mentor programme (Mentor UK, 2005), as well as a study by Sampson, cited in Swisher and Whitlock (2004:225), which revealed a decrease in delinquency and youth crime in neighbourhoods where adults exercised informal social control by ‘watching out for each other’s children and intervening when necessary’. Santrock (1999) confirms that community mentors can serve as protective factors against the identified risk factors, especially when parental and family support becomes insufficient. These findings agree with the experiences of the travellers, who drew on the support and responded to informal social control from teachers, neighbours and support group members, in order to stay on the straight and narrow path of recovery (refer to Sub-theme 4.3 in Chapter Four).

6.3.2.5 Sub-theme 2.5: Risk factors located in societal domain

The consequences of the slow rate of economic and social transformation in South Africa were highlighted in the contextualisation of the study in Chapter One. This aspect emerged as a prominent risk factor in the narratives of all four sample groups, with the
observers and practitioner navigators placing particular emphasis on structural inequalities resulting from racial polarisation in South Africa.

i) Poor socio-economic circumstances and perceived marginalisation

The four sample groups agreed that unemployment, under-employment, fewer advancement opportunities and poor socio-economic circumstances were linked to adolescent and adult drug use – all of which were discussed in detail in Chapter Five and Theme 1 of Chapter Six. Elliott et al. (2006:2-3) and Santrock (1999) confirm that the nature of a community can have a direct impact on the manifestation of risky behaviour by children. They have identified neighbourhoods that have a greater likelihood of contributing to such risky behaviour as follows: those characterised by high unemployment, poverty and a sense of being alienated from the middle class, all these descriptions resonate with the neighbourhoods in the Northern Areas, where the present study was located. The following excerpts from the practitioner navigators’ narratives accentuate these views:

“And also working in the coloured areas, you make that assumption that oh, this is this area… people here use drugs because of the socio-economic circumstances of the area… “so they put that connotation together, they think, ag, it is ma like that, because they don’t have money and they don’t have that and they don’t have that, so that is the way for them.”

“There were less opportunities ….. Now it has changed to the other side again. There are more opportunities, but still the Coloured people are isolated from whatever opportunities there are.”

The practitioner navigators’ feelings were consistent with the views expressed by participants from each of the other sample groups. Their views that the ‘Coloured’ ethnic group is marginalised and is confused about its place in society, is likened to the adolescent life stage and illustrated in the excerpts below:

“You don’t know where you belong….Ja, well, you know, with the Coloured youth; they really don’t know where they belong. They are in the center. They know why they are in the center! But still for them, it is like being a teenager; you don’t belong anywhere, you know you’re a teenager; you struggle with yourself already, because you are developing.”

“They are isolated, also. Because, what I see in my community is… what I always do, Veonna, is if I hear of a place that needs young people for jobs, or if there is bursaries that come up. We have a tuck-shop, and then the Dept. of Health always used to email the bursaries through to
me. Then I would put it up in my shop for the kids. Because they are not informed. Even the Councillors that sit in those different areas; they don’t take up the initiative to inform those people. So they do not hear anything.”

In conveying this view, the practitioner navigator’s use of alternating pronouns (i.e. ‘you’ and ‘they’) illustrates a fluctuation between an internalised shared view versus a distancing from this disempowering position. In response, the one navigator shared how she gave effect to her social work broker role (Potgieter, 1998) by ensuring access to information (Elliott et al., 2006:222) about employment vacancies and advancement opportunities to the youth in her community.

Similarly, upon prompting, the observers during a second round of data generation also reconstructed their initial rather negative perceptions of their neighbourhood and community members (refer to sub-theme 1.2 in Chapter Four).

ii) Media glamorises drug use

Several practitioner navigators suggested that the media glamorised drug use, and in the process, reinforced the construction of its social desirability. The excerpts that follow illustrate the navigators’ perception of the media’s influence on the onset and perpetuation of drug use amongst adolescents:

“I think media has a very, very big role to play in that, because everybody wants to be a gangster and a rap star. And that is the way. Family of ours; they are in Johannesburg and they have very well-mannered children. Really for the age that they are and very submissive, but the mother is very strict. They are very courteous, but he [referring to the one cousin] was also dressed like a gangster and the way they were talking when they were talking when they were by themselves, but as soon as the big people were there, then they would act differently. But when they were in the younger group, then it was gangster all the way. So I can see how you can identify with that and it is just the whole… it’s ridiculous how the children crave that what is on TV. Even on Mtv [music channel] they want that. And I mean how many music videos are there that the rapper [referring the artist performing Rap music] is blowing out a whole puff of … weed.”

“And it’s related with money, clothing, smart cars, brand names, women.”

“And think in terms of advertisements. There’s that Redds cider, they make it so lovely on the TV…The people are dancing all looking so happy… Now what is a child thinking? We must try it.”
“And I think it’s also because our coloured youth wants to be like the Americans, the bling-bling and the style.”

The navigators proposed that the glamorous image that the media painted of drug use, invited a set of materialistic values that were actively pursued in the context of the peer group, and should be mediated by consistent, firm parenting. Ironically, only three of the ten travellers in the study made reference to how a particular type of music and music videos contributed to their use of drugs. These narratives alluding to the persuasive influences of the media concur with the findings cited in McNeece and DiNitto (2013:192) that, ‘Movie alcohol exposure was significantly associated with adolescent alcohol use over time.’ DuRant et al. cited in McNeece and DiNitto (2013:193) conducted research on music videos across five music genres. Their findings revealed that Rap music portrayed the highest proportion of tobacco and alcohol use. The discussion in Section 2.6.1 of Chapter Five, furthermore attests to the important role the media industry can play by reducing its focus on the youth as a target market for advertising, and moderating how drug use is portrayed.

6.3.3 Theme 3: Practitioners’ description of current drug prevention services rendered to Northern Areas communities

One objective of the present study was to review the findings emanating from the participants’ narratives, and the social work and social auxiliary work practitioners’ reflections on their drug prevention programmes against the existing theory on drug abuse prevention. This would allow me to explore whether the content and methods of the drug prevention programmes were coherent with the meaning that the observers and travellers in the present study attributed to drug use, non-use and drug prevention. During the focus group interviews, the peer and practitioner navigators were invited to reflect on the drug prevention programmes that they were presenting to the residents of the Northern Areas communities. The four sub-themes that follow, emerged from the analysis of this data: i) Target audience for the drug prevention programmes; ii) Format and content of the drug prevention programmes offered; iii) Response of the participants to the drug prevention programmes; and iv) Barriers experienced in the
rendering of drug prevention interventions. A tabular presentation of the navigators’ prevention programmes is presented below.

<table>
<thead>
<tr>
<th>Sample group</th>
<th>Practitioner navigators from NGO</th>
<th>Practitioner navigators from government department</th>
<th>Peer navigators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target audience for drug prevention programmes</td>
<td>Pre-primary and primary school learners (POPPETS)</td>
<td>Créches (pre-schools)</td>
<td>Learners at school</td>
</tr>
<tr>
<td></td>
<td>Schools</td>
<td>Primary health care clinics (pregnant mothers and partners)</td>
<td>Parents (at Parent teacher [PTA] meetings)</td>
</tr>
<tr>
<td></td>
<td>Churches</td>
<td>Youth (from high risk communities)</td>
<td>Learners who are referred for drug related transgressions</td>
</tr>
<tr>
<td></td>
<td>Other social service organisations</td>
<td>TADA groups in school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teenagers (TADA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parents (PADA)</td>
<td></td>
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<tr>
<td></td>
<td>Youth (YADA)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Other professionals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Format and content of prevention programmes</th>
<th>Educational campaigns and awareness programmes</th>
<th>Educational campaigns and puppet shows (to pre-primary)</th>
<th>Educational talks to learners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life skills training (POPPETS)</td>
<td>Life skills training at youth holiday programme</td>
<td>Education through drama/poetry (to learners and parents)</td>
</tr>
<tr>
<td></td>
<td>Scare tactics</td>
<td>Pamphlets and educational talks at primary health care clinics</td>
<td>Pamphlets</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Peer counselling to learners with drug related offenses</td>
</tr>
</tbody>
</table>

TABLE 6.3: Summary of drug prevention interventions offered by the three sample groups

An overview of this table reveals that whilst the navigators offered a wide spectrum of drug prevention interventions aimed at different target groups, the exclusion of teachers, out of school youth and community leaders was apparent. The sub-themes identified under Section 6.3.3 will now be discussed. The literature control for these sub-themes will be brief, to allow for a more detailed comparison with literature in Chapter Seven, where recommendations for drug prevention interventions will be discussed.
6.3.3.1 Sub-theme 3.1: Target audience for drug prevention programmes

It transpired that the practitioner navigators from the NGO delivered drug prevention services only upon request, and that they received requests for these services from four different sources. They noted that requests were most frequently received from schools, followed by churches, tertiary institutions and other social service organisations. At school, these requests were primarily for learners in Grades 7 and 8; from the church, the requests were for youth preparing to be accepted as full congregants (i.e. receiving adult status in the church); whilst the requests from universities were primarily for first year students. These are all groups of individuals who are in a transition phase, and hence, at risk of particular developmental and adjustment challenges. The responses below encapsulate the navigators’ description of the requests:

“It’s mostly schools and churches, that’s where we get our requests from, when it comes to coloured youth. Well, we do the whole school, but they would give us the Grade 8’s first. But in some schools they’ll give us the Grade 12s first.”

“At the beginning of the year when the new students arrive, they also request our service, especially for the 1st year [University] students.”

“Other NGOs also make use of our services when it comes to youth groups. Places of Safety are the other places we go to. Places of Safety are the worst places to go to, because they are still using inside there.”

The identification of these high risk periods is in keeping with research findings. National Institute on Drug Abuse (NIDA) (2003), emphasises that the transition periods from primary to secondary school, and then to university, poses particular challenges, as these transitions coincide with many different new experiences, which include closer interaction with a larger peer circle, and moving away from parental supervision. Santrock (1999:344), in supporting this view, refers to the ‘top-dog phenomenon’, which describes

“the circumstances of moving from the top position (in elementary school: being the oldest, biggest, and most powerful students in the school), to the lowest
position (in middle or junior high school, being the youngest, smallest, and least powerful students in the school).”

The navigator’s sentiment about **Places of Safety** ‘being the worst places to go to’, resonates with the findings by Bruskas (2008) and Nilsen (2007), that children placed in statutory care may have any one or a combination of emotional, social, behavioural, educational or developmental challenges, hence enhancing their vulnerability to drug use and other risk inducing behaviour.

The practitioner navigators from the government department reported that their drug prevention services formed part of their Substance Abuse Sub-Programme, and that their focus was on two primary target groups, i.e. **pregnant mothers** (to reduce the prevalence of foetal alcohol syndrome) and **adolescents from high-risk communities**. They reportedly delivered most of their prevention programmes based on their observation of particular needs, in the communities that they served, which were (hesitantly) described as follows:

“**Prevention**…[long silence, followed by non-verbal pressure on the one social worker (assuming the coordinator) to do the talking]. **Okay, being part of the Substance Abuse Sub-Programme here at the Department, we are trying to do at least one or two foetal alcohol syndrome (FAS) awareness at clinics within the Northern areas. We will usually then contact the clinic and they will provide us with a date and a time then we will go and we will do the FAS awareness talk. Not only specifically with mothers who are pregnant; we should do it in the waiting room, so that we can speak to older people and the younger people and even include the men also. So we don’t then just focus on ladies who are pregnant. So we try to share the information with everybody.”

The degree of silence and hesitation in the focus group at the outset of the question, raised questions about the coordination of the drug prevention services and consensus amongst the members of the prevention team. It could also suggest that drug prevention intervention is a secondary rather than a primary focus for the state service – which could concur with the findings of an audit of prevention programmes in the Western Cape by Harker *et al.* (2008:7).

The other target groups of the practitioner navigators from the state department included **children at preschool, and adolescents from high risk communities**,
whilst the peer navigators, whose drug prevention programmes were school based, focused on the learners and their parents. The details of these programmes will follow under the sub-theme addressing the format and content of drug prevention programmes.

The practitioner navigators from the NGO described adolescent peer prevention programmes (i.e. training and supervision of TADA groups) and a national life skills programme (i.e. POPPETS), directed at young children between the ages of 4-11 years, whilst their other drug prevention programmes were presented in response to requests. The practitioners highlighted that their identification of schools for TADA training was informed by their treatment statistics. Their reflections on these programmes follow below:

“We have really targeted the schools in Gelvandale and Bloemendal and the surrounding areas for the year to come. To do youth programmes and TADA programmes and, you know, ja. Even the POPPETS.”

“There are about 18 schools that we have to cover next year. Some of the schools have been trained, but I think there are 12 or 14 schools that we still have to train and retrain.”

The practitioner navigators from the NGO also reported on new programmes they were piloting, i) a Parent Against Drug Abuse (PADA) group and ii) a Youth Against Drug Abuse (YADA) group. The goal of these two programmes would be similar to the peer navigators’ TADA group, focusing on primary prevention, i.e. equipping the target audience with knowledge and skills to reduce the onset of drug use amongst children and youth. The excerpt below illustrates the practitioners’ attempts to tailor their drug prevention programmes to the identified needs of the communities they serve:

“PADA, YADA is still new, I don’t know if you know about YADA? But it is still new. We haven’t even launched it yet. We had a request from a college. They wanted to start up a YADA group at the college, so we are still waiting for them to come back to us.”

Congruent with the principles of effective social work practice (Potgieter, 1998), the practitioner navigators from the NGO reported on their training programme with professionals, in which they aimed to transfer the skills to more practitioners who could expand the drug prevention services. They described their role as trainers as a
modest one against the background of the vast need, to which they were, sensitised from the number of referrals their treatment section received. They reflected on the training programme as follows:

“We do so little, so little. We’ve trained [pause] 23 professionals have graduated in February, this year. And they are from NGOs; they are from the Department [of Social Development], and different schools. And they are supposed to be running POPPETS in their communities. And they do, they do. Once again it is the Motherwell police because they are always requesting training so we have to incorporate them. And the people that have been trained, I must say they are using that training, so that helps us at least. So that there is awareness and it’s free of charge when it comes from them. But when we have to do it unfortunately we have to charge the school. And we know Northern Areas schools don’t have money.”

The narrative provides evidence that the practitioners were aspiring towards making drug prevention services accessible to as many different sectors of society as possible. This approach agreed with the sentiments expressed by prevention experts that multi-level interventions are required to enhance the effectiveness of drug prevention interventions (Harker et al., 2008:17; Loxley et al., 2003; National Institute on Drug Abuse (NIDA), 2003).

The overview of the target groups, for drug prevention interventions, suggests that the navigators responded to requests for programmes from their own observations in practice, as well as treatment statistics alerting them to where the priority areas were. It confirms the findings by Harker et al. (2008:7) that primary prevention activities in South Africa are presented on an ad hoc basis, primarily because official monetary support for prevention activities is restricted (United Nations Office on Drugs and Crime, 2004). The overview of the findings of the present study suggests that, whilst children as young as four years are included in drug prevention programmes, out of school youth, teachers, community leaders and role players are excluded from drug prevention interventions. An audit of drug prevention programmes in the Western Cape (Harker et al., 2008:9), revealed that some organisations offered primary prevention services to street children, early school leavers, youth offenders, gang members and shebeen owners – all of whom can add a meaningful contribution to fighting the scourge of drug use in the Northern Areas communities and the greater Port Elizabeth area.
The next sub-theme examines the content and format of the drug prevention programmes.

6.3.3.2 Sub-theme 3.2: Content and format of drug prevention services

It was evident that the different navigators used diverse criteria to determine the format and content of their drug prevention programmes. The practitioner navigators from the state department reported being guided by identified priority geographical areas, their needs assessments and observations from practice, which is illustrated in the excerpts from their narratives cited below:

“We mostly target the children from the disadvantaged background that is one of our main needs. Like [referring to colleague] said….We had a puppet show…For the smaller ones, it will be a puppet show; but for the bigger ones it will be straight-forward. Questions and things that they have experienced, so it is more open with the bigger children…..It’s more of a sharing of information.

“Like we said, we mainly focus on our case loads from the social workers, so they give us the children. We tell them the [geographical] area we are gonna focus on and they give us the children. So we usually do it in the area where the children are from to help our transport needs, and we usually have an educational day the first day and then the next day we take them on an outing – it’s like a reward system. And we also look at the ages involved, so if it is younger children, there would be a different way of getting the story over and with bigger children it will be a different way.”

“We have an NGO on board and they do come and they do their awareness and after that we’ll just share the realities.”

The narratives indicate that the navigators were cognisant of the need to incorporate cultural sensitivity in their design, as they adapted their format to make programmes age appropriate (Resnicow et al., 2000:272). The identified venues for the drug prevention presentations were determined by the Department’s own transport availability, confirming that restricted funding and resources might compromise the effectiveness of the drug prevention interventions.

The narratives by the practitioner navigators from the NGO suggested that the content of their prevention programmes was informed by surveillance statistics, the latest trends in the addiction field, as communicated by their National Office, and
colleagues in other provinces, as well as the lessons they learn from their clients. They relayed these defining factors as follows:

“It’s the new drugs that come out every year. And we look at the new trends that’s going around, I mean now we have to speak much more about Tik than we did last year, because it’s taking on extreme measures.”

“And our National Office, whatever information they get, they will email through to us as well. And even our other branches right across the country, whatever is new, that comes up in their areas they will… or if I hear something new then I will phone and find out from them if this is really happening.”

“And our clients are not unwilling to share this information with us – ‘when you buy the drugs you buy the bulb as well’ [citing an example of what she was told by an adolescent].”

The narratives reveal that the content of both the practitioner and peer navigators’ drug prevention programmes was largely educational in nature, providing information on the types of drugs, drug effects and consequences of use and abuse. The POPPETS Programme incorporated a skills training element offered to pre-primary and primary school learners, as well as TADA and PADA training by the navigators from the NGO. The navigators from the government department made reference to the department’s national drug prevention programme, Ke Moja, but could not provide further detail on the format or content of this programme. The youth holiday programme skills training camp offered by the navigators from the state department reportedly involved a skills training component, found to be more effective than educational prevention programmes (United Nations Office on Drugs and Crime (UNODC), 2004; Loxley et al., 2003).

The majority of the programmes were reportedly once-off interventions, educational in nature, with little or no focus on effective skills training, such as drug resistance skills (except for the POPPETS and TADA training). According to Loxley et al. (2003) once-off educational campaigns do not yield lasting effects.

However, the excerpts from both the peer and practitioner navigators’ narratives illustrate that they also adopted an interactive approach in their presentations, which
elicited active participation. The practitioner navigators from the NGO described the content of their school based drug prevention programmes as follows:

“In most cases, they want me to come and talk about substance abuse to the kids, and tell them about the effects of abuse. Yes share knowledge with the kids.”

“What is the drug? Because they don’t really understand what a drug is, and nowadays anything becomes a drug, very soon paper will become a drug, too. Anything becomes a drug, so we have to go through that whole thing of the categories of a drug and what is a drug. And when you question them, you know, they will name the drugs, because they don’t really know what a drug is, and where it comes from.”

The preceding narratives allude to the importance of having **competently trained prevention facilitators**, who will ensure that they remain up to date with developments in the field of drug prevention (Harker *et al.*, 2008:11).

The peer navigators (i.e. school-based TADA group) reflected on the nature of their role, which ranged from primary to secondary prevention. The nature of the services that they rendered were **educational talks** to the learners about particular drugs, **creative plays**, to illustrate the effects of drugs and **information brochures**, to raise **drug awareness**, which they described as follows:

“Oh in die LO [lewensoriëntering]-klasse het ons in groepe gewerk, en dan het ons ‘n dwelm gekies en elke groep het ‘n dwelm gevat en dit verduidelik aan hulle.”

“En toe begin ons nou. Ons het goed gedoen soos die “hookah pipe” aan die skool bekendgestel en wat die gevare daarvan is en in die saalbyeenkoms toe doen ons vir die kinders ‘n optrede.”

“Ons het ook ‘n hoekie daar met meer inligting en berigte. En dis like [soos] pamflette wat juffrou by Pick ‘n Pay kry van dwelms, en dan vat die kinders van dit.”

The peer navigators’ **educational interventions** were also directed at **parents**. The quote below suggests that the peer navigators regarded the employment of scare tactics as effective, contrary to empirical evidence about its ineffectiveness (McNeece & DiNitto, 2013:184). The excerpt further illustrates their description of a drug educational programme that they presented at a parents’ day, at their school:
It is evident from the narrative that the peer navigators adopted a socio-cultural approach in their drug prevention programme, focusing on a drug that many parents appear to regard as harmless and socially appropriate (compare Sub-theme 2.5 in Chapter Five). Hearing a message to the contrary from their children’s peers is arguably likely to have a bigger effect.

The practitioner navigators from the government department offered the following description of their awareness campaigns and educational programmes at pre-schools and primary health care clinics:

“Then there is something else that we have also started, now that’s new. We do awareness campaigns at either primary schools or at the crèche, but we do it through puppet shows.”

“So that at a younger age, we can start making them aware of the dangers of alcohol and drug abuse. What I actually do, is I would take a cigarette with me and I also got a little bottle of Amarula and I’ll show it to the children and I’ll ask them ‘Wat is die?’ en dan sal hulle sê: ‘dit is wyn.’ En dan sal ek nou vra: ‘wat weet jy van wyn’? Of ‘wat weet jy van sigarette’ and then they’ll say ‘dit maak mens snaaks loop’ of ‘ek het al gesien my papa tree snaaks op na hy gedrink het’.”

The excerpts above illustrate that the navigators used puppets and other functional aids as creative means of increasing pre-schoolers’ knowledge and awareness about the two most prominent gateway drugs, viz, alcohol and nicotine. Whilst the United Nations Office on Drugs and Crime (2004), suggests that interactive methods subscribe to the principles of effective prevention programmes, The Centre for Addictions Research of British Columbia (CARBC, 2006), cautions that prevention programmes should be evidence based and meet practice standards.

Another programme offered by the practitioner navigators from the state department was geared towards ‘high risk’ adolescents (McWhirter et al., 2007; Fraser, 2004), aimed at educating them about the harmful consequences of drug use in general, with a degree of skills training incorporated. The practitioner navigators also
communicated their commitment to employing expert input, as they involved the SAPS and an NGO specialising in addiction treatment and prevention to conduct the educational input on drugs. Their narrations follow below:

“Us as Auxiliary workers – we have our own Holiday Programme, where we slot in. Actually get SAPS on board and an NGO and then we have an awareness on the use of drugs and what it looks like.”

Considering that adolescents from high-risk groups present with a number of social and other risk factors, it is surprising that they were included in a universal drug prevention programme. In accordance with evidence-based practice interventions, these adolescents should instead, be included in targeted interventions, aimed at ‘building positive connections to family, school and community, thereby promoting positive educational, health and social outcomes’ (Harker et al., 2008:17).

The practitioner navigators from the NGO described POPPETS as a national life skills programme, aimed at imparting knowledge about drugs, whilst at the same time instilling important life skills in the younger children. They described this nine week programme as containing sections on feelings, self-esteem, decision-making, peer pressure, substance abuse, sexual abuse, HIV/AIDS and a final wrap-up session. Selective quotes from this description are cited below, to illustrate the practitioners’ narratives of the programme, with some extracts reflecting on the specific sessions they have had, and their related experiences of presenting these sessions:

“And the 2nd one is about self-esteem. Once again in our coloured communities, our children suffer with self-esteem. We have it in the black areas as well, but if you look at the coloured children, they really struggle with self-esteem, because __________’s [friend’s name] parents can afford to buy name brands and my parents can’t. I want to be friends with her, but she is such a snob, because she doesn’t want to be my friend because I can’t wear name brands. And that all breaks their self-esteem. So through the POPPETS, we teach them what is self-esteem and self-worth.”

“During the one session on ‘who to go to for help’, this one 7yr old didn’t colour in the grandmother. Because we tell them they must colour in the people they think they can trust. If anything happen…who are these certain people they can go and tell? And then there is a blank space where they can draw someone that they, either the mother or someone that they can trust. So grandma was not coloured in. So when we asked the little boy what happened? Why don’t you colour in grandma? Because it’s Northern Areas, they all think about guns and gangsters so this little boy’s response was – if they start shooting, she’s walking with a stick;
she cannot pick me up and run, so we will get shot, so I don't trust her. Because she can't help me'."

The narratives resonate with several of the stereotypical constructions (i.e. of inferior ethnic identity and unsafe neighbourhoods), that were examined in themes 1 of Chapter Five and Chapter Six respectively. It furthermore illustrates the value of engaging the training participants during drug prevention programmes, so that the presenters' understanding of the context, and subsequent adaptation for cultural sensitivity, can be further enhanced (Gosin et al., 2003:132-133).

The peer navigators described their drug prevention interventions with learners who are already using drugs, as follows:

“Soos byvoorbeeld ons het ‘n program as leerders gevang was met dwelms of alkohol, dan gaan ons met hulle deur, hulle kom sit na skool, dan word daar klasse aangebied om te wys wat is die gevolge daarvan, en watter siektes dit kan veroorsaak. Daar is altyd een persoon, maar as dit ‘n groep meisies is, dan doen ‘n dogter dit en as dit seuns is, dan doen een van die seuns dit.”

The approach of the school to referring learners who have committed a drug-related transgression to the TADA group, as opposed to suspending or expelling them, is evident of a positive discipline mechanism. It agrees with the advocacy by Maseko et al. (2003:149-150) for the school to adopt a restorative rather than a punitive approach to learners who have transgressed. The role of peer counsellors is further emphasised by Kim et al. (2002:566), who suggest that drug awareness programmes at school should be presented in collaboration with training in the soft skills, in order to strengthen the learners’ peer resistance skills. The gender pairing of learners is also coherent with cultural sensitivity in drug prevention (Resnicow et al., 2000:281).

The excerpts from the narratives of the practitioner navigators, illustrate their cognisance of using interactive teaching methods and engagement strategies (Harker et al., 2008:19), which cater for the Generation Y adolescent (Weiler, 2004:47):

“For me, why I take graphics to school, I can talk and talk, but I’m still much older than them. They’d be like ‘bru what do you know?’ But if I show them the stuff on there, then I get more reaction than if I was just standing there and I would just speak. Even if I was hip and funky and whatever.”
“And I've seen at Gelvan, at that sport stadium, we took a movie that they could relate to you know, a short movie that they could relate to.”

“Ja, they don't want to listen to words, kids of today, they can't listen, they can't hear, but they can see, because they are used to the medium of watching pictures.”

“Especially for me, if I work with a group, when I see they're becoming tired, then I energise them, because it is no use carrying on and on and they are far gone by then. Especially when you have a few smokers in the group, you lose them quickly. They're getting withdrawals.”

It is evident from the first narrative cited above, that the navigator was emulating the vernacular of the audience which, depending on how and by whom it is used, may be experienced as patronising. Resnicow et al. (2000:272) explain that surface structure cultural sensitivity refers to infusing the audience’s way of speaking into the drug prevention presentation, which can be accomplished with more success if the presenter is from the same ethnic group as the audience. The debate about whether prevention programme presenters should be from the same cultural and ethnic group as the audience is examined in Section 6.3.3.3 of this chapter.

The practitioner navigators further alluded to the importance of drug prevention presenters knowing their audience. The excerpts cited below suggest that group characteristics of the audience determine how they prepare for the group, what is included in the content of the programme, as well as whether they mobilise peer education in the group:

“It depends a lot on who the group is and where they come from, what area they are living in because each area has their own problems and their own drug that they're using. There, in the coloured community, it depends on who your target group is going to be, we prepare according to who requested it.”

“A lot of the times we use the group to educate the group.”

The navigators’ practice approach is in contrast with the general approach to universal drug prevention programmes. However, it concurs with the principles of effective social work practice, which subscribe to undertaking a thorough needs assessment and situational analysis, before goals for an intervention are determined (Weyers, 2011:89;
Potgieter, 1998). Undertaking such an assessment will ensure that prevention interventions are context specific and culturally sensitive (Cuijpers, 2002).

The final category highlighted by the practitioner navigators is that of including recovering addicts in their drug prevention programmes, authenticated by the quote below: “And we also like to make use of recovering addicts to tell their stories.” Whilst the involvement of recovering addicts has been a popular method in universal drug prevention programmes, Myers et al. (2008:12), caution that prevention workers need to be adequately trained. Echoing this sentiment, Harker et al. (2008:18), cite the AA guidelines, which suggest a ‘time frame of 3-5 years of uninterrupted sobriety before an individual enters prevention work’.

An overview of this sub-theme reveals that the drug prevention programmes by the peer and practitioner navigators are primarily educational in nature. Only two programmes (i.e. the TADA and POPPETS programmes), contained an effective life skills training component. The methods of presentation included didactic approaches, transferring knowledge and skills by training teachers and fellow helping professionals, interactive teaching methods, mobilising peer education in the groups and employing recovering addicts as part of the universal drug prevention interventions. At a secondary prevention level, the peer navigators employed peer counselling as an intervention method. The principle of cultural sensitivity appears to underpin several of the programmes, as the navigators adapted their programmes by effecting language, age and gender pairing.

6.3.3.3 Sub-theme 3.3: Responses of participants to drug prevention programmes

The navigators were asked to reflect on the responses that they received from the participants when they presented their drug prevention interventions. None of the navigators reflected on responses from adult participants; hence this sub-theme will only present responses by children and youth, as described by the navigators. The findings that emerged from this sub-theme show significant overlap with the preceding theme. In order, therefore, to avoid repetition, and to enhance the flow of the
information, this sub-theme will be structured according to the following three categories:

<table>
<thead>
<tr>
<th>The nature of the participants responses</th>
<th>The factors that influenced or elicited these responses</th>
<th>Deductions that can be derived from these responses</th>
</tr>
</thead>
</table>

**TABLE 6.4: Outline of the sub-theme’s three categories**

The practitioner navigators from the state department relayed how the **pre-schoolers**, attending their drug awareness programmes **spontaneously shared what they had seen around their own homes and neighbourhoods**, which confirmed the traveller and observers’ narratives (refer to Sub-theme 2.4 in Chapter Five), regarding permissive child-rearing practices, parental role modelling and normalisation of drug use in certain parts of the Northern Areas communities. The excerpt from the navigator’s narrative cited below alludes to the importance of drug prevention programmes, focusing on parenting skills and challenging the social norms of drug use in the Northern Areas communities:

“**Before we started the puppet show you, talk to the children and ask them what do they know about smoking and it was surprising how many of those little kids actually said: ‘my father drinks that’ or ‘I have seen my mother do that’. Or ‘I also do that. I drink with my father, or my father will give me a little [pause] ‘n mondjevol’.”**

A practitioner navigator from the NGO relayed an experience that emulated the aforementioned one cited by her colleagues in the state department. The navigator’s presentation was to a group of pre-schoolers during a church service. The conclusion she reached from this experience was that the children’s high level of awareness about drugs, illustrated the degree of exposure they had to drugs in their neighbourhood, as evidenced from the excerpt below:

“I’ve done a POPPET session at a church during the service in the Shauder[ville] area, and the reverend was so shocked. Because we did the session on substance abuse, and afterwards I was doing the processing, and all the adults were in the church as well. And when I asked the children what do they know about smoking, you know the front row was all your 4/5yr olds, they put them in ages. And they were the ones that were saying, ‘people smoke rocks’, ‘people smoke dagga’, and they named all the drugs. And then I questioned them, ask them where do you see this? ‘Oh at home, my brother, next door’. And when I asked them about alcohol, do
they know what alcohol is? ‘It is that whiskey and brandy’. They named everything in the bottlestore, I couldn’t get them to quiet down. And I could see the reverend you know, turn all colours, because here is all the parents sitting in the church and these children are just blurtng everything out. ‘Well, my mother drinks, and she drinks Archers’, you know they just name it, and that was quite shocking.”

Several practitioner navigators from the NGO contributed to the co-constructed story, that the adolescents they presented the drug prevention programmes to, were generally well informed about drugs. The excerpts below are an illustration of the navigators’ views in this regard:

“Look, they know the names of the drugs, they know where it comes from, they know what it is made of.”

“They know where to buy it.”

“When we talk about the substance abuse in the Northern Areas, you can’t tell them anything about substances that are available. They know every street name of each drug, they know how it’s used, where it’s sold, but they don’t know the effects. Because, you see, when you do a presentation – the effects, they still get shocked. Because they don’t realize when they get into it, this is what can happen to them. It’s like they know of everything, but they don’t know what it going to do to them. And also there are a lot of new drugs available and also a lot of new combinations available and there are a lot of new things that people are using, I mean they sniff Omo [washing power].”

The assumption by the practitioner navigators that the children and adolescents were less familiar with the effects and consequences of drugs concurs with the experiences cited by some travellers (refer to Sub-theme 2.3 in Chapter Four), and a few observers (refer to category 2.1.1 in Chapter Five). This is juxtaposed against the attitude expressed by some travellers (refer to Theme 3 in Chapter Four), who only believed they were susceptible to the harmful effects of drugs upon experiencing it personally, highlighting the need for cognitive-behavioural preventive interventions.

Overall, the navigators reported that the adolescents were generally engaged during the prevention programmes, and suggested that their responses to the programmes were influenced by the presenter’s facilitation style, and the degree of ownership and participation that the adolescents were allowed during the programme. Ungar’s (2006) assertion that youth respond to adult input when adults communicate with them in ways
that they can hear and respect, resonates with the navigators’ experiences, as expressed below:

“When we do the sessions, they are really very talkative. Sometimes you have to allow them to verbalise whatever they are thinking of, because they can become disruptive if you don’t listen to them, and it has happened so many times.”

Concurring with the latter part of this narrative, several practitioner navigators relayed experiences of being on the receiving end of subtle resistance from ‘all-knowing’ adolescents, during their drug prevention programmes. They co-constructed their experiences in this regard as follows:

“The other thing is, especially when we came there, they will have this attitude of you can’t teach me anything.”

“Daai goed wat julle van praat, ek ken daai goed.” [Mimicking the adolescent’s vernacular]

“You don’t know how hard it is to live where I live and do what I do.’ “That is the kind of attitude that we get from the youth. But even with all that, they still do ask questions. Ja, they do, in the beginning they’ll have this attitude.”

“But for the youth, it is like, ‘you are much older than me, what do you know? You don’t know. You don’t see what I see on the streets. You don’t go to the places we go to.’”

It is evident that the navigators interpreted such resistance as adolescents questioning their authority or credibility and as being based on the discrepancy in age and (assumed) living circumstances. Another explanation could also be found in the prevalence of several myths that the navigators encountered during their drug prevention programmes. These ranged from the youth regarding themselves as immune to the drug-related harm, believing they could manipulate the drug to reduce its harm, rationalising their reasons for use. Selected excerpts from their narratives are cited below:

“And I think they are in denial, that, ‘no that is not gonna happen to me, because I can control this. I can control using whatever substance’.”

“I don’t need this, I just do it for fun, there’s nothing to do. I’m bored.”
“The one that I always get is the argument about dagga. Dagga is an herb, and it’s good for you, and Rastafarians they believe in it.”

“And if I cook it, it’s not that bad; if I drink, it it’s not that bad.”

“Ja, it’s just the flavors and it cleans the lungs and my parents said we must do it, because it cleans the lungs.”

Juxtaposed against the myths and resistance cited above, the peer navigators’ co-construction offered useful, promising insights into the school pupils’ responses to TADA’s drug awareness programmes. Their experiences confirm that the content and presentation method need to be synchronised with the **age of the audience and the learning preferences, and composition of the group.** The use of humour and the presenter’s voice intonation were cited as variables that influenced the adolescents’ responses to the programme. The navigators’ experiences furthermore suggested that the **age and status of the presenter** influenced how the audience responded. A selection of the peer navigators’ narratives cited below, encapsulates the views referred to above:


“Jy kan praat en vrae vra, en iets sê, jou mening lug. Jy moet soos ’n vriend praat… nie staan en lees nie.”

“Hulle bietjie betrokke ook maak met dit wat jy aanbied, miskien.. Soos as jy dwelms doen, dan vra hulle vir jou wat is die straatname van alkohol… en die hande wat op is, dan vra jy hulle, en wat is die ouderdomsbeperkings….. En ook hulle opinie te vra.”

“Maar tydens die optrede, vir die wat nou wil lees, dan wys die juffrou dit op die skerm.”

“Dit moet net meer… daar moet ’n persoon wees wie se stemtoon kan verander. Soos die een Meneer, hy praat die een oomblik sag, dan begin hy hard te praat, dan trek dit almal se aandag en dan gaan hy weer sag, en sodra hy jou aandag verloor, dan trek hy net weer die mense se aandag met die manier hoe hy praat.”

“Jy moenie die heeltyd net praat praat oor die ding nie, jy moet soos tussenin moet jy ’n grappie ook insit om die kinders te maak lag, bietjie lag oor dit….. Maar ook terselfdertyd moet hulle weet dat dit iets ernstig is. Hulle moet die ernstigheid van die saak hoor en die nagevolge.”
The excerpts below illustrate the peer navigators’ awareness of the importance of demonstrating a non-judgmental attitude, genuine empathy and the use of self-disclosure in their interactions with school learners who have had drug-related offences at school:

“Soos ons TADA-leiers, ons “judge” nie n persoon nie want ons weet nie wat is die omstandighede. Ons kan net vir jou sê, jy weet, jy moet dit nie gebruik nie, maar ons weet nie hoekom het jy dit gebruik nie.”

“Of om hulle persoonlike probleme te verstaan en te sê, nee ek kom ook al daardeur, maar ek het nie dwelms gebruik nie, ek het iemand gaan vra om saam met my te praat… of hulp gaan vra.”

The peer navigators’ illustrations of cultural adaptation of their programmes (Winters, 2002:101-108) and insights into the qualities of the helping relationship that promote co-operation from the adolescents were admirable. These also cohere with the findings by Van der Westhuizen (2010:123), who reported that the ‘chemically addicted’ adolescents in her study had similar expectations of the social workers who were rendering after-care services to them.

The sub-theme provided insight into the responses the navigators had been receiving from children and adolescents alike.

6.3.3.4 Sub-theme 3.4: Navigators’ monitoring and evaluation of prevention programmes

The navigators were encouraged to reflect on how they received feedback on their programmes and what informed amendments to their programmes. It was evident from responses that there was no formalised outcome evaluation of the programmes, and that there was no systematic evidence to claim programme effectiveness or impact, in relation to the targeted objectives (Harker et al., 2008:14). Instead, the navigators conducted a process evaluation, which was elicited in the form of verbal input from the audience, or written responses to a short questionnaire. The narratives below illustrate that these responses generally provided feedback on how the audience experienced
the activities and content of the programme, and whether the programme met their expectations:

“Especially when we do the evaluations, they’ll start by saying, we initially came here thinking that it was going to be so boring and that it won’t advantage me in any way.”

“But it was actually fun and I learnt this and that and something new.”

“So when we do the evaluation I think that is when we get [pause] their feedback.”

“Yes, we do it verbally, but we also do a questionnaire.”

The peer navigators also did not engage in formal evaluation of their programmes, accentuating the importance of prevention practitioners in process and content evaluation, as a crucial part of programme implementation (Potgieter, 1998). It furthermore calls for closer collaboration between practitioners and researchers to yield to the guidelines for evidence-based practice interventions stipulating the importance of conducting randomised control evaluations of prevention programmes in order to enhance the effectiveness of interventions (National Institute on Drug Abuse (NIDA), 2003; Loxley et al., 2003).

6.3.4 Theme 4: Navigators’ reflection on barriers to rendering drug prevention interventions

The navigators’ construction of barriers to the effective delivery of drug prevention interventions is discussed in the ensuing section.

6.3.4.1 Sub-theme 4.1: Limitations related to resources

The navigators were in agreement that the primary barriers to the effective implementation of their drug prevention programmes were limitations related to material resources, i.e. in terms of transport; to travel to their target audience, especially when conveying large and heavy presentation material. The funding of the presentation material was also a costly exercise, which hampered the effective delivery of prevention
programmes, as well as the shortage of staff. These views were articulated as follows by the practitioner navigators from the state department:

“If I can come back to the transport problem that we have; just to give an example. We have to go do that puppet show: The stand that we use, is rather big and it’s heavy. So I need to go to a supervisor who has a subsidised vehicle, but it is a 4x4 bakkie. So I first have to ask her if she is available on that day to take us to the crèche, drop us off, we do our show and then to come and fetch us again. Because that thing, it can’t fit into a car. And without her, there is nobody else that can help us. It’s not like I can just walk out here and just take a bakkie and then off we go.”

“It’s mainly transport; because there is a lot of things that you can do; a lot of organization that you can do if you have the autonomy to do everything.”

“Venues are a challenge; venues are usually a challenge, but not a big one.”

“So we’ll be going in and training them, but the main problem for us is that we can’t be everywhere. So we do try and service as many areas as we can. But unfortunately, it’s only a few of us. Next year we will be trying to include some of the people in treatment to assist us in some of the areas.”

The practitioner navigators from the NGO echoed all of the afore-mentioned views, but added that their additional limitation was being compelled to charge a fee for their service, in order to ensure their organisation’s financial sustainability, and being accountable to their National Office. The narratives below illustrate their distress at having to exclude those organisations or spouse who cannot afford their services, as well as a suggestion on how to circumvent the challenges:

“Okay, let me speak the truth here, our prevention, and this might sound very harsh, we have to generate funds as well. We do not get external funding, so it is very hard for us. If we have to go and do awareness campaigns, it involves money, and if we don’t have the paper to print, if we don’t have the visual aids. And from our National Office, earlier this year we got a guideline on pricing that we have to work on. So if a church, for instance, requests a talk, I have to charge them unfortunately and it’s not all the churches that can afford. We do try our best, to still go and do the talks where people who cannot afford, but as I said, National Office wants us overall to charge. Then also the information tables, we get requests from the hospitals, we get requests from companies and we have to charge them and it is R600 a table. We as a team have cut it down to R450.

“If there is funding [pause], I said we seriously have to look at companies that can sponsor us. So that we can do these free talks, because otherwise we are not serving our purpose. Really it is breaking my heart to be able to say no to someone, I can’t do it, because you need to pay me. It really breaks my heart, because I know how I’ve worked in the past and this is something
new, and I was really, really not happy when that came around, but I also have to understand that the organization has to survive at the end of the day.”

The need for funding to acquire visual aids (videos), and other interactive media, as opposed to pamphlets and written material is echoed in Sub-theme 3.3.3 of this chapter. The recommendation is also inferred from category 2.4.1 of Chapter Five, where the observers caution that many children who cannot read and therefore, avoid engaging with reading material as a way of concealing their own limitations.

These constructions of resource limitations were also alluded to by the peer practitioners, who reported that the pamphlets they used at school were ones that their teacher collected from the information counter in a shopping mall, highlighting the lengths to which the teacher would go to secure material. These resource limitations are underscored by Harker et al. (2008:30-31), who concluded from their audit of drug prevention services in the Western Cape that the prevention interventions that have the potential to reduce the drug related harms, do not receive adequate funding. To this effect, the authors recommend that NPOs, who render most of the prevention services, receive special funding, predominantly for this type of service, on condition that they can prove the efficacy of their programmes.

6.3.4.2 Sub-theme 4.2: Perceived lack of cooperation from parents and community

Several practitioner navigators, in both focus groups of the state and NGO, expressed their frustration with what they regarded as parents abdicating their parental responsibilities, when children are referred for early intervention or secondary prevention intervention (McWhirter et al., 2013). Excerpts from their narratives, illustrating their frustrations, are cited below:

“But people [referring to the parents], they know what’s going on and they overcompensate. Now when children start displaying their negative behavior; I don’t know if they know what to do or not to do; then it becomes your [problem]. The moment they made contact with the social worker, it is the social worker’s problem. You must now sway your magic wand and then everything must go away. So even if you have a nice programme, you discuss that programme with them [referring to the parents] when you invite the child, the child is responsible to come to that programme on their own and they are supposed to fix themselves. The family doesn’t see
this as a holistic thing. It is between the social worker and this child to fix this thing now, they
don’t have any part in it, because the other children didn’t do it so the problem is not with the
parent; the problem is with the child. The social worker must sort that out.”

“If it is, for example, a child whose problem has escalated and it’s drug abuse; there’s no facility
within the Eastern Cape that take children under the age of 18. And even if we maybe did have
a centre and it is situated in Graaf Reinet, for example, how do we get the child there, because
the people don’t have the means to pay for a bus ticket or taxi fare.”

The narratives clearly articulate the navigators need for closer cooperation with parents
as active partners in prevention in treatment. Their experiences allude to the need for
parents to understand the systemic nature of drug use (Ksir et al., 2008), as well as the
valuable role that an altered environment and consistent, affirming parenting can play in
drug prevention and treatment (Kumpfer et al., 2003:12). The excerpt from a
practitioner navigator’s narrative illuminates this view:

“And sometimes, it really does do a world of good… I had a very naughty child that I took away
and we placed him in Protea [Child and Youth Care Centre] and after a week there was a
significant change in that child’s life. It was just a different environment and he needed to be
nurtured differently to what his parents’ perception is of rearing a child.”

Research evidence denoting the value that positive parenting, a conducive home and
community environment play in positive adolescent development, was discussed in
Section 2.4.2.2 of Chapter Two and category 2.2.2 of Chapter Five.

The practitioner navigators presented an initial construction of the community
members being apathetic and uncooperative; only responding to requests for
participation in prevention activities when they could derive material benefits from
attending, or when the problem had reached alarming proportions. Two navigators
expressed their views as follows:

“If you say food parcels, they come in their masses.”

“It’s only when the problem strikes, then they realise.”

The following excerpts, from one focus group interview, illustrate how this view was
deconstructed and a number of alternative interpretations co-constructed by the
navigators:
“But I also think it has to do with the contact that you get to have with your community, because I think of places that we did. Places I did practical with, where there is a… where they know the services that you do and they see you more often; it’s much more [pause] people attend better.”

“Because if you… people generally want to see you. They respond very poorly to telephonic commitments or organizing, but if you go there and you say, ‘Listen, this is my situation and then [pause]’ because when you do get to that point and you are able to see people physically; they respond very much better, than just a telephonic conversation.”

“Whereas if you go and you have a conversation with the person; the person sees your facial expression, your body language, and it says like this is what we want to do. I’m not coming as a department, I’m coming as a social worker wanting to do something for this community; can you walk a road with me?”

“After building a relationship with them; then it will be better. For instance, the other time we were doing FAS at a crèche. I’m sure the teacher invited parents, but they don’t know what this FAS is about. They cannot just come for that when you don’t know, you haven’t heard about it. Like I won’t go for something that I don’t know about.”

These alternative interpretations suggest that the navigators realised that in order to enhance community cooperation, they needed to negotiate personal entry to the community, invite the community members as equal partners, and address potential impediments to cooperation, such as ignorance and myths about the topic or each other. Their reflections concur with the guidelines offered by Weyers (2011:159) in respect of facilitating cooperation from the community.

6.4 CHAPTER SUMMARY

The research findings emanating from the peer and practitioner navigators’ constructions were presented in this chapter. A brief biographical overview of the navigators was provided to facilitate the contextual interpretation of the findings.

Both the peer and practitioner navigators’ construction of ‘Coloured’ were characterised by negativity and stereotypical attributions. However, one practitioner navigator, who contested the notion of marginality and inferiority, produced a counter narrative of positive ethnic identity characterised by collectivism and social support that resembled a stereotype in itself if viewed as exclusive to ‘Coloured’ identity. The peer navigator
who opposed the stereotypical labelling argued for a recognition of the similarities between people, rather than an emphasis on their differences.

The peer and practitioner navigators’ socio-cultural meaning constructions revolved around drug use rather than non-use. The risk factors associated with drug use were located in the individual, family, peer, community and societal domain and had a close resemblance with the narratives of the travellers and observers discussed in the previous chapter. The navigators’ cognisance of school-based risk factors was only revealed when they discussed recommendations for drug prevention interventions (discussed in Chapter Seven). None of the navigators made explicit reference to protective factors or processes that could prevent drug use during the first part of the focus group session. They proposed recommendations for drug prevention interventions which are discussed in the following chapter.

This chapter also presented the navigators’ experiences of rendering drug prevention interventions and their reflection on barriers to rendering effective interventions. The findings revealed that most preventive interventions were once-off drug awareness programmes presented in either a school or church context and, less frequently, in a primary health care centre. The barriers included resource limitations, supporting the need for funding of preventive interventions. Other barriers included misconceptions around the community’s lack of involvement, which point to the need for a strength based inclusive process where the community are invited as active partners in working towards achieving effective preventive interventions.

Chapter Seven focuses on all four participants groups’ recommendations for drug prevention interventions, culminating in practice guidelines for culturally sensitive drug prevention interventions.
CHAPTER SEVEN

PARTICIPANTS’ RECOMMENDATIONS AND CO-CONSTRUCTED PRACTICE GUIDELINES FOR CULTURALLY SENSITIVE DRUG PREVENTION INTERVENTIONS

7.1 INTRODUCTION

The preceding three chapters collectively illuminated the adolescent and practitioner participants’ sociocultural meaning constructions of the concepts ‘Coloured’, drug use and non-use. The discussion of these meaning constructions incorporated a comparison and contrasting with the extensive body of knowledge in the field of drug prevention.

The purpose of the present chapter is threefold:

- To summarise the findings from the empirical study with the four participant groups, and to draw conclusions from these findings based on the synthesis with existing literature;
- To present and discuss the participants’ proposed recommendations for drug prevention in the Northern Areas communities. This discussion will be juxtaposed against the identified risk and protective factors, as well as resilience processes that emanated from the analysis of the participants narratives. The discussion will furthermore be compared and contrasted with the existing literature, which was foregrounded in Chapter Two;
- To present co-constructed practice guidelines for culturally sensitive drug prevention interventions. As such, this section of the chapter represents the recommendations from the empirical study.

From the description of the purpose and therefore proposed structure of the chapter, it is evident that the chapter title omits reference to the synthesis of the literature which, if incorporated, would have resulted in the chapter title being too wordy. The first section of this chapter would conventionally be presented in the final chapter of a research
study. However, the implicit purpose of foregrounding the summary and conclusion of the empirical findings in this chapter is consistent with the conceptual frameworks that informed this study. The implicit purpose therefore is to foreground the theory and recommendations that can be inferred from the conclusions, and secondly, the explicit purpose is to systematically build on the participants’ proposed recommendations for drug prevention (Section 2 of this chapter), which contribute to the co-constructed practice guidelines (Section 3 of this study). In order to set the stage for the summary of the research findings, it is important to revisit the research questions and the research goals.

7.2 RESTATING RESEARCH QUESTIONS, GOALS AND OBJECTIVES

The three research questions that provided direction to the current study were as follows:

- **What are the social constructions of the concept ‘Coloured’ articulated by adolescents and social service practitioners living and working in the Northern Areas of Port Elizabeth?**
- **What is the socio-cultural meaning of drug use, non-use and drug prevention for adolescents from the Northern Areas of Port Elizabeth?**
- **How do the social constructions of social service practitioners on drug use and non-use influence the drug prevention services that they render to adolescents from the Northern Areas communities?**

In order to address these research questions, the overall goal of this study was to enhance understanding of the socio-cultural meaning attributed to cultural identity, drug use, non-use and drug prevention in the Northern Areas community, with the view to developing guidelines for drug prevention interventions that are culturally sensitive and contextually relevant.

The corresponding **objectives** formulated in order to achieve the goal of the study were:
• To explore adolescent narratives regarding the constructs ‘Coloured’, drug use, non-use and drug prevention programmes by three distinct cohorts of adolescents (drug users, non-users, and TADA peer mentors) from the Northern Areas communities (*the summary of the findings relating to this objective is presented in the graphic depictions under Sections 7.3 and 7.4 in this chapter. The participants’ recommendations for drug prevention interventions are discussed under Section 7.7*).

• To explore and describe the social service practitioners’ constructions of the constructs ‘Coloured’, drug use, non-use and drug abuse prevention in relation to adolescents from the Northern Areas communities, and how such constructions inform the drug prevention services rendered to adolescents from these communities (*the summary of the findings relating to this objective is presented in the graphic depiction and summary of Theme 1 under Section 7.4.*)

• To review the data collected from the adolescent and practitioner narratives and the social service practitioners’ reflections on their drug prevention programmes, against the existing models for drug prevention (*the findings relating to this objective are summarised under Section 7.4, theme 3.*)

• To synthesise the above information, with a view to developing guidelines for culturally sensitive drug prevention interventions relevant and responsive to the specific social constructions of adolescents and practitioners from the Northern Areas communities.

The next section of the chapter will offer a schematic depiction (in the form of a road map) of the findings from the empirical study conducted with the travellers. This will constitute the summary of the findings that emanated from the analysis of the travellers narratives and is presented in accordance with the journey metaphor outlined in Chapters One and Four. This summary and conclusions are foregrounded, for two reasons: firstly, the travellers actively travelled the journey of drug use and therefore narrated their personal experiences as opposed to observations; secondly, the biographical interviews employed as data generation method with this participant group yielded rich, thick narratives that were presented separately in Chapter Four, and
therefore justify a separate section to illuminate the findings and conclusions derived from their narratives.

7.3 SUMMARY OF RESEARCH FINDINGS FROM TRAVELLERS’ NARRATIVES

The analysis of the ten travellers’ narrative accounts of venturing on and later disembarking from the drug use journey resulted in six main themes with their various sub-themes. The summary of findings from Themes 1-4 and their associated sub-themes are represented in Appendix H (Title: Road map of travellers’ journey), whilst the discussion of Theme 5 (recommendations for drug prevention interventions) (labelled ‘recommended road map to avoid embarking on the journey’) will be incorporated in Section 7.7 of this chapter to form a co-construction of the participants’ recommendations.

The reader is reminded that in contrast to the data generation with the other participant groups, the travellers were not presented with any direct question about ‘Coloured’ identity. This was intentional, as I wished to observe whether associations with culture and ethnicity emerged spontaneously in the travellers’ narratives. Several of the travellers’ narratives (reflected as Theme 6) were indeed suggestive of internalised racial stereotypes which depicted drug use as a normalised phenomenon in the ‘Coloured’ communities. Their narratives evidenced entrenched beliefs about ‘White’ supremacy and ‘Black’ inferiority in terms of economic status, intelligence and the nature of social interactions.

7.4 CONCLUSIONS AND INFERRED RECOMMENDATIONS DERIVED FROM THE FINDINGS

It can be concluded from the findings that the travellers’ departure on the drug use journey and continued travels to the fast lane, were facilitated by an interaction of a number of risk factors cutting across the different concentric circles of the systemic risk/protective resilience framework. The conclusions derived from the findings are presented below in the form of knowledge statements (Rosen, Proctor & Staudt, 2003:208) to set the tone for the formulation of the practice guidelines that follow later in
this chapter. Whilst the primary focus of the study was on adolescents, the term *children* is purposefully utilised in several of the knowledge statements below to illustrate relevance to a younger age group as emerged from the findings. The knowledge statements, grouped according to the proposed target audience, follow below:

<table>
<thead>
<tr>
<th>Children</th>
<th>Teachers</th>
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<tbody>
<tr>
<td>- Children who believe they are susceptible to addiction and drug-related harm are more likely to resist experimentation with drugs.</td>
<td></td>
</tr>
<tr>
<td>- Children who grow up in risk-inducing environments, characterised by a combination of risk factors are more likely to embark on the drug use journey. These risk factors, which span across the subsystems of the individual’s life, are as follows: poverty; the emotional and physical unavailability of parents; experiencing the effects of drug use by parents and in the community; low social cohesion in the community, having friends with pro-drug use attitudes, experiencing scholastic challenges, negative expectations about their future, low social competence and internalised racial/ethnic inferiority.</td>
<td>- The value of parents and school as socialisation agents during the pre-primary and primary school years, suggests that they need to be knowledgeable about drugs – this includes knowledge about its nature, type, dangers and the behavioural, physical, emotional and covert signs that can alert to drug use. The findings suggest that parents and the community at large also need to know where and how children are exposed to drug offers and how they access drugs to ensure more effective implementation of their monitoring and protective functions.</td>
</tr>
<tr>
<td>- Children require protection at school to reduce their exposure to drug offers and a safety net when they decline offers.</td>
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<tr>
<td>- Teachers need to be aware that some children communicate their vulnerabilities and emotional needs in destructive ways.</td>
<td></td>
</tr>
<tr>
<td>- Teachers need to communicate with children in an affirming, respectful manner.</td>
<td></td>
</tr>
</tbody>
</table>
Parents

- Parents’ awareness of the importance of their role as socialisation agents and positive parenting skills which facilitate prosocial socialisation can reduce childrens’ susceptibility to venture onto the drug use journey.

- Parents’ knowledge about the developmental needs of their children and cognisance of their responsibility to fulfill such needs can protect children from seeking the fulfilment of those needs from (older) peers.

- Parents’ ability to meet their childrens’ developmental needs during the period that they have agency as the primary socialisation agent, enhances their chances of influencing the decisions their children make during the adolescent phase when peers become more dominant socialisation agents.

- Parents’ knowledge about the processes of peer influence will enable them to equip their children with the necessary skills and attitudes to resist negative influences and to seek out positive influences.

- Parents’ appreciation of their childrens’ needs, vulnerabilities, skills and abilities will enable them to balance their supervision and monitoring role with their children’s needs for increasing independence in

Parents

| Parents’ awareness of the value and role of the adolescent peer group will enable them to adopt an interest in getting to know their child’s peers which enhance parents’ effectiveness in monitoring and supervising their children. |
| Parents’ knowledge of their children’s needs, strengths and skills will enable them to appreciate their children’s ability to positively influence their peer/friendship circles. |
| Open and clear communication patterns in the family home will enable children and parents to articulate what they need from each other more effectively. |
| Clear role delineation and positive family relationships in blended families will reduce children’s vulnerability to negative peer influences. |
| Entrusting children with tasks/duties/responsibilities at home provides them with a sense of belonging and ownership. |
| Parents’ encouragement of their children to cultivate a vision, set long term goals and action steps to work towards realising their vision can reduce children’s attraction to short term goals, and immediate gratification of needs. |
| Rewarding small accomplishments by |
adolescence.
- Parents' pro-drug use attitude and own drug use and abuse enhances childrens’ susceptibility for drug use.
- Providing positive affirmations fulfil significant emotional needs for children.
- Parents who model the value of education and actively ignite and support positive expectations for their childrens’ future contribute to children’s commitment to school and future vision.

<table>
<thead>
<tr>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The availability of aftercare and community resources offering supervision to children whilst parents are at work will reduce their susceptibility to engage in risk-inducing behaviours.</td>
</tr>
<tr>
<td>- The availability of and access to constructive community alternatives (like sport, and other recreational activities) will promote children’s prosocial engagement and serves as a positive distraction from engaging in risk-inducing behaviours.</td>
</tr>
<tr>
<td>- Parents showing an interest and supporting their children’s involvement in constructive alternatives (for example attending their sport events) will enhance children’s commitment to these activities.</td>
</tr>
<tr>
<td>- Nurturing the role of religion and engaging in rituals that enhance spiritual connectedness contribute to resilience at individual, family</td>
</tr>
<tr>
<td>- Closer collaboration between the school and parents will ensure that scholastic challenges and conduct problems are identified and attended to timeously.</td>
</tr>
<tr>
<td>- Enhanced social cohesion in the community where prosocial neighbours serve as mentors and assist with aftercare and supervision of children in the community, strengthen community resilience.</td>
</tr>
<tr>
<td>- Community mobilisation against illegal drug outlets and normative drug use in the community, will contribute to the reduction in the supply of and access to drugs in the community.</td>
</tr>
<tr>
<td>- The presence of visible, active voluntary community organisations and civic leadership that advocate against normative drug use, and advance prosocial community outlets can contribute to community resilience.</td>
</tr>
<tr>
<td>- Actively involving community members (and mentors) in drug prevention programmes, and constructive alternatives can enhance community</td>
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<tr>
<td>and community level.</td>
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<td>---------------------</td>
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<tr>
<td><strong>General</strong></td>
</tr>
<tr>
<td>• Experimentation with illicit drugs AND a combination of drugs enhances the progression to addictive drug use.</td>
</tr>
<tr>
<td>• Early onset of drug use enhances the chances for later addictive drug use.</td>
</tr>
</tbody>
</table>

**TABLE 7.1: Conclusions derived from empirical findings**

The conclusions that can be derived from the travellers implicit reference to drug use being associated with ‘Coloured’ identity and suggestions of ‘Black’ inferiority and ‘White’ supremacy, are as follows:
- Participants view of themselves and the choices they make are constructed through social interactions with peers and adults.
- These social interactions are influenced by numerous factors, including meta-narratives that reinforce experiences of social and economic exclusion.
- Participants’ identity constructions are one of the variables that moderate their receptiveness and responsiveness to drug prevention programmes.

The summary from the findings emerging from all four participant groups are presented in the next section as a co-constructed meta-narrative depicted in graphic form. The findings are presented in accordance with the themes, sub-themes and categories that emanated from the qualitative data analysis. The presentation takes the form of a schematic depiction of Theme 2: the risk and protective factors, as illuminated by the participants (Appendix G) *(Title: Participants socio-cultural meaning construction of drug use and non-use)*, followed by a brief summary of each of the main themes and sub-themes.

### 7.5 SUMMARY AND CONCLUSIONS DERIVED FROM THE FINDINGS FROM THE NARRATIVES OF ALL FOUR PARTICIPANT GROUPS

The summary from Theme 1 is presented herewith in written form as its portrayal is not explicit in the graphic depiction, but embedded in the risk and protective factors at individual, school, community and societal level.
7.5.1 Theme 1: Summary and conclusions derived from the participants’ sociocultural meaning construction of ‘Coloured’ identity

The summary of the participants’ sociocultural meaning construction of the construct ‘Coloured’ revealed an interpretation of ‘Coloured’ as a racial categorisation, with only a few observers and peer practitioners implying that they understood it to be a description for ethnic and or community identity. The majority of observers described ‘Coloured’ identity as being synonymous with: drug use as a normative habit and coping mechanism; intellectual, economic and social inferiority; being less ambitious and having a lower commitment to school and formal education; and trading in drugs as an easy income generator instead of seeking formal employment. Additional descriptions depicted ‘Coloured’ identity as a marginalised identity in post-apartheid South Africa due to the prevailing high levels of unemployment and unequal distribution of employment opportunities and economic power. Those describing ‘Coloured’ identity as a community identity depicted ‘Coloured’ communities as socially disorganised where there is easy access to drugs, low levels of community cohesion and non-existent recreational and cultural activities.

The summary from the practitioner and peer navigators resonated with many of the observers’ descriptions, and added a stereotypical association with gangsterism, on the grounds of dress style. They also proposed that normative drug use was due to either genetic vulnerability or learnt behaviour. The practitioner navigators’ equated ‘Coloured’ identity with teenage pregnancies and single parent families characterised by emotionally over involved mothers whose permissive parenting styles facilitate emotional and financial dependency.

There was a minority voice from the observers, peer and practitioner navigators’ side which challenged the stereotypes, claiming that drug use and the associated negative descriptions can be associated with poor socio-economic conditions rather than ethnic or racial identity. Some observers and one practitioner navigator presented a counter narrative that depicted a reconstruction of ‘Coloured’ identity as synonymous with collectivist values, strong community cohesion and pride in ethnic identity which paradoxically reinforces stereotyping on the basis of race and categorisation of people.
The conclusion that can be drawn from these socio-cultural meaning constructions is that there is a pervasive internalised negative view of cultural, ethnic and community identity. This seems to contribute to low social cohesion in the community, low value attributed to education, and subsequent focus on short-term goals and immediate gratification of needs, as opposed to cultivating a vision and long-term goals.

The summary from Theme 2 and its six sub-themes is encapsulated in the schematic illustration in Appendix G. Many of the conclusions captured in Section 7.4 are relevant to the conclusions derived from the summary of findings in this schematic presentation. Given this overlap and to obviate repetition, only the additional conclusions will be illuminated here. The conclusions will be presented in accordance with the relevant sub-themes which emanated from the analysis of the findings and reflect the intersection between the conceptual frameworks which informed the study.

7.5.2 Conclusions drawn from findings depicting risk and protective factors in the individual domain

The most important conclusion to be drawn from the individual risk and protective factors is that those adolescent participants who had a vision and long-term goals for the future were able to resist the attraction to short-term gains and delay the immediate gratification of their needs. The practitioner navigators similarly emphasised how school pupils’ focus on the short-term excitement of a Matric ball detracted from their focus on studying and planning for post-school studies.

The focus on long-term goals ignited a more positive outlook on life, as opposed to the pessimistic sense of hopelessness characteristic of many of the travellers’ narratives. This pessimistic, negative attitude enhanced the travellers’ susceptibility to join the drug use journey as a form of escape and coping mechanism, and frequently resulted in impulsive risk inducing decisions. Several cited boredom and a lack of recreational outlets as a risk factor. The confidence and self-esteem boost travellers derived from being on the drug use journey reinforced the benefits of staying on the journey. The observers, who were more realistic in their goal setting, identified positive role models.
they could emulate. The travellers who disembarked after travelling in the fast lane as well as those who took an early exit from the drug use journey, appeared to be more realistic in their goal setting and cognisant of the need to have a vision for their lives. Travellers demonstrated the ability to focus on short-term goals and orchestrate creative plans to access their drug supplies, which implies that these learnings and skills could also be applied to achieve more constructive outcomes. The peer navigators echoed how being motivated by having a vision and dream for their future enabled them to resist the short-term rewards offered by being on the drug use journey.

The observers articulated clear anti-drug attitudes entrenched in a strong value system and the belief that they were susceptible to addiction. In contrast many travellers only believed they were susceptible to addiction by the time they had already lost control of their drug use. Many of the travellers cited negative life experiences (like the loss of loved ones or the absence of caregivers) as triggering their attraction to the journey. Whilst many observers had similar experiences, their narratives suggested that focusing on their vision, commitment to their parents/caregivers, and the faith entrenched by Christian values and religious practices enabled them to deal with negative experiences. Moral values of empathy for others, as opposed to acting in self interest, were also more evident from the narratives of the observers and peer navigators.

7.5.3 Conclusions drawn from findings reflecting risk and protective factors located in family domain

The conclusions derived from the summary of the travellers’ narratives mirror those of the other three participant groups’ risk and protective factors in the family domain. Additional conclusions emanated from the narratives of the other three participant groups as follows: Single parents, blended families, as well as children of teenage mothers being raised by their grandparents appeared to be the dominant family types in the Northern Areas communities where the study was conducted. Unemployment and financial stressors appeared to be significant triggers for tension in families which contributed to parents finding an escape in drug use themselves, leaving children unsupervised and unattended to emotionally. The findings suggest that permissive
parenting styles resulting in dependency and a lack of responsibility in children appear to be a general trend in the community. Where parents overcompensated for their emotional and physical absences by providing large sums of pocket money, without offering guidance on how to use the money, this frequently prolonged the travels in the fast lane. There was agreement among the peer and practitioner navigators that the value of the family was waning and that changes in societal and community values resulted in elders not being respected. This may also account for the lack of action by adults who would previously have intervened when they observed children from their neighbourhood engaging in high risk behaviours.

7.5.4 Conclusions drawn from findings reflecting risk and protective factors located in peer domain

The peer domain took centrestage in the narratives of all travellers, most observers, as well as the peer practitioners. Surprisingly, most adolescent participants explicitly constructed narrow, restrictive descriptions of the peer group as either constituting a negative or a positive influence on adolescent development. The adolescent participants agreed that drug use is associated with having friends with pro-drug use norms and being alienated by prosocial peers. The inverse therefore applied for non-drug use.

The value of the peer group was, however, embedded more implicitly in their narratives, and it can be concluded that the peer group became the dominant socialisation influence for most adolescent participants from as early as the age of 10 years. The peer group fulfilled the following important functions for the adolescent participants: protection against bullying; a sense of belonging; social connectedness; fun; a disinhibited space they could escape to; and a sense of identification with others that could understand them. Others derived material benefits and a space in which they could exert their power and influence. It can be further concluded that at the outset of the drug use journey, the primary benefit for the participants was located in attachment to the peer group rather than the actual use of drugs. As they ventured onto the fast
lane, the primary benefit they derived from their peers became the supply and exchange of drugs.

The mechanisms of peer influence occurred predominantly in existing relationships and ranged from conforming to specific pro-drug use peer group norms, modelling peer drug use behaviour, a grooming process culminating in direct and subtle drug offers, and lastly creating structured opportunities (such as parties and outings to cultural and seasonal festivals). The consequences of resisting or refusing drug offers ranged from the participants being ostracised, being coerced or threatened, and harassed.

Very few adolescent participants, excluding the peer navigators, acknowledged the possibility that they could exert a positive influence on their peers and that they could refuse drug offers in a way that would not alienate their peers. They became aware, however, during the course of sharing their stories that they had been exercising effective drug resistance skills, which included jokingly pointing out the dissonance to peers of what they experience subjectively, versus what others observed objectively (deriving the ‘feeling’ from using drugs versus ‘looking so lam [inert] and lazy’).

The drug resistance skills located at peer level included the following: avoidance of contact with previous travel companions by actively changing the route they travelled to and from school; changing schools; and symbolically disengaging from the drug use culture by removing tattoos. Other travellers embarked on a gradual disengagement from their former travel companions, which involved reducing the amount of time they spent with them; declining drug offers, but sitting with them whilst they were using drugs; declining illicit drugs, but using a legal one instead (alcohol and hooka pipe); remaining polite so as to not alienate their former close peers; offering explanations for refusing drug offers (like ‘I have asthma’); finding healthy and prosocial outlets in the form of new friends and constructive recreational outlets.
7.5.5 Conclusions drawn from findings reflecting risk and protective factors located in school domain

The conclusions derived from the summary of the findings are that there is a dynamic interplay between learners having a low attachment and low commitment to school. These two risk factors coincided with the presentation of learning and conduct problems which either preceded or resulted from the travellers being on the drug use journey. Several travellers reported being ostracised by teachers and feeling unsupported by teachers who were focused on earning an income rather than practising a profession. It can also be concluded that teachers can benefit from educational input on how to respond more effectively to the needs of learners who present with drug related problems. The combination of these risk factors contributed to the travellers disengaging from school through disciplinary sanctions, which included suspensions and expulsions. Other travellers were moved to different schools by parents who tried to reduce their access to drugs.

Closer teacher-parent collaboration appeared to make a particularly meaningful difference to one traveller, confirmed by the narratives of the observers and peer navigators. Personal interest shown by teachers also served as a protective measure for other travellers.

There was agreement amongst all participant groups that formal education was not highly valued by the ‘Coloured’ ethnic group. This view seemed to be entrenched by the internalised stereotype of inadequacy and lower intelligence, inequality in study and employment opportunities associated with ‘Coloured’ ethnic identity. This highlights the need for the restoration of a culture of learning and optimism, which could possibly be achieved by exposure to vocational opportunities, inculcating the importance of a vision, making support structures available for learners with learning difficulties or disabilities, and low school attachment. Parental interest and involvement in children’s schooling could also enhance the value they attach to their education. Adolescents’ connectedness to school can further be enhanced by involving them in extracurricula activities, school sport and other constructive alternatives.
The active trading in drugs and drug offers occurring in the school environment fuelled the concern that the employment of school security officers alone is not sufficient. It is concluded that random drug searches and drug testing could assist in making schools safer environments for learners and reduce the supply of drugs and send out a consistent anti-drug stance.

7.5.6 Conclusions drawn from findings reflecting risk and protective factors located in community domain

The conclusion from the findings is that the Northern Areas communities, where most participants in this study resided, are characterised by pro-drug use social norms, where many parents and children drink and smoke the hooka pipe together. The presence of numerous taverns and other informal drug outlets facilitates easy access to drugs.

Most observers appeared to be deterred from embarking on the journey through witnessing the drug-related harm experienced by adults and children in their community, whilst paradoxically the same risk factors enhanced the travellers’ susceptibility. The preceding conclusions illuminated how the complex interplay between the different risk and protective factors at multiple systemic levels accounted for different behavioural outcomes amongst participants growing up in the same neighbourhoods.

The prevalence of self-deprecating generational scripts, absence of recreational activities, poor socio-economic circumstances, poor policing, lack of interest from civic and political leaders and the myriad other community risk factors cited above, contribute to what the literature describe as socially disorganised communities.

The value of community mobilisation was evident from the report that referred to the impact that FAD’s monitoring of learner movements had on the selling of drugs before school. Community cohesion was also evident from the value travellers attached to the support they received from support groups and religious organisations. The practitioner navigators’ narratives, in particular illustrated that practitioners often misconstrue
ignorance, uncertainty and inadequate preparation of community members as community apathy and low community pride, further reinforcing narrow, debilitating assumptions and descriptions of the community. The practitioner navigators acknowledged the existence of dancing and musical talent amongst adolescents in the Northern Areas communities, noting the need for mentors that can guide youth towards capitalising on their talents.

7.5.7 Conclusions drawn from findings reflecting risk and protective factors located in societal domain

It is evident from the participants’ narratives that they experienced the prevailing inequalities in South African society as social and economic marginalisation. The high rates of unemployment and poverty were offered as a justification for the prevalence of taverns and the illegal drug trade, as well as the use of drugs as a coping mechanism. This alludes to the need to advocate for structural changes in the country, and explore prosocial income-generating alternatives and constructive coping mechanisms.

The media’s tendency to glamorise drug use in advertisements and music videos featuring American rap artists was contrasted by some who lauded the media for shaping an anti-drug attitude through its portrayal of the negative consequences of drug use.

7.6 SUMMARY AND CONCLUSIONS ABOUT PEER AND PRACTITIONER NAVIGATORS’ DELIVERY OF DRUG PREVENTION INTERVENTIONS

In the section below, the findings emanating from the four sub-themes relating to this theme are summarised, and conclusions are drawn.

7.6.1 Summary and conclusions about navigators’ current drug prevention services rendered in the Northern Areas communities

The practitioners’ drug prevention strategies predominantly took the form of dissemination of information and prevention education. Prevention programmes were
mostly once off presentations which occurred in response to requests from community organisations, schools, churches, other NGOs, primary health care clinics and parent-teacher associations.

Their target audiences ranged from pre-primary learners to whom they disseminated information in the form of puppet shows, to adolescents and parents. Drug prevention programmes were frequently requested for those that were developmentally in a transition stage. These included pregnant women, learners starting or completing high school or starting university, and youth transitioning from Sunday school to adult status in the church.

Another group of practitioners from a specialist organisation in addiction treatment and prevention used POPPETS as a prevention education programme, incorporating life skills training. This programme is targeted at primary school learners and usually takes place over a 9-week period. The format and content of the programmes included both didactic sessions, and the use of videos. The peer navigators employed more interactive mediums of poetry and drama. It was evident that scare tactics were still being employed to a large extent. The escalating incidence in drug use poses a serious challenge to the effectiveness of this strategy and prevention interventions at large.

The specialist NGO navigators focused on expanding the body of knowledge in the drug prevention arena by training fellow professionals like social workers and teachers.

7.6.2 Summary and conclusions about format and content of navigators’ current drug prevention interventions

As indicated in the preceding Section 7.6.1, most drug prevention programmes were delivered on request. However, some practitioner navigators reportedly based their drug prevention interventions on a needs assessment, informed by social workers’ case files, direct observations from practice, information from their national office, and surveillance statistics released by treatment centres. Following good social work practice principles, they reportedly also adapted their programmes to ensure these were age appropriate.
Considering that the drug prevention interventions mostly took the form of dissemination of information and prevention education, the content focused predominantly on enhancing the audience’s awareness about the nature and dangers of drugs, to assist adolescents in making informed choices whether to use or abstain from drugs. The content of prevention education programmes with parents, usually focused on educating them to identify signs and symptoms of use to ensure early intervention. The peer navigators were enlisted to educate parents about the dangers of a legal drug, the hooka pipe which reportedly demystified many of the myths parents held about the drug. Whilst none of the navigators explicitly identified the need to incorporate training in positive parenting into their drug prevention programmes, this conclusion can be inferred from the family risk factors identified. The need for community-based intervention programmes can also be inferred from the navigators’ reference to the value of high social cohesion and community mobilisation to effect a reduction in the factors that enhance susceptibility to drug use. The navigators confirmed employing former ex-drug users in their drug prevention programmes, citing this as an effective prevention strategy, without demonstrating awareness of the limitations inherent in this approach.

7.6.3 Summary and conclusions about audience’s response to drug prevention programmes

It is evident that the drug prevention programmes which actively drew on the audience’s prior knowledge and experiences, enlisted active participation. The programmes that incorporated experiential methodologies seemingly also maintained the interest and participation of the audience. The use of humour, voice intonation, genuine empathy, a non-judgemental attitude and appropriate self-disclosure were all elements and qualities that promoted positive responses from the audience. Both the peer and practitioner navigators encountered subtle resistance from adolescents who were seemingly already on the drug use journey and subsequently questioned the navigators’ authority and experience.

It was apparent that none of the navigators screened the adolescent audiences (excluding the ones recruited for TADA training), prior to a prevention programme to
ascertain the degree of diversity in terms of levels of drug use, and their corresponding needs. One practitioner navigator ventured the view that ‘Coloured’ adolescents were more receptive to ‘White’ presenters, reinforcing the stereotype of ‘White’ supremacy. The majority of practitioner navigators’ narratives took the form of a descriptive account rather than a critical reflection of their prevention strategies and methodologies. Conversely, the peer practitioners appeared to be cognisant of the strategies and methods that are not youth friendly. In conclusion, the principles of cultural competence and cultural sensitivity in drug prevention were more evident from the peer navigators than the practitioner navigators’ practices.

7.6.4 Summary and conclusions about the barriers to drug prevention interventions as identified by the navigators

It can be concluded that none of the navigators conducted a formalised outcome evaluation of their programmes, implying that they had no systematic evidence to claim programme effectiveness. The practitioner navigators identified resource limitations (of transport, programme material, staff shortages), whilst the peer navigators reflected on barriers relating to presentation methodologies that were incompatible with children’s learning abilities and adolescents’ preferred learning styles.

The practitioner navigators identified the need for closer collaboration with parents in both drug prevention and treatment interventions, and concluded during the data generation process that this could be achieved by professionals entering the community more effectively and respecting the communities’ authority in identifying and communicating their needs.

The co-constructed practice guidelines for culturally sensitive drug prevention interventions were derived from the research findings (summarised and concluded above), a synthesis of the literature, and finally the participants’ recommendations for drug prevention.

The next section of this chapter will begin with a discussion of the participants’ recommendations for drug prevention interventions, supported by their direct
quotations, and verified against a synthesis of research evidence. This will culminate in conclusions, from which the practice guidelines will flow.

7.7 PARTICIPANTS’ RECOMMENDATIONS FOR DRUG PREVENTION INTERVENTIONS

Donalek and Soldwisch (2004:356) propose that people who are affected by a specific problem are best placed to make recommendations on what they need in order to deal with the problem. The adolescent participants were therefore invited to propose recommendations from their expert position of observers about how drug use could be prevented amongst adolescents in their communities. Recommendations for prevention interventions emanated from the following question contained in the written instruction to the observers: ‘How can alcohol and drug use be prevented amongst adolescents from your community?’

Recommendations from the travellers were either induced from the findings which emanated from the analysis of the biographical interviews or invited in the absence of spontaneous recommendations offered. The travellers were presented with a similar question towards the end of their biographical interviews, and these findings are presented under Theme 5 in Chapter Four. The travellers’ voices on recommendations were particularly important as they had travelled the drug use journey and therefore offer recommendations from a position of experience.

The field of drug prevention is considered a specialist field (Harker et al., 2008), and therefore, it was crucial to access the narratives of those navigators who are currently rendering this specialist service within the identified community. Both peer and practitioner navigators were therefore prompted to offer recommendations for drug prevention interventions, as they were in the privileged position of having enabled other travellers to navigate a path away from the fast lane and diverting some observers from venturing onto the drug use journey. Their recommendations will therefore also be presented concurrent to those of the two adolescent participant groups. To avoid overlap and to obviate repetition in the ensuing discussion, similar recommendations are grouped together rather than a discrete focus on a specific participant group.
The participants’ recommendations for drug prevention interventions were analysed using thematic analysis which resulted in themes and sub-themes resonant with the risk/protective resilience ecological systems framework. These recommendations, together with the conclusions emanating from the findings of the participants’ socio-cultural meaning constructions of ‘Coloured’ identity, drug use, non-use, effectively represent the ‘theory’ held by the participants about drug prevention within their local context (Glaser & Strauss, cited in Pretorius, 2004:261). The current theory on drug prevention (presented in Chapter Two of this research report) was subsequently synthesised with the participants’ theory (as described above), and culminated in the articulation of drug prevention strategies relevant to each of the target systems in the ecological systems framework. The participants’ recommendations are subsequently presented according to the six strategy framework proposed by the Centre for Substance Abuse Prevention (CSAP) (cited in SAMHSA, 2011), which was selected on the basis that: i) it coheres with the conceptual frameworks (refer to Sections 2.4.1 and 2.4.2 in Chapter Two) which underpinned the study; ii) the data analysis revealed consistency between the participants’ sociocultural meaning constructions and their recommendations for multisystemic drug prevention interventions; and iii) the framework is accepted internationally as six comprehensive strategies for drug prevention. The six strategies thus constitute the main themes related to the participants’ recommendations and are the following: i) dissemination of information; ii) prevention education; iii) providing constructive alternatives; iv) community-based processes; v) environmental influences; and vi) problem identification and referral.

In the discussion that follows, each of the strategies will be discussed as separate themes presented in table format, with the sub-themes presented in the left column of the table, supported by the participants’ quotes in the right column of the table.

7.7.1 Strategy 1: Dissemination of information

This strategy is aimed at enhancing drug awareness. This include disseminating information about drugs, the nature of drug use, abuse and dependence, their
identification, as well as signs and symptoms of drug use and its impact on all layers of society, and lastly, available resources for prevention and treatment interventions (SAMHSA, 2011). This strategy is also known as information sharing (Foxcroft et al., 2003, cited in Myers et al., 2008), implying that the expert knowledge resorts with the presenters who in a top-down approach impart it to the less knowledgable audience. Media campaigns, drug awareness programmes, dissemination through information brochures, media talks, and provision of resource directories are examples of methods employed for this strategy. The recommendations about dissemination of information from the different participant groups are presented in the ensuing table and have been numbered from A-C to facilitate the alignment with literature synthesis which follows directly after the table.

<table>
<thead>
<tr>
<th>STRATEGY 1: DISSEMINATION OF INFORMATION</th>
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<tbody>
<tr>
<td><strong>Target group for prevention interventions</strong></td>
</tr>
<tr>
<td>a) Parents</td>
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<tr>
<td>The practitioner navigators proposed that parents receive education on the covert signs of drug use, especially considering the degree of innovation and creativity employed by drug suppliers. They furthermore recommended targeting the risk factors of parental ignorance and permissive attitudes towards drug use, especially in the light of the rapid emergence of new drugs onto the market.</td>
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<tr>
<td>b) Children</td>
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<tr>
<td>Several navigators recommended that prevention programmes be presented to children from as early as possible, and especially during transitional developmental life stages, so that they can be equipped with the necessary knowledge and be prepared for potential challenges.</td>
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**Quotations**

a) “And I think another thing that we actually need to also look at is, the information that you give to parents. How you reach your parents, because parents don’t really know what to look for. They are still, I need to smell you and know that you drank alcohol. But with kids you don’t smell it, you don’t really see it, you keep it in this small bag in your pocket you don’t see it. So I think educating the parents more.”

(b) “Talking about prevention programmes, starting very early, teach them about drugs.”

(c) “Well for me, if we can do each and every school, if we can do each and every school. Every church, because if you don’t get them at the school, you’ll get them at the church.”
Whilst the majority of travellers had general information regarding the dangers of drugs which they received from parents, teachers, peers and the Police who presented once-off awareness programmes at school (refer Section 4.5.5 in Chapter Four), it is evident that the manner and context in which the information was imparted can be improved.

**Synthesis of empirical evidence and literature**

Recommendations *a* and *b* align with the conclusions drawn from the findings that parents, as the primary source of socialisation during the early stages of childrens’ development (Louw & Louw, 2007), and children’s preferred source of information (Potgieter et al., 2010), need to be equipped with the latest knowledge about drugs, how it can be accessed and the changing trends in drug use (refer to Section 6.3.2.4 (ii) in Chapter Six). This, together with an anti-drug attitude and role modelling of prosocial behaviours (Falkowski, 2003; National Institute on Drug Abuse (NIDA), 2003), will enable them to exercise their preventive, educational and monitoring role more
effectively. The value of employing adolescent peer mentors to facilitate drug awareness sessions with parents is an important initiative for further exploration, especially in the Northern Areas communities, where a normative drug use culture and the restrictive labelling of peers as negative influence prevails (refer to Section 6.3.3.2 in Chapter Six). Harm reduction approaches are advocated as a more realistic message compared to drug education messages advocating abstinence, especially in communities where normative drug use prevails (Van Wormer & Davis, 2008; Mentor UK, 2005). The Mentor Website (2013) cites numerous studies, the most recent a 2010 English national drug strategy with corresponding public health plans which contest the value of drug awareness programmes when compared to the effects of early years’ parent training instead.

Recommendations b resonate with the conclusions drawn from the study and literature evidence correlating early onset of drug use and propensity for later addiction (Harker et al., 2008:32), as well as the vulnerability to experimenting with drugs during developmental transition periods (Louw & Louw, 2007).

What is apparent from the participants’ narratives (compare recommendation c) is their preferred methods (that of fun events, sport, drama) and settings proposed for drug prevention programmes. Their recommendations for programmes to be presented in local community settings, frequented by community members, such as churches and community centres, resonate with what has been referred to as achieving cultural sensitivity at surface structure level (Resnicow et al., 2000:273). This involves identifying the most suitable channels and settings for delivering the drug prevention message. The participants’ narratives furthermore echo the value participants attached to community cohesion, underpinned by values of communalism and interdependence (Hecht et al., 2003:235). Another noteworthy observation was that the narratives by the peer navigators illustrated that their approach to drug awareness programmes was underpinned by the principles of cultural sensitivity.

It is noteworthy that very few of the participants recommended education on alcohol or drugs as an isolated preventive measure, supporting the research evidence which confirm that education on drugs as a single strategy rarely culminates in a change in drug use behaviours (Miller & Plant, 2010; Plant & Plant, 2006; Foxcroft et al., 2003,
cited in Myers et al., 2008:19). Instead, the latter authors and participants in the present study propose education on drugs as part of a multisystemic preventive intervention (Anti-Substance Abuse Programme of Action, 2011-2016 (South Africa, 2011a); NDMP, 2012-2016 (South Africa, 2012a); Youngblade et al., 2007:S48).

Several of the narratives above also allude to the importance of **media involvement** to increase awareness. This factor is discussed under the theme of environmental influences. One navigator expressed the idealistic wish to render prevention services to all schools and churches in the community, claiming that these are the two certain places where children can be effectively reached. Spirituality and religion emerged as prominent protective factors in the narratives of most travellers and observers and is therefore an important cultural element to consider when designing culturally sensitive drug prevention interventions (Resnicow et al., 2000:279).

The **conclusions** derived from the study, synthesis with literature and the participants’ recommendations, are as follows:

- Parents need to be equipped with the latest drug knowledge and supply processes so that they can prepare more effectively for their prevention, educational, monitoring and positive role model responsibilities.
- Communities characterised by normative drug use and permissive parenting approaches are less likely to be receptive to drug awareness messages that advocate abstinence.
- Drug education should start at pre-primary school level, and be reinforced during vulnerable developmental transition periods.
- Whilst drug education is important, its effectiveness is relatively low compared to early parent training, which focuses on the benefits of health promoting behaviours.
- Drug awareness programmes should not be presented in isolation or as a once-off intervention, but should instead be incorporated with prosocial alternative outlets for children, and the effective use of media.
• Drug awareness programmes that are incongruent with the cultural and contextual realities of the target audience are less effective. Suggestions of creative mediums of presentation include narrating the message through song and drama.

7.7.2 Strategy 2: Prevention education

This strategy is aimed at an interactive exchange of knowledge that enables people to make informed choices around drug use and equip them with skills to strengthen resistance to potential risk factors for drug use. Examples of skills include decision-making, critical analysis of media advertisements, and drug refusal skills and can be incorporated in programmes with parents, peer leaders and youth focused programmes (SAMHSA, 2011:3).

The research participants in the present study recommended prevention education as part of a multisystemic prevention strategy (Medina-Mora, 2005; Loxley et al., 2003). Their recommendations are presented according to the target systems of intervention, viz. children and adolescents, followed by family-focused, peer focused and peer led and lastly school-based prevention education programmes. The analysis of the participants’ recommendations culminated in themes, which are listed in the left-hand column on the table, paired with the participants’ direct quotations, cited in the column on the right. The recommendations are numbered alphabetically in order to facilitate alignment with the travellers’ recommendations and literature synthesis, which follows directly after the column presentations.

7.7.2.1 Prevention education with children /adolescents

In keeping with the goal and the guiding conceptual frameworks of the present study, the interpretive themes for the participants’ recommendations were aligned with the positive youth development literature (refer to Table 2.6 in Chapter Two). The table contains a brief description of these recommendations and the participants’ supporting narratives.
Synthesis of empirical evidence and literature

The dominant recommendation emanating from the findings of all the participants are the need for an increased sense of optimism and control (of their future and making decisions) (refer to bullet b), which concur with the protective factors discussed in chapter 5 and 6. Similarly, recommendations to enhance adolescents’ concept of self (bullet c) and promoting a character of positive values (bullet c) can be correlated with the identified risk factors, as well as the negative stereotypical associations with cultural identity discussed in Chapters Five and Six. The practitioner navigators recommended that children should be equipped with lifeskills (bullet d), but had difficulty in concretising and motivatating the nature of the recommendations. In similar vein, the majority of the practitioner navigators maintained a problem-focused perspective of the ‘Coloured’ ethnic group and residents from the Northern Areas (refer to bullet b), which may account for the narrow descriptions of potential strengths to be developed.
The participants’ recommendations for prevention education directed at the individual subsystem can be located in familiar theoretical models employed in the drug prevention literature. These include the following: The Social Influencing model (a combination of the Theory of Reasoned Action and Social Learning) (Tobler et al., 2000; Johnson et al., 1990); the Competence Enhancement Model (combination of Social Learning and Problem Behaviour theory) (Hill, 2008:453) and the resilience conceptual framework (Ungar, 2006) (refer to Sections 2.4.1.2 and 2.4.2 in Chapter Two).

There is furthermore significant overlap between the participants’ recommendations and the content of three evidence based prevention programmes. These include: i) the SFP (10-14) (Spoth et al., 2001) which incorporate a focus on developing goals and dreams, following rules and reaching out to others, ii) the Familia Adelante (FA) Programme (Cervantes et al., 2011) which focus on enhancing protective decisions and psychosocial coping, and iii) the Resourceful Adolescent Programme (RAP), which resonate with the participants’ recommendations to equip adolescents with lifeskills and productive coping responses, which include self-regulation, self-awareness, thinking resourcefully and developing empathy for others (Shochet, Hoge & Wurfl, 2009:15-19).

The latter authors claim that whilst there is value in targeting those youth at risk, a key focus needs to be on keeping the healthy from becoming at risk. These specific recommendations by the participants also demonstrate overlap with the POPPETS programme by SANCA, which incorporates a focus on self-esteem, decision making and peer pressure.

Conclusions

The conclusions drawn from the synthesised findings are that a prevention education programme directed at children and adolescents need to include the following functional elements: i) control, ii) concept of self, and iii) life skills. Each of these concepts will be operationalised in the practice guidelines and its incorporation in prevention education directed at the other subsystems in the individual’s life illustrated. This integration is informed by the limited impact of a single-focused prevention approach directed at
individual abilities and characteristics. The conclusions in respect of the findings emanating from the practitioner navigators’ narratives and recommendations are that practitioners’ practice interventions will be restricted if they do not question deficit-oriented views of the clients that they serve.

7.7.2.2 Strategy 2: Prevention education at family level

The analysis of the findings from the participants’ recommendations for prevention education at family level culminated in two themes, viz. i) Parenting and ii) Family relationships. A description of the theme is provided in the left-hand column of the table, while excerpts from the participants’ narratives supporting the themes appear in the right-hand column.

<table>
<thead>
<tr>
<th>STRATEGY 2: PREVENTION EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target group for and focus of prevention education:</strong></td>
</tr>
<tr>
<td><strong>FAMILY</strong></td>
</tr>
</tbody>
</table>

a) Parenting

The different participant groups made the following recommendations in terms of parent training: i) consistent emotional involvement in the child’s life, paired with consistency in discipline; parental responsibility to entrench moral values in their child’s life and to model prosocial behaviours; refraining from negative role modeling (such as using alcohol in the presence of or with the child) and responding to early warning signs (i.e., not ignoring cigarette smoking as it can escalate to the use of more harmful drugs).

Several observers proposed that parents need to acknowledge their role as socialisation agents and accordingly assume accountability as role models.

Several participants suggested that children would access drugs more easily when they have the financial resources to do so. The need for parents to refrain from using money as a substitute caregiver and to monitor and administer children’s pocket money emerged as a recommendation by an observer, a peer navigator as well as two practitioner navigators.

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"Yes. Parents need to be consistent and that we find out that parents are not very consistent and disciplined in their activities and ways of parenting. Because today, for example, the child is between the age of seven and thirteen. That child gets to roam the streets, do whatever he wants; the parent is fine with it. Now the child is growing up the child is now 13 years old. Puberty and all those things; now the parent wants to be a parent. That child is now confused. How is he going to relate now to a parent as he could do what he wants?" (Practitioner navigator)

"Because you see your child when the child is starting to smoke cigarettes." (Practitioner navigator)

"Hulle moet ook geënsist word omdat baie kinders hulde goedere doen met hulle ouers dan word daar nie meer respekt getoon nie." (Observer 4)

"Ouers moet goeie voorbeeld stel vir hulle kinders." (Observer 7)

"Die ouers misbruik alcohol, maar hul kinders is honger hoekom?" (Observer 13)

"Kinders moet met waardes en morele groot geneem word wat positief is." (Observer 2)

"Because one child actually said that, my mother married a rich man. He gave me his money so I used his money to buy drugs. They think that money makes the world go round. I think if I give him enough money to keep him occupied then he is out of my hair." (Practitioner navigator)

"And a lot of times they will give money for it because they don’t want the child to steal from other people. Because I don’t know where does he get the money then the mother is always laughing… always laughing." (Practitioner navigator)

"Wanneer ouers hul salaris kry, dat hulle eerst hulle kloutie uitwerk voordat hulle begin drink of sigaretten doen. Vir die vrou om behoef te wees van die salaris as jy nie jouself vertou nie want dit kan baie help." (Observer 8)

"There must be ulm like… you must always keep the boys friends… you must always keep them close. Always keep up to dates with them and that." (Traveller - Andrew)

Die ouers moet note vat van hulle kinders (Peer navigator)
Synthesis of empirical evidence and literature

The most important recommendation proposed for prevention education at family level by both travellers and observers, revolved around parents’ degree of emotional involvement and demonstration of warmth in their relationships with their children (bullets a and b). The recommendations were for parents to offer children more encouragement, affirmation and support which are juxtaposed against the high degree of family conflict and low family cohesion which emerged as prominent risk factors by several participants (as reported in Chapter Five). The identified recommendations are aligned with the vision of the White Paper on Families in South Africa (South Africa, 2012b) to enhance family life, and resonate with the assertion by Youngblade et al. (2008: S52) that the ‘mundane aspects of family life such as talking to one another, having dinner together, and knowing about the adolescents’ friends seem to matter positively across multiple indicators of adolescent well-being’.
Another recommendation was for parents to increase their degree of influence and control (bullet a) in their children’s lives by: i) being role models who refrain from using drugs in their children’s presence; ii) intervening when they become aware of childrens’ experimentation with gateway drugs; iii) educating children about the harm associated with drugs; iv) monitoring not only their childrens’ friends but also monitoring use of children’s pocket money (allowances). The unique recommendations proposed by the observers centred around an improvement in family communication, an enhancement of positive family values and parental consistency, and lastly the utilisation of counselling to address family problems. Both the travellers and practitioner navigators emphasised the importance of parental consistency spanning across the different developmental stages, marked by parents clearly communicating and modelling their non-approval of drug use. The need for parental consistency appeared paramount in single parent and blended family structures. These recommendations resonate with studies which confirm the association between parent-child connectedness, increased positive consequences and decreased negative outcomes (Miller & Plant, 2010; Youngblade et al., 2008:S52) in child and youth development. Swahn (2012:22) suggests that the functioning of the family, the nature of communication between parents and their adolescents, and parents’ monitoring and supervision of their children are key family variables that influence adolescents’ satisfaction with life. The participants’ recommendations, which concur with the conclusions derived from the first part of the empirical study cited in Sections 7.5.3 and 7.5.6 respectively, illustrate the impact of contextual factors on parenting and adolescent outcomes. This confirms the value of practitioners adopting a holistic ecological approach, aimed at building family strengths, identifying, using and optimising larger community and environmental resources and importantly, confronting social toxins (Smith, 2008; Vera & Shin, 2006:83).

The recommendations are furthermore in synergy with the content of the parenting sessions in the SFP 10-14 programme (Spoth et al., 2001). The participants’ recommendations also cohere with the SAAF prevention programme (Brody et al., 2004) which emphasise parental training in rule setting and parental monitoring and supervision (refer to Section 2.4.2.2 in Chapter Two). Addressing the recommendations
of the present study would also amount to enhancing the three processes of family resilience as outlined by Walsh (2003:3) (refer to Section 2.4.2.2 in Chapter Two).

Practitioner navigators echoed the potential value of parents offering support to each other as active participants in drug prevention interventions. However, they refuted parent support groups as a viable intervention method, arguing that since ‘Coloureds’ cannot be trusted’, members’ privacy and confidentiality would be violated. This harmful stereotype not only reinforces other negative perceptions of the community, but also undermines the opportunity to foster cohesive community networks. Pointing out the value of parental involvement in prevention efforts, Harker et al. (2008:32) argue that it equip parents to translate the learning into prevention interventions at home, and in addition, seek treatment services should they themselves present with drug related problems.

The need for ongoing training of practitioner navigators in the field of drug prevention became apparent from some of the recommendations (viz. compartmentalising the role of different stakeholders; suggesting ‘top down’ approach to designing comprehensive community based drug preventions). The practitioner navigators’ recommendation for a comprehensive drug prevention approach that clearly delineates the roles of teachers and parents to ensure that each stakeholder accept accountability and parents do not hold teachers responsible for what should be a parental duty. This is a caution expressed by several researchers in the drug prevention field (Cervantes et al., 2011; National Institute on Drug Abuse (NIDA), 2003; Loxley et al., 2003).

**Conclusions**

The conclusions derived from the participants’ recommendations are: parental training is required to enhance parents’ degree of control and influence; improve parents’ emotional engagement and connectedness with their children; and lastly equip parents with skills to promote consistency in rule setting and interaction with their children, guided by the child’s stage of development. Prevention education directed at parents need to be cognisant of and reflect the contextual variables which influence parenting.
7.7.2.3  **Strategy: Prevention education at peer level**

The participants’ recommendations for peer focused and peer-led prevention education culminated in the identification of four key areas, presented as tasks to be undertaken by adolescent peers and areas to be focused on by prevention practitioners. These recommendations are presented in the left column and supported by excerpts from the participants’ narratives in the right column in the table below.

<table>
<thead>
<tr>
<th>STRATEGY 2: PREVENTION EDUCATION</th>
<th>Quotations</th>
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<tbody>
<tr>
<td><strong>a) Select positive prosocial peers</strong></td>
<td>a) “Ek het vriende wel hard studeer en graag slegs vol wil wees en dus maak ek n poging om altyd hou punte te kry of iets te bereik.” (Observer 2)</td>
</tr>
<tr>
<td></td>
<td>b) “Kies vir jou regte vriende wat jou ondersteun en in positiewe dink.” (Observer 7)</td>
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<tr>
<td></td>
<td>c) I would rather show people, walk rather with your age group and if nothing or whatever walk rather with them. Don’t walk with boys who wanna keep them this or that. [Traveller - Andrew]</td>
</tr>
<tr>
<td></td>
<td>d) “I don’t wanna be like them, I thought they were cool, but now they not cool anymore for me, they will go hit anyone in the street, just like that for no reason.” [Charles]</td>
</tr>
<tr>
<td><strong>b) Resist negative peer influence</strong></td>
<td>“Tiener meer besus te mask daarvan dat jy nie hoër cool te wees deur dingie te doen wat jou vriende doen nie, net omdat hulle so âie nie, maar eerder die beter een te wees en hulle reg te bring. Deur dit te doen sal hulle meer hulle meer uitlaat en hulle vriende sal hulle dan respekdoe.” (Observer 37)</td>
</tr>
<tr>
<td></td>
<td>But they leave me alone now that friends I just started to still greet them and stuff and I sit one side by my classmates boys in my class. No it was easy actually I thought it’s not gonna be easy, I thought it’s gonna like, but then I told myself I thought I’m not gonna care anymore. I just kept far away from them, go, went my own way. [Traveller - Waymaking]</td>
</tr>
<tr>
<td></td>
<td>Ya, er, everytime I try to avoid that people when I see them in the street or something, then I try to avoid them, but then, if they see me they will always come like come to talk to me or something, then I tell them I have to go now or something. [Traveller - Charles]</td>
</tr>
<tr>
<td></td>
<td>So not being around it also, and not having access to it, being around positive things, will get you away from it. [Traveller - Ratson]</td>
</tr>
<tr>
<td><strong>c) Mobilise positive peer influence</strong></td>
<td>“Be with good friends involved. We can make groups and go to school and go and talk and can take and do good things. I would like to be the youth example who they can look up to. Having a march to stop it.” (Observer 14)</td>
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The findings revealed that adolescent participants, similar to the practitioner navigators categorised the peer group as either having a positive or negative influence on adolescents, instead of viewing peer influence as operating on a continuum where each adolescent has agency to influence the outcome of the social construction (Smith, 2008; Ungar, 2006).

Accordingly, the participants described the ‘prototype’ of a positive peer as someone who is achievement oriented and exhibits prosocial behaviours. Conversely the travellers indicated that ‘nerd like’ characteristics rendered prosocial peers unpopular. Whilst these characteristics cohere with the recommendations (to be guided by a vision and increased control of the future) cited under strategy 2.1, it evidently excludes a host of other ‘positive, growth-promoting qualities’, which can be enlisted to promote positive youth development (Karcher et al., 2004:193), and which may make them more attractive as positive peer prototypes (Spijkerman, Van den Eijnden, Overbeek & Engels, 2007:9). These restricted descriptions of prosocial peers furthermore do not
correlate with observations from practice, suggesting that modification of these prototypes (both of drug users and non-users) may be a viable peer focused drug prevention strategy (Spijkerman et al., 2007:9).

The participants’ recommendations confirm the processes through which peer influence occur (refer to Section 2.4.2.3 in Chapter Two and 2.3.1 in Chapter Five). Borsari and Carey (2001) suggest that adolescents’ awareness of these processes (and their limitations), will enable them to enhance peer protective behaviours. Similarly practitioners should utilise this knowledge to enhance the effectiveness of peer-led and peer focused drug prevention interventions, as well as provide additional support structures or skills to adolescents with an increased vulnerability to psycho-social influences for drug use as the observation of modelling of prosocial behaviours will not be sufficient (Kim et al., 2002).

The travellers recommended resisting negative peer influence through avoidance of social contexts in which drug offers are likely to occur, as well as reducing the amount of time spent with former travel companions, gradually withdrawing from former travellers’ circles and physically moving from the environment (like changing schools or moving to another suburb). The participants’ recommendations are fairly similar to the findings from a study conducted by Hecht and Miller-Day (2009), which found that Latino-American adolescents employed drug refusal and resistance strategies that were embedded in their cultural values. These strategies resulted in a drug resistance strategy called the ‘Keeping it REAL’ strategy, which included refusing a drug offer, explaining the reason for refusal, avoiding drug offer opportunities, and leaving the context in which the drug offers occur. An important starting point in any community would thus be to explore the cultural and family values that could form the foundation of drug resistance strategies.

As peer pressure is a systemic interactive process (Hecht & Miller-Day, 2009), it is important that adolescents learn to, instead of simply just declining drug offers, to invite their peers to: i) challenge the prevailing norms about drug use, as well as the ii) contradictions between assumed benefits of drug use and the observed disadvantages. The cognitive dissonance theory as drug prevention methodology could also be
employed when it is evident that there is a contradiction between the adolescents’ attitudes and behaviours (Ager et al., 2008). Prevention practitioners should therefore employ a cultural resilience approach in equipping adolescents to decline drug offers using a communication style that resonate with and refrain from alienating their peers (Pettigrew et al., 2011:103-108; Cuijpers, 2002), as well as the importance of honouring cultural values (Gosin et al., 2003:128).

Section 2.4.1.4 in Chapter Two highlights that a drug prevention programme embedded in the Social Influencing Model needs to be directed at cognitive, affective and behavioural levels, aiming to effect changes in adolescents’ cognitive schemas and views; altering how they evaluate a particular phenomenon and or bringing about an explicit change in behaviour respectively (Botvin et al., 1994:117).

The participants’ recommendations reflect on the value of peer-led interventions which have the potential to fast track peer influences in environments that are permissive of drug use (Crockett, 2012; Kerr et al., 2010:39). Peer mentors can actively model prosocial behaviour, offer protective and monitoring behaviours to adolescents (Buckley et al., 2010), and challenge normative drug use (Gosin et al., 2003:128-130). Further benefits are that peer educators are perceived to be more credible, especially since adolescents are likely to experience them as less threatening than an adult presenter. They are also deemed to be more effective role models as their behaviour provide social information relevant to youth. Ke Moja, South Africa’s national drug prevention strategy also employs peer education and media campaigns assigned to their “Ke Moja Champions” (youth facilitators) (Ke Moja Integrated Strategy, 2007).

Several participants recommended drawing on ex-drug users in prevention interventions. The limitations to using ex-drug users for prevention education were noted earlier in Chapters Two and Six, resulting in the recommendation for peer educators to receive supportive mentoring, and accredited training (South Africa, 2012a).
Conclusions

The conclusions that emanate from the participants’ recommendations are that adolescents need skills in how to attract and enhance prosocial peer influence, how to resist negative peer influence, and how to mobilise peer mentors as influential drug prevention facilitators. Recommendations from literature suggest that adolescents need to be equipped with knowledge about drugs and processes of peer influence; they need to be motivated to resist drug use, and have the skills to resist drug offers in ways that will preserve their peer relations and emphasise their cultural values.

7.7.2.4 Strategy: School-based drug prevention

The recommendations for school-based drug prevention interventions were derived from overt proposals by the research participants, as well as inferences drawn from the school-based risk and protective factors emerging from the participants’ narratives (refer Section 7.5.5 of this chapter). The participants’ recommendations are reflected as four key areas to be focused on, listed as a-d in the left column, and supported by excerpts from the participants’ narratives in the right column in the table that follows:
STRATEGY 2: PREVENTION EDUCATION
Target group for and focus of prevention education: SCHOOL

a) Learner attitude to school
Several observers asserted the view that learners need to be more connected to school in terms of regular school attendance, involvement in extra-curricula activities and working diligently to achieve success at school.

b) Teacher attitude to learners
They furthermore proposed that teachers should be equipped to offer emotional support and guidance to learners who experience personal problems.

c) Counselling support based at school
One observer expressed the need for counsellors (instead of teachers) at school that would be available to listen to learners’ problems in confidence.

d) School security
All the participant groups highlighted the availability of drugs on school premises as a risk factor, and the inverse, including random drug searches and drug testing as protective factors. The recommendations pertaining to drug searches are captured under strategy 5 in this chapter and include:

Drug testing
Random drug searches
Community collaboration to enhance school safety

Quotations
a) “Motiveer hulle om skool te loop.” (Observer 9)
“Doing good in your school work you can achieve.” (Observer 12)

“Skole moet tiener correed om in sport byeenkomste deel te neem.” (Observer 3)

“Tienar wat vasgevang is in hierdie akies, is gemoenlik diégene wie nog op skool is, Rapporteer dit sodat iemand met hierdie persoon kan geseën en die ene van die saak te sê: Kinders kan ook met onderwyser praat, hulle sal altyd uit hul pad sit gaan om die beste vir die tiener te gee.” (Observer 15)

I don’t know. I try everything, I sit right in front of the class, and the one Marn even stand with her back towards me, cause she don’t wanna. I sit just there in front and then if I move back she looks there in front and talk to the children, like she don’t wanna see me. She gives notes, she don’t give me and if I tell the principal or whoever they don’t take note of me. I don’t know what to do to change that. [Traveller - Waydin]

c) Alcohol en dreinlusbruik kan voorkom word deurdat daar n groep mense by die skool is wat jy mee kan praat, nie jou onderwyser nie. Kinders voel soms dat hulle nie met onderwyser kan praat nie. Dit moet mense weet wat jou nie kan nie en wat al jou problems sal kan hou vir hulself sodat dit prent mag wees.” (Observer 5)

d) Search the school… Search the bag and stuff, like they normally tell the children, what’s the use you tell the children tomorrow we gonna have a big search, obviously they gonna now leave the stuff…. Ye like just come, cause in the toilet the boys toilet, then we hear some of the boys talking, put this away and stuff, they did hear there’s a search and stuff. [Waydin]

Synthesis of research evidence and literature

Recommendation a coheres with research findings which illustrate the correlation between school connectedness and overall mental health (compare Crockett, 2012; Youngblade et al., 2008; Gomez & Ang, 2007). Whilst none of the participants recommended assistance for learning problems, the findings emanating from the travellers’ narratives illustrated a relationship between learning problems, reduced commitment to school and engagement in risk behaviours (refer to Section 7.5.5).

Based on the observations from practice, an inhibiting factor to effecting recommendation a is a lack of available resources for learners presenting with learning difficulties. The effectiveness of this strategy can however be enhanced by:
• drawing on a collaborative approach between parents and teachers. Terrion (2006:155) assert that parental involvement with their children’s education can produce the three dimensions of social capital ‘(which are bonding, bridging, and linking) through human interaction in the school that reduces risk factors in vulnerable families’;
• deploying adult mentors from the learner’s community;
• providing flexibility and choices in the learning process, validating learners’ skills rather than traditional scholastic abilities (Bower et al., 2012:10);
• enhancing the value that learners attach to education in the community, since education has been employed as a mechanism for escaping the poverty trap by many disadvantaged communities (Sonn & Fisher, 1998).

The effective implementation of recommendation a require ‘systemwide change efforts’, which Greenberg et al. (2003:469) describe as multicomponent programme, consisting of functional elements such as communication between the teacher and parent; cooperative learning in small interactive groups (peer support); and enhanced connection between the learner and the school. Botvin et al. and Scheier et al. in National Institute on Drug Abuse (NIDA) (2003:3) propose that school-based drug prevention (informed by the Social Influencing Model) for middle, junior high school learners focus on the following areas: academic support and study habits, self-efficacy and assertiveness, communication, drug resistance skills, reinforcement of anti-drug attitude, strengthening of personal commitment against drug, peer relations.

Recommendation c concurs with the findings from a survey administered to over 20 000 grade 8-10 learners in the Western Cape, which revealed that 34.8% of learners requested a need for career counselling; and about a fifth of reported a need for crime prevention and counselling services for family or school-related problems (ADRU, 2012 draft report). The intervention of school based counsellors and adult mentors are particularly relevant in the Northern Areas community, against the background of the need to reconstruct the value of education. The empirical findings from the present study validates the assertion by Greenberg et al. (2003:467) that the 21\textsuperscript{st} century
school is required to expand its role beyond that of the academic domain, in the light of the wide range of socio-emotional and economic challenges learners experience.

The additional demands placed on teachers, juxtaposed against the challenging conditions prevailing in South African public schools (Modisaotsile, 2012; Gernetzky, 2012) (refer to Section 2.4.2.4 in Chapter Two), may in part account for the participants’ recommendation b (for improvement in teachers’ attitude towards learners). Findings from a study conducted by Van Heerden (2008) in a Northern Areas school concur with the assertions by several travellers in the present study who felt misunderstood and judged by teachers, which in turn ignited further oppositional behaviours by the learners.

The participants’ recommendation d suggest that school leadership and teachers need to be capacitated to enhance the effective implementation of The Department of Education’s Policy Framework on the Management of Drug Abuse in all Public Schools (South Africa, 2002a:5). This will require a collaborative approach in conjunction with parents, learners, social service agencies, community resources and the South African Police Services. Learners also need to be educated on the Policy Framework to enhance their understanding of the conditions under which random drug searches and testing can be undertaken. Although drug education has been integrated into Life Orientation (a compulsory learning area in schools), Wegner et al. (2008:1087) reported on the need for teachers to be trained and supported in the implementation of experiential methodologies and integration of related learning areas, to enhance learner interest and participation. Teachers need to be encouraged to invite drug prevention specialists to conduct drug education presentations in Life Orientation lessons (South Africa, 2002b).

The need for a developmental (as opposed to a punitive) approach to dealing with conduct problems by learners (Recommendation c) was illustrated in the narratives of the peer navigators (attending a former model C school) and is discussed in more detail under strategy 6. Reddy et al. (2010) caution about the limitations inherent in school-based drug prevention programmes that automatically reach youth of all risk categories, as it is impractical to separate them in a school context.
Conclusion

The conclusions drawn from the findings are that closer collaboration between schools, teachers, learners, parents and surrounding communities is required to not only deliver effective drug prevention strategies but also to enhance a positive attitude to education and holistic development. The implementation of the Department of Education’s Policy Framework on the Management of Drug Abuse in public schools (South Africa, 2002a) will promote a safe and conductive environment to learning however teachers and learners need to be capacitated with knowledge and resources to enhance its effective implementation. Teachers can benefit from continuous professional development in adopting culturally sensitive approaches to enhance their understanding of adolescent learners and those from specific environmental contexts.

7.7.3 Strategy 3: Alternative activities

This strategy is aimed at providing the target populations with the opportunity to participate in drug free activities such as ‘drug-free social and recreational events, dances and parties, youth and adult leadership activities, community drop-in centers, community service activities, and mentoring programs’ (SAMHSA, 2011). These healthy, constructive alternatives would obviate the attraction to and need for drug use.

The participants’ recommendations in respect of strategy 3 revolve around three aspects, which are reflected in the left column of the table below, supported by quotations in the column on the right. Each of these recommendations is discussed in the ensuing section.
STRATEGY 3: ALTERNATIVE ACTIVITIES

a) Prosocial community outlets
There was consensus amongst the observer and travellers about the need for constructive alternatives to drug use and prosocial community outlets.

b) Inculcate culture of learning combined with using free time constructively and productively

b) “And I think in your other communities they have school until 5’o clock they are busy with stuff and then they go and do their homework. Our coloured children are not into the culture of going home and doing your homework. They do it in the morning quickly. If they do it or like my cousin does it late at night after he’s done his whole day’s teasing around which is also not good for him. But I think this is a place where after care center comes in very handy. Where you do it, there is playtime there’s a pool table, there’s table tennis, there’s chess, there’s things like that; educational stuff. There can be video games and all these things. Because the parents are a lot of the parents are at work. The grandparents don’t have…- spoiling the children as well. What do they do? They tattle.” (Practitioner navigator)

“Im thinking now, programmes that started in the Northern Areas like this dancing groups; children were excited to do that but then it goes nowhere, they just dance and then there’s not a promising future in it because it just stays here in the Northern areas and then it’s finished.” (Practitioner navigator)

“But at least that group now is doing training for other groups as well. But then again where does it go? They like to dance, they are cultivated by TV now they also have their movies, than what? They don’t, there’s no shows to do it… one is nie in daai kultuur van let’s organise an arts festival… and even if it is like that people don’t, okay but the timing for that thing is always bad because the weather is always bad during that weekend.” (Practitioner navigator)

Quotes

As hulle ook belangstel aan enige aktiwiteite soos sport. Baie van voormalige direkmisbruikers speel sport omdat hulle weet wat diehuis aan in mens kan doen.” (Observer 4)

“The people in our communities and parents should get more involved in different sport codes because playing sport keeps you active and away from standing around and doing nothing. We believe that the community and parents should get more involved in developing different sport codes in their communities because playing sports keeps you active and when you active you stay away from bad company because you’re out as a sports playing person you have a routine and things you can achieve so therefore you stay away from drugs and alcohol abuse.” (Observer 28)

“Dier buitennuurs aktiwiteite deel te neem, bv sport sal hulle vergast van direkins, want party kinders doen dit omdat hulle vereerd is.” (Observer 29)

Problems… mostly peers forcing them, and I think sport would get them out of drugs, playing sport will help them stay away from drugs. [Tyler]

Sport, yes - to keep me busy and also keep me not bored I was starting to get like bored sitting on my own and stuff. [Charles]

Ja daar was minder gevalle van alcohol misbrui by sport byeenkomsels…En die aktiewiteite op die skool gronde. [Peer navigator]
Synthesis of empirical evidence and literature

Several of the observers implied that the proposed alternative activities (recommendation a) (viz. performing arts, game centres, sport activities) were not available in their community, underscoring the earlier assertion of a resource-deprived community (refer to Section 7.5.6 in Chapter Seven). Some of the participants’ narratives hinted at the need for infrastructure to be developed, others implied that the infrastructural resources are available and that the only requirement is for human capital (and financing of the persons’ time) to realise the activation of these constructive alternative activities. Embedded in some of the recommendations is the suggestion that adolescents could occupy their free time by engaging in community-based activities, attending to the needs of others (recommendation a). If adolescents engage in such altruistic activities they would also respond to the recommendation listed under strategy 2, for adolescents’ to enhance their levels of empathy (Louw & Louw, 2007). The implication is therefore prevention practitioners should prompt adolescents to adopt creative approaches to identifying and establishing constructive alternatives which are sustainable (requiring minimal financial resources and low maintenance). The excerpt from the narrative of observer 17 in particular implies that if these recreational spaces (like parks) were readily available, they could serve as a communal resource where family bonding activities could take which in turn would promote family and community cohesion (National Institute on Drug Abuse (NIDA), 2003). The evidence from the travellers’ narratives confirms that the social cohesion in their communities served as navigational strategies to stay clear from the fast lane (refer to Section 4.5.4.3 in Chapter Four).

Recommendation b illustrates the consensus amongst practitioner navigators that adolescents need to be equipped with skills on how to use their time constructively and productively. This recommendation intersects with the HealthWise programme (Wegner et al., 2008) (refer to Section 2.4.2.4 in Chapter Two).

The practitioner navigators’ narratives reflect the comparison that they drew between children from socially integrated neighbourhoods where supervised aftercare and recreational activities are available, compared to the inverse for adolescents from the
neighbourhoods where the study was located. The narratives, however, imply that the constructive use of time is subject to children adopting a culture of learning, which is consistent with one of the school-based risk factors that emanated in the study (refer Section 7.5.5 in Chapter Seven). The resultant recommendation is suggestive of a holistic approach to drug prevention which simultaneously addresses childrens’ educational needs, mobilising community social support to enhance childrens’ safety and availing facilities where creative talents can be nurtured (Wegner et al., 2008:1089). The practitioner navigators’ narratives illuminate their perception about the prevalence of natural dancing and musical talent and interest in the community that can be nurtured, however emphasise that prevention interventions need to focus on equipping the aspiring dancers with skills in constructive goal setting, planning, working in a team, perseverance and financial planning.

The recommendation for involvement in sport (Bullet C) dominated the narratives of mostly the observers. These recommendations cohere with the narrated experiences of two travellers whom confirmed that their withdrawal from sport coincided with their recreational use of drugs. Their experience corroborates the research evidence which confirms that involvement in sport and different art forms not only serve as a distraction from drug use, it reduces childrens’ involvement in maladaptive behaviour (Mentor UK, 2005), and facilitates a goal driven future focus, which are key ingredients for positive youth development (Gomez & Ang, 2007; Hamilton & Hamilton, 2004). In launching their Hip Hop campaign in 2012 (South Africa, 2008a), the Ke Moja programme developers illustrated their awareness of the importance of cultural sensitivity in health promotion, describing hip hop as a universal language that has the ability to transcend racial, social and geographical, gender and social boundaries.

The purpose of the South African Institute for Drug Free Sport Act, Act 14 of 1997, is to ensure that stakeholders are equipped with the knowledge and skills that are required to ensure participation in sport remains a protective factor rather than a risk factor (Balsano et al., 2009; Dorgan & Ferguson, 2004:272). The narrative of a peer navigator furthermore illustrates how drug awareness programmes at their school contributed to the reduction of drug related offenses at school sporting events. The value of sport and
can be enhanced by strengthening adult and peer supervision, and reducing enabling environments.

**Conclusions**

The conclusions emanating from the findings are that existing constructive alternatives in the community need to be identified and strengthened by drawing on the assistance of adult mentors, supportive parents and prosocial peers. Guiding adolescents to formulate a vision and goals for their involvement in constructive alternative activities will enhance their commitment to and the long-term benefits they can derive from it. Protective processes need to be put in place to ensure that adolescents’ involvement in sport do not culminate in engagement in risk behaviours.

**7.7.4 Strategy 4: Community based processes**

This strategy aims to mobilise the community’s resources and abilities to provide prevention and treatment services for drug related conditions. This encompasses the development of community coalitions, facilitating networking and enhancing community cohesion (SAMHSA, 2011). This strategy is founded on the principles of community development, where community members and stakeholders are primarily responsible for organizing, planning and promoting the efficiency and effectiveness of service implementation. Based on the conceptualisation of the study and the findings relating to the community and cultural narratives, the drug prevention interventions located in community processes are a prominent focus. The recommendations summarised in the ensuing table confirm that activating community based processes as drug prevention strategy should encompass the mobilisation of social support in the community (**A**), concurrent to promoting support in the family (**D**), establishment of an adult mentorship network (**B**) and mobilising for the non-approval of drug use (**C**) in the Northern Areas communities.
**STRATEGY 4: COMMUNITY BASED PROCESSES**

**a) Mobilise social support in the community**

The practitioner navigators’ proposed that community members can benefit from offering social support to each other.

Twelve of the 29 observers recommended that the community should mobilise and form coalitions with people who are motivated, have a genuine interest and belief in the community’s ability to effect positive community outcomes. The suggestion is for a coalition of parents, older community role models, professional and non-professional stakeholders who will align as active community change agents rather than passive observers.

**Quotations**

1. “There needs to be more parenting groups. Parents who have the same problem, because that is where support comes in. Parents can also stand together.”
   - (Practitioner navigator)

2. “But people are afraid of that as well, and now this is now really a coloured issue because people, we always say that coloureds break each other down so people are afraid of these groups because now there’s no such thing as confidentiality - ‘coloureds can see in’s secret now’.”
   - (Practitioner navigator)

3. “So there’s... I am afraid to go to a group because if I know you, you are my neighbour and I know you, you are her neighbour, you live behind me. But if I go there I know you won’t honour the rules of this group. So people are afraid to even share.”
   - (Practitioner navigator)

4. “Ja, because privacy, they won’t. Because I discussed it with one mother and she said she’s learning from all the other mothers. And then she says that they know her child is going through this and their child is also going through the same thing but they will keep on picking on her child but they don’t worry about their own child. So now she’s over punishing her child because other people are putting that pressure on her as well. Where they could stand together and really have that the child is raised by a village mentality.”
   - (Practitioner navigator)

5. “Doing this research and speaking to friends about how we can stop drug and alcohol abuse amongst coloured people has shown me that by standing together within our communities we can achieve anything especially stopping drug and alcohol abuse amongst our youth.”
   - (Observer 26)

6. “The only way to prevent drug and alcohol abuse is if the community stand up against gangsterism, let them know that they won’t be allowed to destroy our future.”
   - (Observer 24)

7. “As a community we need to help our people to get away from drugs and other substances.”
   - (Observer 26)

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**STRATEGY 4: COMMUNITY BASED PROCESSES**

**b) Adult mentors**

Two observers spoke about the value of adult mentors from the community who could offer advice, support and be a role model.

**c) Community norms of disapproval of both legal and illegal drug use.**

The normalisation of drug use in the Northern Areas, and in society as a whole, surfaced as a risk factor in the narratives of all the participant groups. However, none of them ventured a recommendation regarding challenging the community norms.

**Quotations**

1. “People, older ones, must give advice and be the example.”
   - (Observer 14)

2. “Vind in die omgewing ‘n groep persone, wie instaas as om deel te het in die taak. Nie net al dit namens een persoon, bedraagd wie nie, maar al die leenmaats. Die gemeen besoek die huis van in die gemeen waar die persone van die gemeen kom en help.”
   - (Observer 10)

3. “Dit het ‘n norm kom word in ons gemeen, dat die dink dat dit gewoon is om drugs te gebruik. Kinders so jong as 12 jaar sit op die hoekie van straat en Tik. Hulle het geen regtuig vir ons ouer gemeende nie.”
   - (Observer 15)

4. “Cos there was a drug house opposite my house first. They, they get evicted coz the community used to complain and all that, there I actually learnt and experienced all this stuff.”
   - [Andres]

5. “They opened a Neighborhood Watch there because we were like for the area, cos we were like a bad influence there. That’s what I heard.”
   - [Andres]

6. “Ya, but that FAD’s, [Families Against Drugs] that guy [referring to drug supplies] is no more also there since they made a difference. A certain time we must be at school. I saw them [FAD] taking photo of the children, that don’t wanna listen, that go their own way.”
   - [Wayin]
Synthesis of research evidence and literature

The risk factors (summarised in Sections 7.5.6 of Chapter Seven) illuminate the participants’ construction of what needs to be altered in their communities, whilst the protective factors reflect the participants’ suggestions of substitutes for these risk factors. Whilst the establishment of trust (A) is a general prerequisite in community development (Weyers, 2011), the practitioner navigators emphasised this step as a cardinal one considering their perception that there is a lack of a trust amongst the ‘Coloured’ community. This implies that prevention interventions need to focus on enhancing a sense of community in the Northern Areas, which Bess, Fisher, Sonn and Bishop (2002:6) define as a ‘process in which the members interact, draw identity, social support, and make their own contributions to the common good’.

The travellers’ recommendation that FAD, a community based support structure should be strengthened (A) resonate with a number of interdependent recommendations proposed by the observers. These include: reducing the normalisation of drug use in the community (C); enhancing social cohesion and neighbourhood support; enhancing level of care and support in the community towards at risk children; community advocacy against drug outlets; collaboration between key role players; modifying the
nature of celebratory functions in the community; establishing community projects to occupy the youth; mobilising drug awareness in the community and lastly, engineering closer cooperation between the community and police (Aguirre-Molina & Gorman, 1996:338). These recommendations clearly indicate a need for the community to mobilise against the identified negative factors with the view of initiating the implementation of safer, drug free neighbourhoods in the Northern Areas communities. It also underscores the need for more stringent policing of the licensing and operation of taverns/drug outlets (Herrick, 2012) (which will be discussed as part of strategy 5).

The recommendation that the community should adopt anti-drug use norms resonates with the stipulation in legislation (NDMP, 2006-2011; Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008). Similarly, research findings confirm that those adolescents who experience affirmation from their community for positive behavior, and who are subjected to anti-drug norms in their communities are less inclined to use drugs (Hawkins et al., 1992:88). Van Wormer and Davis (2008) and the Mentor Website (2013), however, propose that communities where normative drug use prevails, may be more receptive to health promotion messages, as opposed to messages of abstinence.

Twelve of the 29 observers recommended that community coalitions should be formed, constituting people who have a genuine interest and belief in the community’s ability to produce positive community outcomes. The suggestion is for a coalition of parents, older community role models, professional and non-professional stakeholders who will align as active community change agents rather than passive observers. It will be important to get participants in the drug prevention programmes to identify potential community sources or members they would like to identify as a prosocial adult mentor - a concept which is similar to the Mentor UK programme (2005).

These recommendations imply a comprehensive approach to drug prevention characterised by collective action and community support (Clauss-Ehlers, 2008); which have also been termed community empowerment (South Africa, 2012a; Aguirre-Molina & Gorman, 1996:340-341; Rappaport, 1987). Fagan et al. (2011:167) concur that community mobilisation is the most effective approach to transcend non-conducive
environmental conditions and may entail changing structural and ecological influences to heighten success of preventive interventions. Community involvement of this nature will not only enhance community ownership and participation, but will also reinforce partnerships between interested parties, and offer protection to the most vulnerable groups in the community in particular. Fagan et al. (2011:169) however caution that the effectiveness of community coalitions is subject to the following conditions: the community being organised around a common goal and coalitions being planned and monitored closely.

Dorgan and Ferguson (2004:272) report on two community-wide initiatives for youth development (‘The Beacons’ and ‘New Futures’) in New York and the factors that promoted and inhibited their success. The Beacons, which emerged as a more effective, sustainable project over 20 years, had the following features: i) it used school facilities under the direction of community-based organisations; ii) organised advocacy by grassroots groups; iii) had good technical assistance; iv) conducted evaluation structured to measure (and induce) adherence to youth development principles; and v) had core funding from a city government agency that also monitors performance and enforces quality control. The authors assert that the characteristics of flexibility, transparency, capacity, and accountability further enhanced the effectiveness of ‘The Beacons’.

Ward, cited in Hlgagla (2012:92), draws attention to how the enhancement of solidarity and responsible citizenship can yield positive outcomes in a community that has been weakened by colonialism and apartheid. This implies approaching drug users and dealers as people trying to create a livelihood under circumstances created more by structural constraints, economic marginalisation and institutionalised racism than by the effects of crack cocaine.

**Conclusions**

The conclusions emanating from the findings are that a comprehensive community based approach to drug prevention is reliant upon the active mobilisation of community members and all relevant stakeholders, commitment of community members to invest
their personal time and resources to serve as adult mentors, and lastly, adopting prosocial community norms that contest narrow, stereotypical descriptions of the community. A community-based approach embedded in the culture and history of the community, should focus on enhancing solidarity and citizenship, actively including those members of the community deemed to be the source of negative influence in the community, like shebeen owners.

7.7.5 Strategy 5: Environmental Influences

This strategy aims to revise community norms and attitudes that normalise drug use and its consequences. This includes methods that would reduce the occurrence and prevalence of drug use and drug related harm in the community. Examples of such methods include the development and review of drug policies in educational settings, enhancing effective law enforcement to reduce the supply of and demand for drugs, media focused methods aimed at promoting media literacy, and altering advertisements that promote the demand for drugs, and lastly, influencing the pricing of products as a way of reducing its demand and accessibility (SAMHSA, 2011).

The observers made explicit recommendations about how environmental influences could be regulated and mediated, whilst recommendations were deduced from the way in which the other three participant groups narrated environmental risk factors. The recommendations are depicted in the left-hand column, supported by direct quotations displayed in the right-hand column of the table.
Synthesis of empirical evidence and literature

The observers recommended more stringent enforcement of legislation by the police, community members as well as drug traders. Their recommendations called for closer collaboration between the community and the police to ensure a reduction in the
availability of drugs in the community, which is an approach strongly endorsed by Medina-Mora (2005:25). Observers’ recommendations included having random drug searches at schools and places of employment, regulating the trading hours of liquor outlets, enforcing the age restriction on the purchase of alcohol, to proposals of harsher sanctions for those who violate the laws. Komro and Toomey (2002, in Myers et al., 2008) who propose a risk reduction approach suggest that community coalitions could also focus on training drug outlets regarding the risk and consequences associated with the retail of legal drugs to children under the age of 18 years. Aguirre-Molina and Gorman (1996) however remark that such educational interventions are only effective in the short term and that improved law enforcement is required to ensure continual reduction in drug supply.

It was interesting that most of the recommendations were suggestive of harm reduction approaches which called for responsible and regulated trading compared to only a few who suggested the closure of liquor outlets and removal of beverages from the shelves, as a way of reducing the demand. The proposed recommendations nevertheless require a zero tolerance to illegal drug use and drug trading in the community to ensure the effectiveness of such community action. The risk attached to this community based process is the possibility of intimidation by drug suppliers. The reality of this risk became evident during the recruitment of an adolescent sample for the present study (documented in Section 3.6.1 of Chapter Three of this thesis).

Two observers implied that the effectiveness of law enforcement could be enhanced by a more alert, committed and responsive Police force. Herrick (2012), endorsing such a collaborative approach, made reference to the Community Policing Forums (CPF s) and Neighbourhood Watch, which could aid with the enforcement of the drug control laws, but also observed that communities characterised by a loss of hope would first need an increase in enthusiasm to ensure relative effectiveness and commitment from such community cooperatives. Aguirre-Molina and Gorman (1996) furthermore alert that community policing, aimed at ensuring a reciprocal relationship between the Police and the community they serve, is influenced by the communities’ assessment of the Police’s commitment and efficacy in executing their role. The latter is particularly challenging in
economically disadvantaged communities, where communities hold the general contention that their needs are subservient to that of the more privileged communities.

McNeece and DiNitto (2005:240-241) have referred to the proposed strategies as ‘get tough’ efforts, which have not proven very successful in South Africa, given the costly nature thereof; high demand on limited police resources; and the resourcefulness of drug users in accessing their supplies.

The proposed recommendations by the participants (with the exception of random drug testing at schools) are in line with existing legislation in South Africa, however the number of all drug related convictions do not give an accurate reflection of the magnitude of the drug related problems in Port Elizabeth’s Northern Areas and the country at large. This could be a reflection on what is perceived as apathy amongst the Police and suggestions of corruption by some of the Police officers who benefit financially from the proceeds of these crimes (refer to Section 6.3.2.4 in Chapter Six) and echoes the importance of offering protection to communities that have higher levels of vulnerability. The Minister of Social Development reported on changes in policy and practice aimed at reducing the supply of illegal drugs, which range from improved monitoring of the importation and manufacturing of compound materials, ‘tightening up on banking procedures to make money laundering more difficult, and pursuing persons involved in organised crime more vigorously by using asset forfeiture provisions’ (Peltzer et al., 2010:10).

Ironically, despite the high number of observers who referred to school being a significant risk factor, only one observer recommended drug testing at school. The narratives by the travellers confirm schools as a crucial environmental context for drug prevention interventions (South Africa, 2002b:6). The potential inhibiting factors attached to locating drug prevention interventions in schools were highlighted under Section 2.4.2.4 in Chapter Two. Random drug searches at school were a further recommendation that emanated from the narratives of the participants; however, the South African Education Amendment Laws Act, Section 8A (8) of 2008 (South Africa, 2008c) stipulates that random drug searches and testing can only be administered by the principal or his or her delegate when there is a ‘fair and reasonable’ suspicion of
illegal drug use by learners. The Act stipulates further that any random search, seizure and drug testing can only be undertaken after due consideration has been given to the learners’ rights, as stipulated in the Bill of Rights, in particular the right to human dignity (Section 10), the right to privacy (Section 14) and the right to property (Section 25). The learners’ right to education in a drug free environment may therefore provide the impetus to proceed with the drug test and body/property search.

Only one observer suggested the undertaking of mass media campaigns about the dangers of drug use as a preventive intervention, which is a long-standing drug prevention strategy that has been employed in various countries. McNeece and DiNitto (2005:211-214) argue for the inclusion of media-based preventive interventions under two categories, i.e. firstly, public information and education and secondly, legislative and regulatory measures. Mass media educational campaigns aimed at reducing the incidence of alcohol and drug use by warning about the dangers of smoking and drinking have reportedly yielded little success (McCaffrey in McNeece & DiNitto, 2005:205). Pairing these media campaigns with other interventions, however, appears to present a more optimistic picture, as reported by Longshore, Ghosh-Dastidar and Ellickson (2006). The focus of their National Youth Anti-Drug Media Campaign was on three themes, i.e. promulgating anti-drug norms; enhancing the youth’s belief in their ability to resist drug offers (i.e. resistance self-efficacy); and warning about the consequences of drug use. They presented the media campaign (via television, radio and printed media) concurrent with a school-based drug prevention intervention, and concluded that it only effected a reduction in marijuana use amongst adolescents when it was paired with the interactive school based education programme. Several other authors have highlighted the effectiveness of media based drug prevention interventions when their implementation coincided with other preventive interventions (i.e., peer education; parental support interventions) (compare Johnson et al., in Longshore et al., 2006:502; Hopkins et al., in McNeece & DiNitto, 2005:205; Pentz, 2003:149). Murray, Prokhorov and Harty in Longshore et al. (2006:505), however, warned that ‘even a strong mass media campaign may have little effect’ unless the school-based drug prevention programme it is paired up with is an adequately effective one. Derzon and Lipsey in Longshore et al. (2006:505) have also pointed out that anti-
drug messages that are broadcast repetitively rather than only once-off yield more positive health outcomes.

Parry *et al.* (2010) have reported that the National Department of Health's Strategic Plan for the Prevention and Control of Non-communicable Diseases includes a proposal to ban alcohol advertising in South African media; and also to have the warning labels on alcohol containers enlarged and printed in bold (SACENDU presentation, 2012). This drive has been fuelled by evidence from empirical research about the link between advertising and increased onset and consumption of alcohol and tobacco products. Ksir *et al.* (2008:422) have reported on the strategy to teach children to adopt a critical approach to advertisements of cigarette products. This inoculation training involved showing children samples of cigarette advertisements and getting them to identify the covert message (i.e. the social desirability of the product and its user) and then to compare it with the actual known effects (i.e., stained fingers, yellow teeth etc). This approach has parallels with the cognitive dissonance theory referred to Section 2.3.2 in Chapter Two. In addition, Ksir *et al.* (2008:423) propose closer consultation with television film producers to ensure that influential television stars are portrayed as prosocial role models instead.

The recommendations by both travellers and observers for the community to have anti-drug marches was discussed in the preceding theme under the community domain, but is mentioned here again due to its powerful potential for advertising against drug use, especially if reported on in the television and newspaper media. One of the five key objectives of the anti-substance abuse programme (2011-2016), developed at the Second National Biennial Conference on Substance Abuse in South Africa (South Africa, 2011a), is to enhance prevention through education and creating awareness on substance abuse. This objective was allocated to the commission of demand reduction, and has also been referred to under Section 7.7.4 of this chapter, i.e. the community domain.

The observers added the following aspects to societal preventive interventions: job creation; enforcing harsher sanctions for drug related crimes and mass media campaigns.
The recommendation for the eradication of poverty and high unemployment rates resonated through the narratives of all the participant groups in this study; however, none of them offered recommendations of how this could be accomplished other than through formal employment. Altman (2012) (associated with the Human Sciences Research Council, HSRC) reflected on a number of special employment programmes that are already in place in South Africa, i.e. intensified labour use in Public Works projects; community based services are stimulated as part of service delivery (i.e. via teacher); community work projects are funded two days per week on projects identified by ward committees. Some of the proposed special programmes to enhance employment creation in South Africa include: the youth wage subsidy for private companies (which has been vigorously opposed by labour union, COSATU). Whilst there is a recommendation to expand the Further Education and Training (FET) sector substantially, there is also caution not to just add to the unemployment rate of the educated.

It was furthermore proposed in the NDMP (2006-2011) that the implementation of the New Partnership for Africa’s Development (NEPAD) would play a key role in addressing South Africa’s drug abuse problems. In addition, the Master-Plan will also aid in the implementation of a ‘coordinated, multipronged plan that takes cognisance of legal, health and socioeconomic issues and is supported by all spheres of government and all sectors of society’.

**Conclusion**

The conclusions drawn from the participants’ recommendations are that the majority proposed a harm reduction approach, viz. responsible and regulated demand for and supply of drugs rather than the closure of drug outlets. The proposed methods ranged from having effective legislation and resources in place for the stringent and sustained enforcement of these laws, to facilitating equal access to developmental opportunities. A collaborative approach involving the mobilisation of the different roleplayers (viz. the
Police, educators at school, community members, societal agencies and media) was proposed.

7.7.6 Strategy 6: Problem identification and referral

According to CSAP this strategy is directed at those individuals who have had a drug related transgression and can possibly benefit from an educational intervention to bring about the required behavioural changes. The CSAP emphasise that this strategy is located at an early intervention level where it would identify individuals who are in need of treatment. For the purposes of this study, this strategy will include methods such as educational peer interventions, recommendations of counseling for parents and families at large.

The recommendation for **counselling or support services** to be available to adolescents (and their families) going through difficult times have been echoed by all the participant groups (refer to Section 2.4.2 in Chapter Five; category 1.1.5 in Chapter Six). The finding is however also contradicting the one practitioner navigator’s sentiments about the ‘Coloured’ ethnic group’s non-receptiveness to counselling (refer to Section 1.1.5 in Chapter Six). Although these claims were challenged by the other practitioner navigators, it alerts to the need for practitioner navigators to interrogate stereotypical assumptions and to rather focus on augmenting interventions to make it culturally appropriate. Crockett (2012) asserts that adolescents prefer to have information about drugs and mental health issues conveyed to them by their peers or other young adults. However, they prefer to consult their parents in the event of problems (Mattebo & Nord, 2010; Potgieter et al., 2010). These findings are in line with the recommendation in the National Drug Master Plan (2006-2011) for early
intervention services to be readily available to reduce further escalation on the risk continuum, and to ensure that such services are culturally sensitive. Spoth et al. in National Institute on Drug Abuse (NIDA) (2003:3), on the other hand, propose that brief, family focused interventions should focus on altering specific parenting behaviours that can minimise later propensity for drug abuse.

Conclusions

The conclusions derived from the findings are that parents, teachers, adult and peer mentors should be equipped with the necessary knowledge to identify signs and symptoms requiring a referral for early intervention. The latter services should be easily accessible and should be contextually relevant and culturally sensitive to enhance people’s receptiveness to the service.

7.8 PRACTICE GUIDELINES FOR CULTURALLY SENSITIVE DRUG PREVENTION INTERVENTIONS

7.8.1 Preface

Resnicow et al. (2000:272) define cultural sensitivity as the extent to which the design, presentation and evaluation of prevention and health promotion programmes are representative of the ‘ethnic/cultural (and linguistic) characteristics, experiences, norms, values, behavioural patterns and beliefs of a selected population’. Culturally sensitive programmes therefore incorporate material that resonates with the historical, environmental and social forces in a particular cultural context. The authors argue that the principle of modifying interventions to achieve congruence with the social and cultural features of the targeted service recipients should be indisputable on ethical and philosophical grounds. On empirical grounds, the need for cultural sensitivity is informed by the different cultural constructions around drug use, the different patterns and prevalence of drug use, as well as the factors that predict drug use in a particular cultural context.
7.8.2 Revisiting conceptual definitions

As an introduction to the practice guidelines, two key concepts are revisited: drug prevention and practice guidelines. Rosen et al. (2003:209) define practice guidelines as: ’systematically compiled and organised knowledge statements to help practitioners select and use the most effective and appropriate interventions for attaining desired outcomes’. Hofstee (2006:159) asserts that practice guidelines emanating from a research study should cohere with the findings of the study and relate to the existing theory. The content of the ensuing practice guidelines are hence informed by empirical evidence from the current study of four participant groups (viz. adolescent drug users, non-users, peer mentors, and drug prevention practitioners), which focused on their socio-cultural meaning constructions of the concepts ‘Coloured’, drug use, non-use and drug prevention, and a literature study on drug prevention and cultural sensitivity. Hofstee (2006:159) furthermore states that practice guidelines should specify the detail in terms of the ”what”, “how”, “where” and “why” of the proposed interventions. In addition, practice guidelines should be so tangible that they can easily be transformed into specific programmes for implementation, with clearly defined goals and objectives.

7.8.3 Focus of intervention

The focus of the practice guidelines is on preventing and delaying the onset of (legal and illegal) drug use, thereby reducing the health and social consequences of drug abuse (World Health Organisation [WHO] 2002). The practice guidelines are therefore located in the domain of primary or universal prevention (McWhirter et al., 2007). Universal prevention focuses on larger numbers of people who have either no or very little experience with drug use (Ksir et al., 2008:415). The practice guidelines are aligned with the vision of the National Drug Master Plan (2012-2016) (South Africa, 2012a) which is to have a drug-abuse free South Africa, acknowledging that the vision of a drug-free society is an unrealistic one.

The practice guidelines incorporate recommendations derived from theory on what constitutes effective drug prevention interventions at each of the levels of the ecological systems framework (refer to Chapter Two). The ensuing practice guidelines were
therefore informed by theory and emanated from research findings. The guidelines were also informed by the needs and the degree of risk assessment of the target population (United Nations Office on Drugs and Crime (UNODC) in Myers et al., 2008:20); and place emphasis on continuous interventions as opposed to once-off awareness or educational programmes, directed at multiple systems simultaneously. The practice guidelines hence contain goals for intervention at individual, family, school, peer, community and societal subsystem levels thus reflecting the conceptual framework underpinning the study. Drug prevention programmes that are developed from the practice guidelines should ideally be presented on school premises, as the primary sites of delivery. Section 2.4.2.4 in Chapter two details the motivation for delivering drug prevention interventions at school, and also highlights the potential limitations attached to this approach. Since the practice guidelines propose multisystemic interventions, the articulated programme should ideally be an after-school programme to allow the parallel presentation of parent and adolescent sessions for an hour at a time, followed by a joint session in the second hour. This proposal is informed by the positive results achieved by the Strengthening Families Programme: For Parents and Youth (10-14) (Spoth et al., 2001) (refer to Section 2.4.2.2 in Chapter Two).

7.8.4 Comprehensive, multisystemic drug prevention

Although the research focused on participants in a particular geographical and cultural community, motivated by their specific socio-political history and association with drug use, the practice guidelines may be applicable or transferable to other communities where the scourge of drug use is prompted by socio-economic deprivation and the rising levels of inequality in South African society (Herrick, 2012).

A comprehensive multisystemic drug prevention approach draws on the experiences and input of various stakeholders. For the purposes of the present study, a collaborative approach to drug prevention is proposed with social service practitioners (social auxiliary workers and social workers) facilitating the development of active and collaborative partnerships with all the relevant stakeholders in planning drug prevention services. This approach resonates with the Ke Moja Integrated Strategy (African Youth Development Fund, 2007:15-16), which stipulates the roles and responsibilities of each
of the government departments (viz. Departments of Social Development, Arts and Culture, Correctional Services, Education and Health, the SA Police Services, Sport and Recreation, National Youth Commission, and the United Nations Office on Drugs and Crime).

In terms of the individual subsystem level, the proposed target system is scholars/learners in the early and late adolescent stages of development (viz. 12-18 years) (compare Section 1.9 in Chapter One), ensuring that the group is as homogenous as possible in terms of age and exposure to risks. The content of the practice guidelines can also be adapted for the purposes of developing a programme for a younger audience. The different developmental tasks associated with this life stage are outlined in Section 2.4.2.3 in Chapter Two. At the family subsystem level, the proposed target system is the parents or guardians of the adolescents involved in the adolescent group work programme, to ensure the transference of skills and optimising of the joint parent-child sessions (refer to Section 2.4.2.2 in Chapter Two for guidelines to be followed when constructing family-based interventions). At the school subsystem level, the target of intervention is Life Orientation teachers, who present drug awareness programmes as part of the compulsory Life Orientation learning area (South Africa, 2003) (refer to Section 2.4.2.4 in Chapter Two for guidelines to be followed when constructing school-based drug prevention interventions). The practice guidelines, however, recommend the active participation of parents in school activities and programmes and the broader community system. At peer subsystem level, the proposed participants are peer mentors (refer to Section 2.4.2.3 in Chapter Two for guidelines to be followed when constructing peer-led drug prevention interventions). At community subsystem level, the following stakeholders are proposed as crucial participants: representatives from the school governing bodies (SGBs), unemployed parents (who can assist with aftercare services in the community), adolescent volunteers (and/or peer mentors), the Local Drug Action Committee (LDAC); representatives from support groups like FAD and the AA, representatives from street committees; Neighbourhood Watch; the South African Police Services; the Northern Areas People Development Initiative (NAPDI); representatives from government departments, such as Social Development, Health, Sports and Recreation; NGOs working in the field of drug prevention and positive youth/community development;
representatives from sport and recreational bodies in the community and local emerging artists; and adult mentors (who grew up in the community and wish to be mentors of positive youth development). (refer to Section 2.4.2.6 in Chapter Two for guidelines to be followed when implementing community-based drug prevention interventions).

Prevention efforts at a societal/community level should be focused on improving socio-economic conditions that contribute to the protective processes in the environment and community. These include employment opportunities, adequate housing, child-care, social support and health promoting community norms and values. The fulfilment of needs at community and societal levels enhances the prevalence and impact of health promoting behaviours in all the other target systems of the ecological framework (Rand Health, 2007; Medina-Mora, 2005; Loxley et al., 2003).

The relationship between the different target systems will be illuminated in the discussion of each of the practice guidelines. I recommend that the interventions in each of these settings be considered on a continuum from a) early broad-base prevention, to b) early intervention efforts to coordinate support and training activities, and eventually to c) treatment approaches (McWhirter et al., 2013:293). The three rectangles in Figure 7.1 denote the three settings; each is separated by a diagonal line to illustrate that some strategies and programmes should preferably be implemented earlier in the risk continuum, and others at a later stage. Tolan et al., cited in McWhirter et al. (2013:293) furthermore emphasise the importance of the timing of interventions.
7.8.5 **Theoretical basis and practice principles of practice guidelines**

The guiding conceptual frameworks for the present study were the social constructionist and risk/protective resilience frameworks, which also form the basis of the practice guidelines. Both these frameworks were discussed in detail in Chapters One and Two of the research study, and therefore this section is reserved for outlining the assumptions and practice principles that underscore the practice guidelines. The practice guidelines will, however, also incorporate elements of the Social Influencing and the Competence Enhancement Models (the successful application of both models in effective drug prevention programmes were detailed in Section 2.4.1.4 of Chapter Two of this research study).

Drawing on the work of Saleebey, 1996 cited in Healy (2005) and Ungar (2006), the following assumptions and practice principles underpin the practice guidelines:
<table>
<thead>
<tr>
<th>Theoretical assumptions</th>
<th>Practice principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reality is socially constructed, and can therefore be co-constructed, deconstructed and re-constructed.</td>
<td>Practitioners need to explore the socio-cultural meaning constructions of service users, rather than responding on the basis of their own assumptions. Practitioners need to guard against assuming there is a 'homogenous community identity' (Motala, 2013:88). Instead, they need to listen and observe closely and guard against stereotyping on the basis of assumed similarity. Practitioners need to reflect on how they engage with service users and utilise opportunities to deconstruct and reconstruct harmful, restrictive internalised stereotypes by service users.</td>
</tr>
<tr>
<td>Problematic behaviour is often adolescents’ way of expressing their needs.</td>
<td>Practitioners need to refrain from judging and labelling and instead adopt a genuine curiosity to understand the meaning of service users' behaviour. Practitioners need to try and understand rather than try and change service users.</td>
</tr>
<tr>
<td>Every individual has strengths, capacities and resources/assets.</td>
<td>Practitioners need to adopt a positive and optimistic attitude and communicate hopeful expectations in their interactions with service users. Practitioners should substitute problem-focused language with solution-focused language.</td>
</tr>
<tr>
<td>Communities have existing assets and capacities that are often overlooked in the presence of socio-economic and resource limitations.</td>
<td>Focus primarily on service users’ assets, and facilitate their identification of these assets and capacities by using solution-focused language; working in environments that service users feel comfortable in; conversing in the language they are comfortable with, being receptive to feedback; and making appropriate use of self-disclosure.</td>
</tr>
</tbody>
</table>
Encourage service users to remain optimistic, to approach their identification of assets as a ‘treasure-hunt’ exercise.

| Individuals and communities are capable of determining what they need, and change should therefore be directed by the service user. | Practitioners need to adopt a collaborative approach from the point of needs identification and asset mapping to the final stage of evaluation of an intervention with the service users. |
| Practitioners often focus on the limitations and problems of individuals and communities, ignoring their strengths and resources. | Practitioners need to adopt a reflective practitioner approach, where they reflect on the content of their interventions; the nature of their interaction with communities; invite service users to evaluate their inputs; and respond to suggestions from service users where cultural augmentation and attitude adjustment is required. Encourage and facilitate strong partnerships between community, practitioners, schools, religious institutions, sport and recreational resources. |
| Practitioners often reinforce feelings of dependency, inequality and beliefs of inferiority by how they engage with service users. | Practitioners need to foster a sense of community by validating the worth, importance, mutuality and equality in their practitioner-service user relationship. Whilst it may not always be feasible, practitioners need to conduct prevention programmes in the primary language of service users, in the social context that is conducive to the social users’ participation. |
| People function in and are influenced by multiple systems. | Adopt a multisystemic approach to intervention rather than working with service users in isolation. |

**TABLE 7.2: Assumptions and practice principles inherent in the practice guidelines**

*Source: Information extracted from Ungar (2006); Healy (2005) and Saleebey (2006).*
The assumptions and practice principles outlined above will become evident in each of the drug prevention practice guidelines that follow below.

### 7.8.6 Required knowledge, skills and attitudes of prevention practitioner

The field of drug prevention is regarded as a specialist field (Harker et al., 2008), requiring of the practitioner to have specialised **knowledge** of the stages of addiction; the proposed intervention applicable to each stage (refer to Table 2.1 in Chapter Two); substance use disorders; the prevention of risky behaviours and working with young people (refer to Section 2.4.2.3 and Figures 2.17 and 2.18 in Chapter Two). The Centre for Addictions Research for British Columbia (CARB, 2006) furthermore emphasises that prevention practitioners should base their initiatives on evidence-based interventions. The latter is based on evidence of *‘what works and what works most effectively, to bring out the best possible outcomes for the client and target population’* (CARB, cited in Harker et al., 2008:11). Prevention practitioners should furthermore be knowledgeable about the guidelines to follow when planning and implementing interventions at each of the different subsystems levels (refer to Chapter Two of this research report). The rapid advances in prevention research furthermore require prevention practitioners, to ensure their continuous professional development and training. Each of the six practice guidelines draws on a specific knowledge base of the prevention practitioner which will be highlighted as each is discussed.

Prevention practitioners should possess basic professional helping **skills**, and since most prevention interventions occur in a group work context, prevention practitioners should be skilled in communication, facilitating groups and managing group dynamics (Shochet et al., 2009:26). In addition, Hill (2008:458) asserts that prevention practitioners should be proficient in facilitating the content of the group as well as the group processes, employ questions proficiently to elicit considerate responses, and refrain from expressions of deviance.

The required **attitude** on the part of the practitioner is embedded in the practice principles described in Table 7.2 above. The issue of cultural homogeneity is a contested topic in prevention literature. Ager et al. (2008:307) suggest that practitioners
that are from the same culture as the programme participants have fewer barriers to navigate in connecting with the participants. Hamilton and Hamilton (2004:12-13), however, contest the need for such pairing off, claiming that it further perpetuates stereotypes. They cite the evaluation of the Big Brothers/Big Sisters project by Rhodes, Reddy and Grossman (cited in Hamilton & Hamilton, 2004:13), which concluded that the race of the adult mentor showed no significant effect on the behaviour of the adolescent mentee. Their argument was that racial matching seemed relevant to those adolescents who were still struggling with racial identity issues – an argument seemingly applicable to several participants in the present research study. Motala (2013:88) referring to the fluidity of culture, also cautions against assuming that people living in the same neighbourhood share a ‘homogenous community identity’ (Motala, 2013:88). The onus is therefore on the practitioner to be guided by the participants’ questions and responses and to rather adopt a genuine interest to learn with the participants (Loxley et al., 2003). Gullota and Bloom, cited in Harker et al. (2008:18), caution that ‘programmes that attempt to impose values, practices or judgments of one group on another without considering the culture of and resources available to the target audience are destined for failure especially when the targets are adolescents’.

An evidence-based practice approach to drug prevention entails reducing the risk factors that prompt the onset and continued use of drugs, and enhancing the protective factors that buffer against drug use (National Institute on Drug Abuse (NIDA), 2003). The drug prevention strategies contained in these guidelines are therefore based on the identified risk and protective factors constructed by the research participants and synthesises with research evidence, and aimed at contributing towards the following GOALS:
• To promote the development of life skills and social competencies in adolescents that will enable them to develop into healthy, strong and contributing individuals, capable of effecting health promoting behaviours and engineering prosocial influences.

• To promote protective peer, school, family, community and societal processes which, through collaborative interaction, will contribute towards the delay and reduction in the onset of drug use and culminate in the development of stronger and more supportive and cohesive systems.

7.8.7 Practice guidelines

The practice guidelines, embedded in a comprehensive multisystemic drug prevention approach, consist of an amended or adapted version of the six strategy framework proposed by the Centre for Substance Abuse Prevention (CSAP) (SAMHSA, 2011). The four amended strategies hereafter referred to as practice guidelines are listed below:

| Practice Guideline 1: | Co-construction of information |
| Practice Guideline 2: | Promoting positive youth development |
| Practice Guideline 3: | Promoting family, peer, school, community and environmental protective processes |
| Practice Guideline 4: | Problem identification and referral |

Each of the six strategies as defined by SAMHSA (2011) was explained in detail earlier in the chapter, and hence an adapted conceptualisation for application in the practice guidelines will be presented in this section of the chapter. In the discussion that follows the amended strategies will be presented independently, but should be read as components of the multisystemic drug prevention interventions.

Each of the strategies has its own objectives which, according to SAMHSA (cited in Rand Health, 2007:21), should be related to changes in:
• **Knowledge**: The information and learning that is acquired as a result of the drug prevention intervention. In the context of the study, this may refer to acquiring information about how to enhance health promoting behaviours.

• **Attitudes**: People’s feelings toward a topic. For example, adolescents may feel that peers have a natural ability to influence each other positively.

• **Skills**: The development of specific abilities to resist drug offers from peers.

• **Behaviours**: Emergence of an increased number of prosocial behaviours amongst adolescents.

### 7.8.7.1 Assessment and planning of drug prevention services

The assessment of the needs of the target community forms a crucial part of drug prevention interventions to ensure that programmes address the needs of the target community (United Nations Office on Drugs and Crime (UNODC) in Myers *et al.*, 2008:20). Rand Health (2007:13-15) proposes seven steps that can be followed in conducting a high-quality needs and resource assessment. Each of these steps is discussed below:

i) **Convening** an assessment team (consisting of prominent stakeholders such as Police officers, schools, youth, parents, businesses, prevention and treatment providers) to collect the data. The stakeholders should be in a position to advise on the current contextual social factors that influence the behaviours and social patterning in the target audience (Pickett & Chiricos, 2012; Pycroft, 2010; Pilkington, 2007; Rand Health, 2007; Papalia *et al.*, 2001);

ii) **Determining** the nature and type of data available to assess the underlying conditions. This may include epidemiological statistics in terms of the primary drugs of abuse, the high risk age and gender groups, high risk occupational groups and geographical area. Similar information can be derived from observations, crime statistics, and reports from schools.

iii) **Ascertaining** what data is still outstanding to obtain a holistic picture of the target community.
iv) Deciding on the best approach to follow to obtain the outstanding data and devise a data generation plan.

v) Implementing the data generation plan.

vi) Analysing and interpreting the findings from the community profile.

vii) Using the data to determine the priorities, to develop goals and objectives and choose environmental intervention strategies to implement.

Should the assessment team determine that they do not have enough information about how adolescents, parents and teachers in the community view the issue of drug use and non-use in the community, their data generation plan can take the form of a focus group session with the relevant role-players. The data generation plan referred to in point v) above, will constitute a co-construction of information, since the nature of the practitioners’ (or assessment team’s) assessment questions and how they are experienced is bound to influence the nature and type of information the target audience will generate (Crossley, 2003). Further to these considerations and the conclusions cited in Section 7.7.2 of this chapter, the first practice guideline is termed **co-construction of information**, as is described below:

### 7.8.7.2 Practice Guideline 1: Co-construction of information

Certain aspects of this practice guideline are universal to the traditional assessment followed in social work practice and resonates with the community-based participation approach adopted by Wegner *et al.* (2008:1086) in undertaking the cultural augmentation of the HealthWise Programme (see Section 2.4.2.4 in Chapter Two). The approach incorporates both a ‘*top-down approach*’ (which gives recognition to drug prevention being a specialist field), combined with a ‘*bottom-up approach*’. The latter involves actively mobilising the target audience to draw on their valuable contributions and facilitating the process of them taking ownership of the reciprocal learning process. This approach resonates with the social constructionist framework and ensures that the initial engagement with the target audience culminates in an understanding of the meaning they attribute to drug use, non-use and drug prevention. Such engagement would advise the practitioners on the language the target audience use to describe these concepts (Gergen, 2005), as well as the settings in which they feel most
comfortable. This participatory engagement process furthermore reflects the principles of sound group work practice (Toseland & Rivas, 2005), and is aligned with evidence-based principles for drug prevention (National Institute on Drug Abuse (NIDA), 2003), as accentuated in the principles underpinning the National Drug Master Plan (NDMP, 2006-2011), and the Prevention of and Treatment for Substance Abuse Act (70 of 2008:15).

In reflecting on the nature of their drug prevention interventions (refer to Section in Chapter Six), the practitioner navigators reported that they usually rendered drug prevention programmes in response to requests from schools, churches and other non-government organisations. This implies that the co-construction of information will occur in two phases as standard practice: Firstly, with the person requesting the drug awareness programme, and secondly, with the target audience. Guided by the assumptions and practice principles underpinning the guidelines (refer to Table 7.11), practice guideline 1 will then translate into an invitation to the person who requested the service to attend a co-construction session, accompanied by representatives from the target community. If the requester is a teacher, the representatives from the target community may include Life Orientation teachers, learners who are peer mentors, learners who have experimented with drugs, and parent representatives. The representatives would then constitute a focus group (of no more than 10 members) (Wegner et al., 2008) with whom the practitioner can collaborate on the needs, strengths and views of the target audience (community).

In traditional social work terminology, this step would constitute the exploration session and needs assessment phase, culminating in an assessment statement that answers the following questions: What is the problem?, Why is this a problem?, For whom is this a problem?, What has been done about it? and What is required to solve the problem? (Potgieter, 1998). The strengths perspective, however, focuses on the 'capacities and potentialities of service users' (Saleebey, 2006). Thus, the goal of the first meeting between the drug prevention practitioner and the representatives from the target community will be to arrive at a common understanding of the needs, strengths and resources of the community in relation to the problem identified by the service requester. In order to facilitate the paradigm shift and in keeping with the
underlying principles of the practice guidelines, typical questions that may be posed in this co-construction of information session would be the following:

<table>
<thead>
<tr>
<th>Proposed question</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell me about the target audience (community) that you are requesting the drug awareness programme for.</td>
<td>Open invitation to ascertain the community representatives’ views of, assumptions about and concerns for the community. The diverse nature of the focus group allows for a rich, thick description of multiple views and opens possibilities for the deconstruction of narrow descriptions (Pilkington, 2007).</td>
</tr>
<tr>
<td>What do you appreciate about the target audience/community?</td>
<td>Elicit the identification and rich description of health promoting behaviours and positive aspects of a community rather than fostering a problem-focused approach. In narrative therapy terms, this step entails getting to know the person/community apart from the problem and allows for the identification of unique outcomes (viz. strengths in the person and community that can be employed to enhance person and community competence) (White &amp; Epston, 1990).</td>
</tr>
<tr>
<td>What prompted your request for the drug awareness programme?</td>
<td>The practitioner is able to explore the community representatives’ thoughts, feelings, experiences, associations, language, assumptions, environmental enabling and constraining factors’ relating to drug use. Such a focus group discussion could also explore the community members’ observations regarding the frequency and context of drug use (Resnicow et al., 2000:279-280). This information will enable the practitioner to achieve cultural sensitivity at a deep structural level as the information session will contain content that speaks to the specific meaning that drug use serve for the individual or community (Resnicow et al., 2000:272).</td>
</tr>
<tr>
<td>What in your view explains the non-drug use by community members/target audience?</td>
<td>Considering the conclusions about the social environment in the Northern Areas communities, the exploration stage with the community members could also explore their existing knowledge, views and observations relating to non-drug use in their community. This would set the stage for eliciting an</td>
</tr>
</tbody>
</table>
alternative community story that defies the narrow debilitating
descriptions of community identity and acceptance of drug
use as a community norm.

It could further prompt the identification of protective factors
that can be incorporated in the drug prevention programme
(Practice guidelines 2, 3, 4, and 5). Several programmes
have highlighted the advantage of focusing on the value of
health promoting behaviours, as opposed to focusing on the
harm associated with drugs (Mentor, 2013; Aguirre-Molina &

What would be different
about the target audience/
community when drug use
ceases to be a problem?

This question facilitates the visualisation of the solution or the
alternative story. Ungar (2006:10) suggests that the co-
construction of powerful substitutes to problematic behaviours
enlarges the youth’s search to expand their search for more
positive substitutes.

**TABLE 7.3: Proposed questions and rationale for focus group with community representatives**

The co-construction session would typically include an invitation to the community
representatives to pre-test the practitioners’ existing drug education material (Wegner et
al., 2008) and messages. In the focus group setting the community representatives are
invited to give feedback on the format, content, surface and deep structure of the
prevention material. Examples of facilitative questions would include: 'Look at the
pictures on the power point slides/posters: what thoughts come to mind when you look
at them? Can members from this community identify with them? Which pictures would
you propose instead? This is a typical video we would show during a school drug
prevention session. What are your thoughts on the video? Which parts will the learners
find relevant?'

Further suggestions are offered by Engelbrecht (2006:258) on how to acquire culturally
friendly terminology:

- Enquire directly from the target audience – ask openly
• The practitioner needs to acknowledge that he or she does not need to be an expert; instead, he or she should open him-/herself to learning about cultural diversity.

• Remind self that cultural friendliness include cultural sensitivity.

The collaboration during such a co-construction session not only accentuates the worth of the community members’ input (Schenk, Nel & Louw, 2010), it also serves as a social learning opportunity where practitioners model: i) the importance of listening in order to develop an understanding of the communities’ views (Hill, 2008:453); and ii) their expertise by providing guiding on all the different elements to consider when planning a drug awareness programme. These include elements such as the size of the target audience, the language and gender composition, diversity with regards to exposure to drugs, previous prevention interventions (viz. how it was received and the learners’ feedback on the programmes), amount of time allocated to the dissemination session, suitability of the venue in terms of size, ventilation and access to audiovisual and sound equipment, skills, knowledge and attitudes required of the facilitators; ratio of target audience: facilitators; once-off vs follow-up sessions, and incorporating drug awareness programmes with lifeskills training and broader community based prevention programmes (Miller & Plant, 2010; Brody et al., 2004; Cuijpers, 2002; as well as the guidelines in Sections 2.4 of Chapter Two).

Drawing on parents as valuable sources of information and knowledge could ignite the potential to challenge internalised assumptions of intellectual and social inferiority, and reinforce their ability to be powerful change agents in the lives of their children.

Practitioners can also utilise the focus group session to invite feedback from the community representatives on how they demonstrated their cultural competence (Gosin et al., 2003:123-125) during the session. The latter author asserts that cultural competence not only requires practitioners to be equipped with the knowledge and skills to be sensitive to racial and ethnic identities, but also that they are cognisant of differences pertaining to gender, geography, disability, language and sexual orientation.
The text box below contains suggestions for the practical implementation of Practice Guideline 1: Co-construction of information.

### Practical suggestions for implementing the practice guideline

- **Depart from where the audience is at**: Conduct a needs assessment prior to the information co-construction session. If this is not feasible, at the onset of the programme; get members of the audience to post questions in a box; or get a parent representative to write down their questions and pass it on to the presenter before the onset of programme.

- **When conducting drug education programmes with parents**: Divide parents into smaller groups where they can share all the information that they have about drugs; what is their current awareness of behavioural, physical, and emotional indicators of how to identify alcohol/drug use; knowledge of how drugs are accessed by children; knowledge of how drug offers are made or presented.

- **Use a visual stimulus**, like the hooka pipe (a popular drug in the Northern Areas communities), and solicit the audience’s views of the hooka pipe. Draw a mind map on a flip-chart or whiteboard where all their views and thoughts are recorded and compare the information with the information you have prepared prior to the start of the programme.

- **SANCA’s POPPETS and Grinch programmes** are good examples of age-appropriate drug education programmes (including life skills) for children under the age of 10 years.

- **Based on the conclusions of this study**, it is recommended that this practice guideline incorporate an exploration of how children access drugs, the grooming process involved in preparing children for drug offers, the exploration of high risk periods and environmental circumstances that enhance attraction for drug use. This information will enable participants to mobilise community resources and support structures to reduce children’s exposure to risk-inducing environments and to prepare the children to resist drug offers independently.

- **Dissemination of information to group of adolescents**: Divide the audience in two groups and get one group to stage a role play/drama that depict drug use – its signs, symptoms, dangers, and where to access it. The second group to stage a role play regarding non-use (**Prior screening of the group is important to reduce deviancy training or ‘coaching’ of adolescents that may be in the experimental stage of use and hence more curious to explore other drugs**)

- **School based dissemination of information**: Prior to the start of a programme, let the learners participate in a written questionnaire from which the practitioners can gauge the prevalence of myths about drugs vs factual information.

- **The implementation of parallel or concurrent drug education programmes** where parents and children share their views about drugs, their dangers and how to detect drug use (using their community context as reference point) can serve as an effective inventory of existing knowledge, to which prevention practitioners can add their expert knowledge. Parents can benefit from acquiring information about the behavioural, emotional and physical signs of drug use, to ensure that they are familiar with the ‘covert signs’ of detecting drug use, hence affirming their position as an informed, empowered parents.

- **To enhance parents’ effectiveness as facilitators of drug awareness programmes**: Conduct a parallel session where one facilitator facilitates a
discussion by parents on their existing approaches to imparting drug education to their children. In the adolescent session, the second facilitator will explore the adolescents' experiences and perceptions of how parents can enhance the effectiveness of drug education sessions with their children (based on the principles of HOW and WHEN to talk (and DO) so that children will listen and respond to drug education messages from parents).

- The literature incorporates a variety of methodologies for the operationalisation of this practice guideline. Interactive experiential presentation methods were identified as the preferred ones, combined with engagement in constructive alternatives (such as drama, music and sport).
- At the end of a dissemination session, invite the audience to design posters that can be erected in strategic public places in the community (like bus shelters, church halls, schools, supermarkets, taverns) about the dangers of drugs/myths regarding drug use.
- Explore the possibility of displaying/distributing posters and pamphlets (containing pictures of consenting members of the community) in taverns or other high risk zones (hotspots for drinking and drugging).
- Video recording of parents/adolescents where they share their knowledge/views prior to the workshop or video recording of the dissemination session that can be used in a follow-up session with the same group.
- Invite adolescents to debate the harm vs lack of harm associated with the use of legal drugs (the hooka pipe and alcohol).
- Assess prior knowledge and informational needs on protective factors by giving adolescents the assignment to write an essay about the benefits of a healthy lifestyle.
- Provide teachers and parents with links to websites (such as the Medical Research Council) that offer quick access to information about the latest drugs and how to detect usage.
- Since children learn through repetition, parents to be empowered to reinforce information about drugs, and their non-approval of drug use (with reasons) prior to the onset of high risk periods (including school holidays; exam periods; or starting high school or university).
- Dissemination of information by ex-user – prevention practitioner to coach the ex-user to keep the presentation factual and authentic.
- Dissemination of information sessions must employ interactive methodologies, practitioners to use voice intonation, vary visual stimuli with oral presentations, and actively engaging the audience throughout the session.
- Dissemination of information must be combined with prevention education, life skills training and the provision of constructive alternatives.
- Groups should be kept as homogenous as possible, especially in terms of language and educational level.
- Prevention practitioners can collaborate with organisers of popular social events in the city (viz. the Battle of the DJ's), which is a drawcard for thousands of adolescents during the December holiday, to advocate the adoption of harm reduction approach. The aim of this collaboraton would be to reduce the access to drugs at the event paired with communicating harm reduction messages by local artists (see attached lyrics of a song called 'Tik Monster' – written by a resident artist from the Northern Areas communities).
- Guard against assuming homogeneity amongst community members living in the same neighbourhood. Use the initial exploratory focus group session to gauge how community members identify themselves, and then follow their lead.
- In communities with normative drug use cultures, rather focus on the benefits of a
healthy lifestyle and of using alcohol in moderation. Disseminate information about ‘safe drinking’, concretising it in terms of the number of drinks.

- Focus more on the benefits of healthy living as opposed to the dangers of drinking and drugging – embedded in a resilience approach. Messages advocating abstinence may be more readily rejected.

**Suggested Reading**


Shaido: Tik Monster (see Appendix F for the lyrics)  

### 7.8.7.3 Practice Guideline 2: Promoting positive youth development

SAMHSA (2011) referred to Strategy Two as prevention education, which resorts under affective education programmes, aimed at value clarification, goal-setting, decision making, self-esteem building and stress management. In keeping with the overall theoretical underpinning of the study, the conclusions derived from the research findings, and the literature review, I wish to rename this practice guideline: **PROMOTING POSITIVE YOUTH DEVELOPMENT**. The strengths perspective purports that intervention strategies should focus on increasing people’s strengths, assets and abilities, rather than repairing deficits (Shochet *et al.*, 2009:31; Healy, 2005:152). Similarly, the field of prevention science has also evolved to focus more on processes that can promote better outcomes for youth (Catalano *et al.*, 2002:101), enhancing family resilience (Walsh, 2003:3) and promoting community resilience in socially toxic environments (Vera & Shin, 2006:81). This approach is particularly relevant in the Northern Areas communities, where an internalised inferior ethnic and cultural identity was evident from the narratives of numerous travellers, observers and navigators.

In order to implement Practice Guideline 2 (directed at children and adolescents) successfully, prevention practitioners require an in-depth knowledge of child and
adolescent development, the principles and processes inherent in child and youth development, as well as how to work with children and young people. In addition to the required skills highlighted above, Shochet et al. (2009:26) assert the importance of prevention practitioners’ demonstrating unconditional positive regard, modelling positive coping skills and promoting and rewarding the use of skills being taught in the programme. Ungar (2006:4) claims that one way of connecting with adolescents is to ‘hear their truth’ and ‘speak in ways that they will hear and respect’. Hearing their truth basically requires the practitioner to take the time to listen to the adolescent; maintain a positive attitude towards the adolescent; attempt to comprehend the world from the adolescent’s perspective; and remain curious by the stories adolescents may tell (p.40).

In addition to the skills highlighted above, Ebersohn and Eloff (2003:69) assert that practitioners need to be empathic (viz listening attentively and demonstrating to the adolescent that they are worth listening to); demonstrate respect for adolescents by using examples and activities that resonate with the adolescents’ world; and model integrity, congruence and trustworthiness, as adolescents are bound to model the behaviour of someone they trust and feel safe with. Adolescents also interact and participate more readily in life skills training programmes when they feel safe. Young and Long (2007:113) report on techniques used in brief counselling (a postmodernist approach to counselling) that highlight the importance of adopting solution-focused language as opposed to problem-focused language when speaking to clients. In order to incite hope and raise self-efficacy, practitioners need to adopt solution focused language, speaking about ‘not yet’, ‘not enough’, instead of ‘never’; referring to ‘possibility’ instead of ‘limitation’; talking about the future, instead of talking about the past.

Phase 1 of the present research study (the empirical study with the participants), constituted a co-constructed information generation session (viz. a risk and protective factor/processes asset mapping exercise) which, combined with the comprehensive literature review, enabled me to arrive at goals for intervention with each of the target systems. The reader’s attention is drawn to the interdependence between the protective factors/processes; for example, an increase in adolescent anti-drug attitude is facilitated by an increase in parental education on the dangers of drugs and benefits of a healthy
lifestyle. These protective processes and factors are therefore assets and capacities that the participants aspire towards or wish to strengthen in order to promote positive development at individual, family, peer, school, community and societal level.

Many of these desired assets can be developed by means of life skills training. I propose the adoption of the life-skills model cited in McWhirter et al. (2013:316) combined with the experiential learning approach proposed by Ebersöhn and Eloff (2003:26) as an appropriate model for the positive youth development programme proposed for the adolescents. McWhirter et al. (2013:316) outline the five step training model as follows:

i) **Teach**: The facilitator explains the specific skill, the rationale for its inclusion in the programme, and provide verbal explanation on how to perform it. Ebersöhn and Eloff (2003:68) however emphasise the importance of presenting an activity which can raise adolescents’ self-awareness, since it can culminate in understanding and action. The authors assert that adolescents’ self-awareness need to be internalised as this is when meaning-attribution happens.

ii) **Show**: The facilitator model the skill either in person, in cooperation with one of the learners or co-facilitator or the facilitator show a video which illustrate the skill. Adolescents who are able to understand the meanings they attach to their feelings, insights and standards, are more receptive to reconstructing (Ebersöhn & Eloff, 2003:68) harmful attributions into more productive health promoting skills demonstrated by the facilitator.

iii) **Practice**: the learner is then given an opportunity to practice the skill (in a role play) and the role of the facilitator is to guide on the learners conceptualisation and illustration of the skills in the role play.

iv) **Reinforce**: The facilitator provides additional scenarios and opportunities to enable the learner’s illustration of the skill in different contexts.

v) **Apply**: learners are encouraged to transfer the learnt knowledge and confidence gained from practising the skill to an application in a real life situation. Learners are encouraged to document their experience and report on their experience at the next life skills training session. The facilitator and fellow
learners jointly review the factors that influenced the successful and unsuccessful application of the skill and co-construct recommendations for future implementation.

The desired assets to be developed at the individual level (with adolescents) are presented in Table 7.13 below, followed by the factors that can promote or enable the achievement of the assets (skills), as well as the factors that may inhibit or delay the mastery of the skill. The inhibiting and enabling factors were derived from the synthesis of the findings from the empirical study with the literature.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Inhibiting factors</th>
<th>Enabling factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance adolescents’ competence in exercising control over decisions; over their future and over their lives.</td>
<td>Low hope for the future. Low value attached to education. Surrendering to problem saturated constructions of individual and community identity. Low self-efficacy Demand instant gratification of needs. Learning difficulties Poor self-regulation Poor decision making skills Poor planning Inadequate or lack goal setting</td>
<td>Anti-Drug Attitude High self-efficacy Decision making skills Optimism Parental support of vision High value attached to education Parental monitoring and supervision Conducive learning environment with supportive teachers Equal opportunities to study Hopeful about the future Strong spirituality Self-regulation</td>
</tr>
<tr>
<td>Promote enhancement and effective implementation of coping skills.</td>
<td>External locus of control Limited external support</td>
<td>Self-efficacy Positive belief system Internal locus of control Spirituality Commitment to parents</td>
</tr>
</tbody>
</table>
Table 7.4: Goals for positive youth development with inhibiting and enabling factors

[Sources: Information extracted from McWhirter et al. (2013); Oliver et al. (2006); Catalano et al. (2002)]

The ensuing section is devoted to a discussion of goal one, which surfaced as the most prominent protective factor articulated by the different participant groups.

**Goal 1**: Enhance adolescents' ability to exercise control over decisions, over their future and over their lives.

**Description of life skill: CONTROL**

McWhirter *et al.* (2013:333) denote control as one of the 5 C’s of competency that appear to be most likely in the lives of young people who are resilient. Control encompasses control of decisions, control of self, and control of the future. An adolescent’s lack of control is often associated with the inhibiting factors listed in the table above, and will be illustrated in the ensuing discussion.
Catalano et al. (2002:106) propose that a belief in the future is the internalization of hope and optimism about possible outcomes. Research demonstrates that positive future expectations predict better social and emotional adjustment in school and a stronger internal locus of control, while acting as a protective factor in reducing the negative effects of high stress on self-rated competence (Wyman et al., cited in Catalano et al., 2002:106).

Bower et al. (2012) concur that adolescents often think about their dreams but is seldom able to articulate a clear plan, hence pointing to an important void in drug prevention interventions. Bower et al. (2012) furthermore suggest that in order to make a dream a reality, an individual requires the skill of self-regulation. According to these
authors, self-regulation is comprised of three essential elements which are goal-setting, planning and self-monitoring. The authors suggest that the presence of these intrapersonal skills reduce the propensity for negative behavioural and emotional outcomes (Bower et al., 2012). An adolescent who has a belief in the future is more inclined to set long-term goals and value higher education. Gillespie, Chaboyer and Wallis (2007:129) assert that goals actually represent the manifestation of the person’s hope, which is closely linked to one’s self-efficacy. Possessing these skills manifest in effective decision-making abilities.

Offering a slightly different approach, Smokowski et al. (2000:438) propose that resilient adolescents are motivated by dreams and hopes for their future- regardless of how realistic these are. The authors argue that these positive expectations help adolescents to remain hopeful about a future that might otherwise have seemed hopeless, supporting Walsh’s (2003:8-9) assertion that hope is closely linked to spiritual beliefs.

The above discussion illustrates the different interdependent intrapersonal and interpersonal functional elements the prevention practitioner needs to take into consideration when planning tasks objectives and activities to facilitate the attainment of the goal (of enhancing the adolescents’ competence in exercising control). The discussion also illuminates the other target systems that need to be strengthened and activities that can be undertaken (viz. parental support; teacher-parent collaboration; exposing the adolescent to vocational opportunities) to ensure the accomplishment of the goal. A logical point of departure would be to ignite the adolescent’s ability to create a dream and vision for his/her future.

The following functional aid can be implemented to achieve this aim:

- Step 1: The facilitator would ask the adolescents to brainstorm words that come to mind when they hear the word ‘vision’
- Step 2: Following on inputs and the processing of the different conceptualisations, the facilitator will give the definition of a vision as follows:

  ‘A vision is your personal mental picture of the future’
• Step 3: The facilitator will invite the participants to look at the picture below, and ask them to describe what they see:

![Image](image.jpg)

• Step 4: Processing of the participants input and discussing the factors that influenced their different perceptions of the picture.

• Step 5: Discussion of the different factors that can influence the vision that they have for their own lives, explaining that: ‘by creating your own vision, you will create your own destiny. A vision is created in your imagination. What do you visualize or imagine right now? Remember, everything is created twice. First in the mind and then in reality.’

• Step 6: Explain the difference between a vision and a dream: 'Vision without action is a dream. Action without vision is simply passing the time. Action with Vision can change the world.' – Joel Barker

• Step 7: The facilitator then provides the participants with an opportunity to create their own vision in writing, drawing, singing, or pasting pictures. Culturally competent facilitators will invite participants’ suggestions on the most suitable material they require to represent their vision statements (Gosin et al., 2003:123).

• Step 8: After completion of each participants vision statement, the facilitator will process the feedback from participants, making sure to illuminate social, cultural, environmental and identity issues that may impact on how narrow or broad they defined their vision statements.
Further practical suggestions for operationalising the strategy

- In group work session on promoting self-efficacy:

Play the video of the song 'Roar' by Katy Perry (rated as top song for 2013 and highly popular amongst adolescents) and present participants with the lyrics (see Appendix F).

The purpose of the exercise is to enable the participants to identify the resilience processes the artist implemented to enhance her self-efficacy and increase a positive identity.

- Working in small groups of 4, request participants to identify the lyrics that explain why the artist doubted her ability to survive in the jungle on her own? ['So I sat quietly, agreed politely'; 'I stood for nothing and then fell for everything']

Processing questions:

- Why do you think she had those views of herself?
- What kept those negative views alive?
- Identify the lyrics in the song that illustrate her decision to start protecting herself.
- What triggered her ability to take action?
- Identify the new ways in which she redefined herself ['Now I'm floating like a butterfly. Stinging like a bee I earned my stripes, I went from zero, to my own hero; I got the eye of the tiger, the fire; Dancing through the fire; 'Cause I am a champion']
- What enabled her ability to redefine her view of herself? (Made friends with the animals; thinking about herself differently)
- Next set of processing questions will focus on integrating the learnings from the exercise with the participants own views of self

[The song is particularly appropriate for adolescent participants who uphold very narrow, self-deprecating descriptions/identities]

Suggested reading


7.8.7.4 Practice Guideline 3: Promoting family, school, peer, community and environmental protective processes

Youth development programmes offered to adolescents in isolation are unlikely to yield long term benefits, if parallel positive development does not occur in the adolescent’s family, peer, school, community and environmental context. Catalano et al. (2002:110) assert that 'both positive youth development advocates and prevention scientists now encourage attention to the importance of social and environmental factors that affect the successful completion of developmental tasks'. Practice guideline three is therefore directed at strengthening the protective processes in the significant subsystems in the adolescent’s life, as positive interpersonal and interactive processes in these areas are bound to increase the likelihood of positive adolescent development outcomes. In the table that follows, the goal and objectives inherent to practice guideline 3 are outlined, and matched with the knowledge base required of the practitioner. The third column contains practical suggestions of how the strategy can be operationalised.

<table>
<thead>
<tr>
<th>Goal: Enhance the promotion of family, peer, school, community and environmental protective processes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td>Strengthen parents’ skill in effective management of adolescents’ behaviour.</td>
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<tr>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Enhance parents’</td>
</tr>
</tbody>
</table>
| Demonstration of affection and emotional involvement with adolescents. | Especially in the absence of parents having received this in their own childhood. | Together ensuring all distractions are eliminated. In blended families, parents and adolescents discuss need for 'nuclear family time' vs 'blended family time.'

Have weekly family meetings where family communicate openly and honestly about what they appreciate about and need from each other. Parents to demonstrate and model clear, open and honest communication.

Weekly meetings to include interactive discussions on topical issues (viz. drug use, HIV, relationships).

Parents to be attentive to adolescents' needs and to provide additional support during vulnerable times.

Parents to reinforce positive behaviours with affirmations and praise.

Adolescents to show appreciation and consideration to parents, especially when parents work long hours and struggle with financial resources.

Parents and adolescent to agree on practical tasks the adolescent can take responsibility for at home. |
| Enhance parents' involvement in adolescents schooling. | Parental attitude and activities that enhance adolescents' commitment to and achievement in school. | Parents to be involved with school projects (e.g. painting or cleaning of school).

Parents to be involved with planning and assistance with school activities (at athletics meetings; invigilating during examinations periods; assist with feeding schemes at school).

Regular communication between teacher and parent (via school diary). If parents' literacy level is low, the teacher can arrange for personal meetings to discuss adolescents' progress. |
| Strengthen parents' emotional coping resources. | Coping resources that will enable parents to buffer stressors of daily living. | Self-sustaining parent support groups to be established in the community. 

Prevention practitioners facilitate training in parenting skills, viz. parents' socialisation role, parents delivering drug |
<table>
<thead>
<tr>
<th>Plan Area</th>
<th>Strategies/Actions</th>
<th>Outcomes/Expected Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen parents' management of financial stressors.</td>
<td>- Community based processes to enhance self-supportive initiatives</td>
<td>Parents to be active initiators and participants in community based income generating projects.</td>
</tr>
<tr>
<td>Enhance teachers' emotional support to learners.</td>
<td>School ethos that promote learner cooperation. Teacher behavioural management strategies that enhance learner cooperation. Teachers skilled in early identification of learning (and emotional) problems and linking child to resources for necessary assistance.</td>
<td>As part of a continuous professional development training session with teachers (in group work programme): <strong>Individual exercise</strong> where teachers reflect in writing on at least 3 concrete positive encounters they have had with learners. Following the individual reflective exercise, they discuss their responses in small groups of 4. Probing questions for small group discussion: i) describe the experience to your colleagues; ii) what do you notice about the experience; iii) what invited the positive experience; iv) what reinforced the positive experience; v) what are you learning about eliciting positive responses from learners; vi) what may inhibit continued implementation; vii) how can you enhance continued implementation</td>
</tr>
<tr>
<td>Promote school protective processes to ensure a conducive learning and socialising environment.</td>
<td>- Roles and responsibilities of teachers to enhance learner safety. - Roles and responsibility of learners to enhance learner safety. - Legislation</td>
<td>Learners design a personalised billboard for their school which depicts their school's ethos. <strong>[Rationale: Teachers to mobilise peer advocacy against drug use]</strong>. Learners to critically analyse media advertisements <strong>[Rationale – teaching them critical analysis skills and illuminating the</strong></td>
</tr>
</tbody>
</table>
permitting drug testing, drug searches and drug seizures at school (and operating guidelines to follow).

- Processes to follow to mobilise parent and community involvement in enhancing learner safety in the school environment

| Enhance awareness and skill in initiating and eliciting positive peer influences and mediating/resisting negative peer influences. | The value of peer relationships to adolescent development. The value of peer relationships to adolescent development.  
Knowledge, motivation, skills  
Processes of peer influence  
Conditions and factors that enhance resistance to negative peer influence.  
How to prevent deviancy training or harm inducing peer socialisation  
Recruitment, training and continued support of peer-led initiatives | Adolescent to make an inventory of the characteristics that they admire in their peers and peer circles and to reflect on what motivates the attraction [Rationale – adolescents gain insight into i) their choices; ii) behaviour being socially constructed; iii) and their own constructions of prosocial prototypes. This awareness will aid them in the decision making process when presented with a challenge in a social context].

Class debate: what motivates non-use of drugs or a decision to resist drug use?

Give homework assignment for adolescents to do a google search on the characteristics of negative peer influences and the processes of how peer influence occurs. Process their feedback and offer supportive guidance [Enhance their preparation and equip them with knowledge which can be utilised when they are in harm inducing socialisation context].

Small group activity: divide adolescents into groups of 4. Each group need to brainstorm the qualities of prosocial peers and ways in which peers influence each others positively. Adolescents to draw on personal experiences and observations as far as possible. [Rationale – increase their insight into how to enhance their own effectiveness as a prosocial peer influence].

Follow up activity – give adolescents instruction to model ONE positive behaviour for a week and to observe the effect it has on peers [Rationale – validate]
the positive influencing skill and reinforce the retention of the skill).

Teachers to mobilise the peer group as a source of support and guidance to each other, viz.

- Establish a buddy system where class groups take turns to share a positive message of encouragement with rest of the class at start of school day. This should be a group effort and message can be presented in song; a rhyme or drama
- Establish peer tutoring system/peer mentoring or peer support system to address specific developmental needs identified in the classroom by teachers.

<table>
<thead>
<tr>
<th>Promote community (♯) and environmental (√) protective processes.</th>
<th>Community norms/ socio-cultural views of drug use/ (♯)Maximising neighbourhoods positive influence on adolescent development (♯)Characteristics of community resilience (♯)Processes to enhance community resilience (♯)Mobilising social capital in the community ✓ Legislation and implementation processes ✓ Socio-economic profile and prospects of the community and societal impact ✓ Media strategies</th>
<th>Draw up an asset map of the prosocial resources in the neighbourhood/community. Identify potential adult mentors in the community. School premises to be utilised as aftercare facility and unemployed parents to be assisted to set up an integrated child-care monitoring and support service Mobilise adolescents and adult coalitions to assume advocacy. Advocating for health promoting behaviours. Development of street committees to enhance safety in streets; deliver drug prevention messages to taverns in the community; educate tavern owners on the consequences of early onset of drug use. Street cleaning projects to enhance the aesthetics of the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobilise and promote constructive health promoting alternatives for adolescents to choose from</td>
<td>Current prosocial outlets in the community Networking opportunities Knowledge about sport, recreational,</td>
<td>Practical suggestions are described in the text</td>
</tr>
</tbody>
</table>
TABLE 7.5: Goals and objectives inherent to practice guideline 3, combined with required knowledge base and practical suggestions for implementation

7.8.7.4.1 Promoting family protective processes

The first five objectives listed in Table 7.5 are relevant to the promotion of family protective processes. Considering the prevalence of single parent and blended families in the Northern Areas, practitioners are reminded of the importance of focusing on the characteristics of healthy families in general and blended families in particular (cited in Table 7.6 below). Prevention practitioners focused on enhancing family protective processes are thus encouraged to formulate their interventions around the strengths listed in table 7.6 and to draw on the practical strategies suggested in table 7.5 above.

<table>
<thead>
<tr>
<th>Six attributes of healthy families</th>
<th>Characteristics of healthy step (blended) families</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appreciation: Family members validate each other and offer active support.</td>
<td>• Flexibility and adaptability: Stepparents acknowledge and respect childrens' need to spend private time with their biological parent.</td>
</tr>
<tr>
<td>• Spending time together: Joint time is spent around the house and activities outside the home (viz. church, sport).</td>
<td>• Patience: Children in single parent households learn to be considerate of limited time parents have available to spend with them (as result of balancing work and household commitments).</td>
</tr>
<tr>
<td>• Good communication patterns: Characterised by open, clear and honest communication and feedback to each other.</td>
<td>• Realistic expectations: Parents and children in blended families acknowledge that trust and respect is earned and therefore allow each other time to adjust.</td>
</tr>
<tr>
<td>• Commitment: Prioritising the family ahead of individual focused needs.</td>
<td>• Cooperation of separate households: Parents deal with their own disagreements in adult manner and try to find synergy in rules for the different households to enhance consistency for the child.</td>
</tr>
<tr>
<td>• Ability to deal with crises in a positive manner: Offer mutual support to each other during a developmental and unexpected crisis.</td>
<td>• Unified couple: The couple rally</td>
</tr>
<tr>
<td>• Religious orientation: A strong set of beliefs grounded in a spiritual orientation and a sense of purpose.</td>
<td></td>
</tr>
</tbody>
</table>

472
together, reaching consensus on family rules.

- **Establishment of constructive rituals**: Ensuring consistency and therefore child’s sense of security, parents agree on regular rituals (viz. having quiet time together; having a family meal together; joint family outings once a month).

- **Formation of satisfactory step-relationships**: Both stepparent and child actively work on validating each other and nurturing their relationship.

### TABLE 7.6: Characteristics of healthy families in general and healthy blended families in particular


The value of parent training in child management is indisputable; however McWhirter *et al.* (2013:376) caution that this needs to occur before children reach adolescence. Parent training is particularly important in socially disorganised communities. Foster cited in Nziyane (2010:164) encourages that even financially disadvantaged families ‘have resilient and coping mechanisms that enable them to deal effectively with their life situations’. The author makes reference to entrepreneurial ventures (such as stokvels or savings clubs and burial associations) initiated in the African content as a strategy to ensure financial support.

Parents and families who have a positive family and cultural identity are more inclined to place a high premium on education and to support their children’s’ vision for their future. The practical activity that aims to strengthen the family’s vision and identity can hence be a useful one for parents in the Northern Areas in light of the internalisation by several participants of being part of the ‘nowhere people’ (Oppelt, 2012:15). The text box below contains suggestions of useful sources of information.

### Suggested Reading

The objectives derived from the research findings and the literature control is in synergy with the objectives of the White Paper on Families in South Africa (South Africa, 2012b:8), which clearly illustrate the interdependence between family, school, peer, community and societal interventions. The next objective linked to Practice Guideline 3 centres around the promoting of school protective processes which is discussed in the ensuing section.

7.8.7.4.2 Promoting school protective processes

The late South African President Nelson Mandela placed a high premium on education which is evident from his famous quote: ‘Education is the most powerful weapon which you can use to change the world.’ The practice guidelines are geared towards enabling adolescents, teachers and parents to internalise this message, starting with enhancing a positive attitude by adolescents towards school (and their futures); enhancing teachers’ emotional support to learners and enhancing safety at school which will contribute towards a conducive learning environment. These objectives intersect with the interventions directed at enhancing adolescents’ sense of control (of their futures and decisions); and are furthermore aligned to enhancing parents’ involvement in their children’s’ schooling and future.

Intervention strategies aimed at enhancing a positive attitude towards school need to start in the pre-primary years, focusing on children’s’ attachment and commitment to school. Promoting children's’ attachment to school begins with inciting an excitement about learning and cultivating a nurturing learning environment that is fun and affirming of the child’s abilities. Prevention practitioners therefore need to work closely with parents to cultivate a curiosity about the world and making new discoveries by reading, teaching nursery rhymes, playing games that teach them to read and write and watching educational television programmes. Parents can furthermore cultivate a culture of learning by investing in educational toys that are fun and interactive in nature.
Such activities also enhance a culture of engaged dialogue between parents and their children.

The practical intervention proposed under practice guideline 2 for adolescents’ cultivation of a vision for their future, can be strengthened by parents’ support for their vision and teachers arranging educational excursions or career information sessions at school. Parents’ active involvement in school related activities have also proven to enhance children’s integration into the school environment and contributed to an increase in social competence (McWhirter et al., 2013:314). The authors describe critical school competence as consisting of academic skills (viz. reading, writing, arithmetic) and academic survival skills. Teachers and prevention practitioners can strengthen learners academic survival skills by training them in social competency skills, i.e., mobilising their peer support networks and enhancing their interpersonal skills, which in turn will help them achieve positive outcomes at school and later in life as an adult (McWhirter et al., 2013:315).

Children’s commitment to school is frequently negatively affected by unattended learning problems, resulting in the child internalising negative messages of inadequacy and incompetence. The early identification of learning difficulties or barriers to learning and appropriate remedial interventions can thus mediate children’s’ commitment to school and enhance children’s’ self-efficacy. The role of the prevention practitioner (either as case worker or prevention practitioner when engaging with practice guideline 1: co-constructing information) is to advocate for both the screening of learning difficulties and the implementation of appropriate enabling remedial interventions.

August, Realmuto, Winters and Hektner (2001:144) confirms that teachers can enhance children’s’ adjustment to school and improved achievement by employing teaching methods and curricula:

“that improve basic learning skills in reading, written language, and mathematics; by employing teaching techniques that maintain student attention and on-task behavior; by incorporating incentives in learning tasks that enhance interest and
motivation to learn; and by working continuously to cultivate positive attitudes toward school.

The practical activity recommended in Table 7.5 above, is aimed at enhancing teachers’ awareness of how they can expand their repertoire of supportive interventions. Prevention practitioners also have a role to play in strengthening teachers’ coping resources given the challenging conditions under which they have to perform their tasks. It is evident from practice observations that stress management workshops for teachers are a sought after intervention. Practice guideline 4 contains recommendations for promoting the availability of counselling services at schools.

Teachers, learners, parents and the community at large need to coordinate their efforts to enhance learners’ safety at school, which entails reducing the demand for drugs as well as reducing the supply of drugs. Prevention practitioners can serve as the broker (Potgieter, 1998), linking teachers to the South African Police Services and specialist organisations like SANCA for drug information sessions. However, the efficacy of this conventional approach has been questioned and practice guideline 1: Co-construction of information is proposed as an alternative approach. Whilst it is the mandate of the Department of Education to support principals and teachers with the implementation of the Policy Framework on the Management of Drug Abuse in all Public Schools and Further Education and Training Institutions (South Africa, 2002b:5), prevention practitioners can assist with linking the school to treatment facilities in the event of learners needing early intervention. As part of the multisystemic approach to positive youth development, prevention practitioners can also facilitate the establishment of a school safety initiative, incorporating community stakeholders like FAD whose physical presence around the school have reportedly reduced the presence of drug suppliers. This intervention strategy however needs careful planning and clear delineation of roles to ensure its sustainability and alignment with the Schools Act (South Africa, 2002a).

Learners can also be mobilised to assume their peer advocacy role by designing billboards for their school, clearly depicting the school’s ethos and its underpinning health promoting behaviours. Consonant with the principles of the practice guidelines, learners can also be encouraged to co-construct a vision statement for their different
class groups which communicate the values they *stand for* (viz., the desired behaviour) rather than what they *stand against* (viz., the undesirable behaviour).

Teachers can, furthermore, encourage learners’ application of critical thinking skills and provide an opportunity to illuminate dissonance in behaviour and attitude. An effective exercise in this regard is getting learners to critically analyse media advertisements of cigarettes for example, getting them to look at the covert message(s) in the advertisement as opposed to the known effects of smoking (Ksir *et al.*, 2008:422).

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**Suggested Reading**


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7.8.7.4.3 Promoting peer protective processes

Prevention practitioners, who embrace the adolescent peer group as a valuable asset worthy of investment, are more likely to enlist the *positive growth-promoting qualities* in peer interaction successfully (Karcher *et al.*, 2004:193). Prevention interventions informed by the Social Influencing Model focus are directed at the cognitive, affective and behavioural level, aiming to effect changes in adolescents’ cognitive schemas and views, altering how they evaluate a particular phenomenon and or bringing about an explicit change in behaviour respectively. Specific interventions may include:

i) Mobilising adolescents to establish and maintain prosocial peer relations.

ii) Training adolescents in effective interpersonal skills (Karcher *et al.*, 2004:196).

iii) Teaching adolescents to model prosocial behaviours.

iv) Encouraging adolescents to interrogate the truth value of the perception that *most adolescents use drugs*.
v) Preparing adolescents for high risk situations where drug offers may occur (pointing out that they may receive direct and indirect offers).

vi) Equipping adolescents with the different peer resistance strategies. Amongst these is the ‘Keep it REAL’ strategy, which includes: resisting a drug offer without offering any explanation; explaining the reason for the refusal; avoiding a high risk situation; and physically leaving a high risk environment (Hecht & Miller-Day, 2009). Brainstorm potential explanations they may offer to peers for declining drug offers. *The lessons from practice also revealed that adolescents frequently refuse drug offers, using the explanation that their parents subject them to regular drug tests*. Brainstorm strategies with adolescents about how to deal with threats and coercion as direct methods of peer influence. Loxley *et al.* (2003:128-129) recommend training in decision-making following the five steps in the DECIDE model (viz. identifying/defining the situation; exploring a range of alternatives; evaluating the alternatives and deciding on and implementing the decision).

vii) Challenging adolescents to deconstruct the ‘mental pictures’ or prototype of the ‘cool’ teenager, and instead invite a co-construction of a prosocial adolescent prototype (Botvin *et al.*, 2001).

The outcomes of each of the interventions above are contingent upon a number of factors, one being adolescents’ perception about their susceptibility to drug related harm and addiction (refer to Section 2.4.2.1 in Chapter Two). Interventions informed by the Theory of Reasoned Actions (Azjen & Fishbein, cited in Hill, 2008:453) and the Cognitive Dissonance Theories (Ager *et al.*, 2008) can thus be incorporated in promoting peer protective processes as it focuses on a critical interrogation of the adolescents perceptions and illuminating the dissonance between their attitudes and behaviours.

August *et al.* (2001:135) offer concrete skills in which adolescents can be trained to enhance prosocial peer affiliation. These include:

*behavioural social skills that facilitate peer acceptance and friendship making (e.g. sharing, offering help, cooperating, joining in, playing a game); to
encourage use of effective communication exchanges among peers (e.g. ask questions, listen carefully, make suggestions, apologise, compliment); and teach skill alternatives to aggression (e.g. responding assertively to teasing, accepting consequences and negotiating).

Ungar (2006) and National Institute on Drug Abuse (NIDA) (2003) concur that adolescents will be more attracted to prosocial substitutes or alternatives that can produce the same degree of confidence, self-affirmation and self-worth as their earlier conventional associations. Rewards offered by prosocial peer association also need to be genuine, and attractive enough to captivate and sustain attention. Since adolescents are best placed to advise on activities and associations that may produce the desired effects, practitioners can draw on their expertise during on-going consultations with the adolescent. Two examples from practice include arranging activities that can produce ‘natural highs’ and linking adolescents with prosocial peers that are involved with high energy recreational activities like hip hop dancing (Ke Moja Integrated Strategy, 2007).

Another focus of peer focused training is on promoting the development of peer networks and bonds that can serve as a source of ‘mutual restraint and protection in risk-laden decision-making’ (Pilkington, 2007:217). Peer mentors enable adolescents to assert their agency, allowing them to experience a sense of power, acceptance, recreation and protection. However, peer mentors require guidance, supervision and support from competently trained prevention practitioners. Section 2.4.2.3 in Chapter Two makes reference to five principles and guidelines to follow when planning peer based prevention interventions.

Suggested Reading


7.8.7.4.4 Promoting community and environmental protective processes

Community protective processes are evident in strong community coalitions, community networks and the presence of social cohesion in the community. These are all protective processes which were identified as desired assets by the majority of the participants in the present study, although an encouraging observation was the acknowledgement of social cohesion as a community asset during a second round of data generation with the non-drug users. Environmental protective processes on the other hand, constitute health promoting community and societal norms, protective policies implemented by an adequate complement of police officers, sufficient employment opportunities and a media screening health promoting advertisements and television programmes. Community and environmental protective processes are closely linked as a socially cohesive community with strong prosocial community networks is unlikely to endorse normative drug use or ignore illegal drug trading in its community environment.

The prevention practitioner has two primary roles to fulfill to enhance community and environmental protective processes. The first one is being a public policy advocate (partnering with the community to achieve community identified objectives) and the second one is to mobilise community organisation whenever spontaneous community organisation is lacking. Practitioners therefore need to be conversant with the policies pertaining to drug prevention and community upliftment as well as be efficient and effective in implementing (or advocating for the implementation of) the policy. Practitioners also need to be knowledgeable on how to support the community’s spontaneous organisation, planning and promotion of community based services, instead of steering the process.

The Asset Based Approach to Community Development (ABCD) is proposed as a suitable match to the principles underlying the practice guidelines. The ABCD approach was designed and applied by Kretzmann and McKnight in Illinois, United States of America, who recognised that socially disadvantaged communities had many assets that were underutilized (Pretorius & Nel, 2012). By applying the ABCD model, the
practitioner will be assisting a community who views itself as marginalised, to develop ‘new eyes about themselves and their surroundings’ (Morse, 2011, cited in Pretorius & Nel, 2012). Similarly it also liberates practitioners to regard community members as ‘assets to tap’ (p.10). The ABCD approach starts with ‘a period of building relationships with community members with a particular emphasis on the inclusion of marginalised groups’ (Mathie & Cunningham, 2003 cited in Pretorius & Nel, 2012). Identifying the network of existing associations and local groups within the community is an important part of the process,

Most of the specific targets of intervention to bring about community protective processes have already been addressed under the objectives aimed at promoting family, school and peer protective processes. These intervention strategies are therefore merely summarised here:

- To enhance social cohesion: community members can be encouraged to continue with the culture of sharing of material resources and giving of their time to help others in the community (as evident from the narratives of mostly the non-drug and drug users). Specific interventions mentioned by the participants of drug users included the care shown by community members in either getting them to a support group and or constructive alternatives (like church gatherings). Religiosity or spirituality surfaced as a consistent cultural resilience factor in the narratives of the majority of adolescent participants, seemingly serving as a source of hope for the future and strengthening cultural identity (Clauss-Ehlers, 2008) which should be nurtured as a target of intervention.

- The establishment of community networks will however be a more sustainable reinforcement of community cohesion. A starting point can be a community network focused on providing collective safe care and especially school aftercare to children in the community. Following the ABCD model, unemployed parents in the community can be mobilised to adopt proactive roles, forming partnerships with parents whose children are left unsupervised after school due to their parents’ employment commitments. In the process the community members will replace passive dependent roles which refute the identity construction of inadequacy and inferiority (Patel, 2005).
Linked to the aftercare community network can be an increasing number of adult mentors from the community who can offer practical guidance, assistance with homework, and spending quality time with vulnerable children (Mentor UK, 2005). The Helenvale community (located in the Northern Areas) early childhood development initiative focusing on training parents to improve the cognitive development of their children through outdoor play and playing educational games, is an example of an asset based community initiated initiative (Gadd-Claxton, 2014:6). Besides enhancing a sense of unity in the community (Gadd-Claxton, 2014:6), the objective of this initiative also links to the recommendation to enhance adolescents’ sense of control of their future and parents’ involvement in their children’s schooling (refer to practice guideline 2). Sonn and Fisher (1998) endorse these constructive coping responses in the midst of resource-restricted environments as strategies through which communities can reduce the negative chain reactions associated with apartheid-generated adversity.

The prevention practitioner needs to influence the adults ‘whose decisions and daily interactions with youth have a direct influence on strength development’ (Vera & Shin, 2006:85). One example would be to advocate for the introduction of culturally appropriate health promoting activities (like Hip Hop dancing classes). Whilst this may be viewed as undermining the strengths of adolescents to advocate on their own behalf, it is in fact a recognition that parents are often more powerful in influencing school authorities on behalf of their children.

The community pride derived from a well-kept physical environment (Elliott et al., 2006:277) is also a community protective factor that can easily be achieved by a community network mobilising the residents to collectively attend to the aesthetics of the community. Elliott et al. (2006) reiterated from a large scale study in Detroit that deterioration and not poverty in a socially disadvantaged community was the most significant deterrent to community cohesion and community pride.

The ensuing section is devoted to a discussion of interventions targeting environmental protective factors.
Defying normative drug use behaviours in the Northern Areas (and South African society at large) was listed as the most significant target of change by the majority of participants in the present study (Elliott et al., 2006).

Specific interventions targeting cultural norms include: training local drug outlets (Komro & Toomey, 2002 cited in Myers et al., 2008) on responsible trading and the consequences of especially adolescent drug use and abuse. However to enhance its effectiveness this intervention must be combined with efficient and regular policing. Community drug counsellor in Port Elizabeth, John Preller has made a persistent call for the return of the South African Narcotics Bureau (SANAB) (disbanded in 2004) as a mechanism to reduce the rapid increase in adolescent drug use in the city (Gillham & Van Aardt, 2014:6). Practitioners can mobilise community members to support this call and escalate it to national government. The role of adolescents as advocates of health promoting behaviours was already highlighted in an earlier section. Active partnerships with volunteer support groups like FAD, supporting marches in favour of healthy, strong communities are also environmental based interventions that practitioners can support.

Strengthening the Local Drug Action Committee (LDAC) is an important prevention strategy, since this is the body steering the drug prevention interventions in the community. The LDAC should be small enough to be effective and efficient but large enough to accommodate key role players, especially ordinary members from the community.

The issue of unemployment and financial hardship featured as significant contributing factors to adult drug use and drug trading in the community. Practitioners can focus on actively mobilising micro enterprises. In partnership with functional, efficient community networks they can arrange for skills training initiatives that can benefit the community to become more self-sustaining. These efforts require knowledge of resources, proposal writing skills, financial management skills, and administrative management. A thorough exploration of assets in the community is bound to deliver human resources or social capital that could be harnessed to fill these portfolios.

The community’s social construction of being the ‘forgotten people’ can also be deconstructed in community workshops and through becoming involved in the
community upliftment projects like the Helenvale Youth Enrichment Initiative (HYPE) and the Northern Areas History and Heritage Project (NAHHP).

Suggested reading

Conference: healing through heritage and memorialisation. SADRAT Institute and NAHHP.


7.8.7.4.5 Promoting involvement in constructive health promoting activities

The recommendations from the study point to the need to promote adolescents’ involvement in constructive health promoting activities. The reformulated practice guideline not only specifies the desired action, but also implies that the adolescents (and their support networks) are active participants in sourcing, creating and participating in the constructive, health promoting activities. The desired outcome connected to this practice guideline is described in the table below, adjacent to the factors that may inhibit and enable the achievement of the goal.

<table>
<thead>
<tr>
<th><strong>Objective:</strong> Mobilise and promote constructive health promoting alternatives for adolescents to choose from.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inhibiting factors</strong></td>
</tr>
<tr>
<td>Assumption that all alternative activities require expensive monetary investment and need to be elaborate efforts that rely on outside expertise.</td>
</tr>
<tr>
<td>Specific activities are unaffordable e.g. sporting equipment; enrolment</td>
</tr>
</tbody>
</table>
TABLE 7.7: Inhibiting and enabling factors pertaining to constructive health promoting activities for adolescents

<table>
<thead>
<tr>
<th>Inhibiting factors</th>
<th>Enabling factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working single parents unavailable to be physically present at e.g. child’s soccer game.</td>
<td>Parents aligning with family members and/or adult mentors who avail their time to support children.</td>
</tr>
<tr>
<td>Lack of vision and future focus inhibit interest and enthusiasm in prosocial engagements.</td>
<td>Parents modelling belief in future focus and supporting their children’s involvement in constructive activities.</td>
</tr>
</tbody>
</table>

The desired outcome is based on the findings that adolescents growing up in socially disadvantaged communities where normative drug use prevails, can benefit from expanding their repertoire of positive engagements. The successful implementation of this practice guideline is contingent upon enlisting community resources in terms of infrastructure and human resources and is therefore well placed to be incorporated with the practice guideline promoting protective community processes.

Ungar’s approach to promoting resilience in adolescents (2006:7-10), underscores this view and emphasises the importance of presenting adolescents with substitutes to problem behaviour (or an unproductive existence) instead of trying to suppress problem behaviours. The author specifies that problem behaviours are all attractive to adolescents because of the value that they derive from these behaviours. According to the author they satisfy the youth’s ‘need for power, recreation, acceptance, or a sense of meaningful participation’ (p.7). The findings from the present study resonate with this view (refer to Appendix H for a review of the benefits the travellers derived from travelling in the fast lane). Prevention practitioners therefore need to take time to understand the value adolescents derive from engaging in particular behaviours or specific peer associations.

Prevention practitioners need to be authentic, and avoid being judgmental when undertaking such an exploration, as it is bound to invite resistance from the adolescent and result in the practitioner losing credibility.
In mobilising constructive alternatives, prevention practitioners need to take heed of the following:

- The practitioner needs to involve the adolescents as active partners when planning and mobilising constructive alternatives;
- The practitioner needs to be cognisant of the adolescent’s current use of free time and understand the value they attach to their existing activities and associations;
- The substitutes co-constructed with adolescents need to be powerful alternatives that are appealing and attractive enough (Ungar, 2006:13), and should be culturally relevant in order to draw the adolescents (Ager et al., 2008:307);
- The substitutes need to be accessible and feasible, considering financial, time and emotional resources;
- Adolescents’ involvement in constructive alternatives should involve the presence and influence of prosocial peers and adult mentors (Botvin et al., 1994:117);
- Constructive alternatives need to be personally meaningful and offer healthy ways for adolescents to use their free time and avoid boredom (Wegner et al., 2008:1086);
- Constructive health promoting activities that incorporate altruistic acts of service to others provide adolescents with socio-emotional rewards at multiple levels; [opportunities to engage in activities of this nature can be built into compulsory school assignments for example in the Life Orientation learning area to offer exposure, as not many adolescents would initiate these activities. Adult guidance is however required to ensure that the experience is a pleasurable and rewarding one which the adolescent would volunteer to return to];
- Remain cognisant of the inhibiting and enabling factors cited above and explore the adolescents’ views of factors that promote and enhance their involvement;
- Adolescents (and many adults – including teachers and parents) are often unaware of the holistic developmental benefits of engaging in constructive healthy alternatives (such as exercise and sport) and thus the practitioner needs to have practical evidence to illustrate such benefits (Wegner et al., 2008:1087);
In light of the afore-mentioned point, practitioners need to draw on experts in the sports science (human movement science) and recreational field as well as adult mentors from the community that can model and actively support initiatives to adopt a more healthy lifestyle.

Practical suggestions for operationalising the practice guideline

A functional aid that can be utilised with adolescents to explore their current use of free time is to divide them into small groups of five. Provide each group with an A4 sheet and ask them to compose a song or rhyme. The song or rhyme is supposed to reflect the following:

- The adolescents’ current use of free time
- The personal value or meaning they derive from how they spend their time

Processing questions by the facilitator would include:

- What informs the adolescents’ choice of activities in their leisure time;
- What informs the amount of time that is devoted to the activity;
- Factors that enhance and inhibit the enjoyment of the activity.

Another functional aid could also be to get the adolescents to construct a profile of constructive health promoting activities in their community and then to evaluate each of the activities and resources in terms of how accessible it is; its level of attractiveness and deterrence to adolescents and the reasons for these.

In order to aid the practitioners’ implementation of the practice guideline the following list of existing community resources aimed at offering constructive health promoting activities are provided. A contact person and web address is provided where available:

<table>
<thead>
<tr>
<th>Existing community projects that offer constructive health promoting activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Star Project - Northern Areas People Development Initiative (NAPDI) launched North Star Future Scenarios Project aimed at enhancing community pride; productive outlets, Mr Neil Campher (041) 4571422</td>
</tr>
<tr>
<td>Safe School project – Marching Drill</td>
</tr>
<tr>
<td>Nelson Mandela Metro Music Assembly, Alton Van Heerden – 071 921 4371</td>
</tr>
<tr>
<td>Endangered Species, 147 Kobus Road, Justin Oliphant</td>
</tr>
<tr>
<td>SADRAT (South African Development Research and Development Institute).</td>
</tr>
<tr>
<td>Surfing project in Plettenberg Bay (Focused on providing adolescents the opportunity to experience ‘natural highs’ and master a health promoting skill)</td>
</tr>
<tr>
<td>Body building at Erica Child and Youth Care Centre (041) 4562112</td>
</tr>
<tr>
<td>Karate club at Erica Child and Youth Care Centre, (041) 4562112</td>
</tr>
<tr>
<td>Famhealth – healthy body, healthy mind concept (gym) – Dr Govender (041) 457 2075</td>
</tr>
<tr>
<td>Helenvale Youth Enrichment Project (HYEP)</td>
</tr>
<tr>
<td>Northern Arts Festival (annual event hosted on heritage day, aimed at celebrating</td>
</tr>
</tbody>
</table>
Suggested reading


7.8.7.5 Practice guideline 4: Problem Identification and Referral

The practice guideline problem identification and referral is equated with early intervention (secondary prevention) on the Risk, Approaches and Prevention Continuum (McWhirter et al., 2013:289). Since the practice guidelines are located at a primary prevention level, it will not be discussed in the same amount of detail as the other five guidelines. In order to effect a referral for early intervention for drug related problems, parents and significant others need to be familiar with the warning signs of drug use. This aligns to the recommendation linked to practice guideline 1 for parents to be familiar with covert and overt signs of drug use. Practice guideline 1 would therefore be followed when working with parents, adolescent peers and teachers.

In addition, the indicators of drug use (as compiled by SANCA) are included in the practice guideline as an easy reference.

**INDICATORS OF DRUG USE**

<table>
<thead>
<tr>
<th><strong>Physical indicators</strong></th>
<th><strong>Behavioural indicators</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Changes in level of activity - periods of lethargy (common with dagga, alcohol, sedatives, cocaine and heroin) or periods of hyperactivity (common with dagga, stimulants and alcohol).</td>
<td>(a) Sudden aggressive and violent behaviour, unexplained outbursts of anger.</td>
</tr>
<tr>
<td>(b) Drastic increase or decrease in appetite.</td>
<td>(b) Unexplained restlessness.</td>
</tr>
<tr>
<td>(c) Unexplained increase or decrease in weight.</td>
<td>(c) Destructive behaviour, e.g. punching walls, swearing, fighting.</td>
</tr>
<tr>
<td>(d) Lack of coordination, staggering or slow movements, dropping of objects, clumsiness and falling.</td>
<td>(d) Unexplained irritability.</td>
</tr>
<tr>
<td>(e) Altered speech patterns: slurred or garbled speech, expressionless speech, abnormally fast speech, forgetting of</td>
<td>(e) Lack of motivation - sudden loss of interest in hobbies or sport previously enjoyed.</td>
</tr>
<tr>
<td></td>
<td>(f) Ongoing episodes of unexplained giggling.</td>
</tr>
<tr>
<td></td>
<td>(g) Sudden apathy towards life in general.</td>
</tr>
<tr>
<td></td>
<td><strong>Emotional indicators</strong></td>
</tr>
</tbody>
</table>

**Emotional indicators**
thoughts and ideas, incomplete sentences and incoherent conversations.
(f) Unusual shortness of breath, persistent cough, strange odour to breath and clothes (often with dagga and inhalants).
(g) Red-rimmed, bloodshot or watery eyes, drooping eyelids.
(h) Little sores around the mouth and unexplained chapped or cracked lips (inherent users).
(i) Yellow or brown stains on hands.
(j) Continuously runny nose and constant fidgeting with nose.
(k) Unexplained bleeding of nose.
(l) Increased susceptibility to infections and colds.
(m) Changes in sleeping habits: staying up all night but sleepy all day, or restless sleep.
(n) Changes in physical appearance: drastic changes in style of clothes, less concerned about appearance, which may become sloppy and unkempt.
(o) Severe agitation, lack of concentration.
(p) Unexplained shaking, tremors, nausea, vomiting and sweats or chills (may be an early withdrawal symptom).
(q) Distortion of perception of time.
(r) Reaction time slower; child becomes sluggish.
(s) Needle marks made by intravenous injection of drugs. If a child has such marks, he or she may start wearing long-sleeved shirts even in hot weather.
(t) - Unexplained and ongoing headaches.
(u) Drowsiness, especially during the day.
(v) Unusually dreamy, absent demeanour.
(w) Unusually or constantly dry mouth, or exaggerated or constant thirst.

(a) Sudden unexplained and ongoing nervousness.
(b) Low self-esteem.
(c) Decreased sense of responsibility.
(d) Sudden feelings of depression, despondency and hopelessness.
(e) Severe mood alterations, or mood swings, from euphoria to sudden anxiety and depression, and sudden hypersensitivity.
(f) Alterations in thought patterns - strange and bizarre thinking, hallucinations, paranoid delusions, abnormal suspiciousness, depressed thoughts, suicidal thoughts.

Social indicators
(a) Sudden withdrawal from family and friends.
(b) Sudden secretiveness, deviousness, vagueness, lies and deceit.
(c) Sudden change in friends, with the new friends usually older and/or suspected of using drugs, and a reluctance to introduce friends to family.
(d) Drop in school performance - overall lack of motivation with regard to schoolwork. Regular truancy, especially on Mondays - school attendance register can be utilised to obtain an overall view of absenteeism. Resentment towards all authority and disregard of all rules (at school, home, etc.).
(g) Disappearing for periods of time without being able to account for that time, e.g. coming home late at night or missing classes at school.
(h) Unusual interest in money.
(i) ‘Lost’ clothes or equipment, or money that cannot be accounted for

Further to the recommendations by the participants, problem identification and referral also pertains to adolescents’ needs for supportive counselling especially when parental support is ineffective or lacking. There is widespread consensus about the need for counselling services to be available at schools (NDMP, 2012-2016), but in the absence of available resources, teachers have been called upon to extend their role. The TLC initiative (Teacher Learner Care Initiative) at one of the high schools in the Northern Areas is a typical example of initiatives that can be undertaken by teachers.
Besides the fact that teachers lack the professional training and capacity to perform this role, the participants also expressed a preference for access to professional counselling services. In addition to the stipulations in terms of professional competence, Sue and Torrino cited in Simmons, Ungemack, Sussman, Anderson, Adorno, Aguayo, Khary Black, Hodge and Timady (2008:42) found that communities of color (viz. African American and Hispanics) expressed preference for services that were closely associated with their cultural values. The assertion by the authors that ‘people from historically underserved racial and ethnic groups often need support services in addition to therapy to maximimse the effectiveness of the intervention’ (Simmons et al., 2008:43), suggest that practitioners need to assess the nature and extent of clients’ needs. The assertion by several practitioners in the present study that group work is not a viable method of intervention in the Northern Areas communities, contradicts the recommendation for increased community cohesion, and therefore is regarded as a social construction that needs to be deconstructed.

Practical suggestions for operationalising the practice guideline

- Prevention practitioners can present brief information sessions to parents at parent meetings where they advise on the nature, capacity and procedure of their services.
- A culturally sensitive functional aid that can be used at the start of such a parent gathering is a group discussion that can be implemented as follows: The practitioner can introduce herself as a 'Welfare Lady' (a common term used to refer to social workers in the Northern Areas), and then ask the parents to brainstorm in small groups what they think: i) the role of a 'Welfare Lady' is, and ii) what they would wish the role of a 'Welfare Lady' to be in schools. The purpose of the exercise is to gain insight into parents’ constructions of social workers’ roles as well as serving as a non-threatening assessment of parents’ needs for social work services. It also provides practitioners with an opportunity to deconstruct any misconceptions which may have served as a barrier to seeking professional assistance.
- Practitioners need to guard against raising expectations that they would not be able to meet due to resource or other limitations.
- Schools and social service professionals can collaborate with the university Departments of Social Development Professions and Psychology, for the placement of student counsellors in training who can render youth development services at under resourced schools.
7.9 Conclusion of the practice guidelines for culturally sensitive drug prevention interventions

The practice guidelines were formulated to reflect the findings from the empirical study and a synthesis of the existing body of knowledge in the area of drug prevention. The guidelines are thus predicated on a clear empirical and theoretical foundation, and specify the knowledge, skills and attitude pre-requisites of the prevention practitioners. Furthermore, the guidelines specify the functional elements inherent in each of the strategies and offer practical suggestions in terms of how each practice guideline can be implemented, followed by a resource list or recommendations for useful reading where applicable.

7.10 CHAPTER SUMMARY

Chapter Seven provided a summary of the findings from the empirical study with the four participant groups, and culminated in the presentation of conclusions derived from these findings and the literature synthesis. The chapter further provided an overview of co-constructed recommendations for drug prevention interventions from each of the participant groups. These recommendations were subjected to a literature control, and combined with the earlier conclusions from the empirical study, served as the premise for the construction of the practice guidelines for culturally sensitive drug prevention interventions. The latter was presented in the second half of Chapter Seven. The final chapter of the thesis deals with the summary and conclusions derived from the research methodology, and concludes with recommendations for practice, further training and future research.
CHAPTER EIGHT

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

The present research study centred around the socio-cultural meaning constructions of adolescents from the Northern Areas communities in Port Elizabeth, a historically marginalised community, frequently called ‘the nowhere people’, and associated with stereotypes of drug use, intellectual inferiority and marginalised identity. The central focus of the study was to enhance an understanding of adolescent drug users, non-users, peer mentors and social service practitioners’ socio-cultural meaning constructions around the constructs ‘Coloured’, drug use, non-use and drug prevention. These findings served as the premise for the co-constructed practice guidelines for culturally sensitive drug prevention interventions.

Chapter One contextualised the focus and provided an overview of the study methodology implemented. Chapter Two provided a description of the literature around cultural sensitivity and a critical overview of existing drug prevention models. Chapter Three detailed how the narrative tradition of inquiry was employed as research design and how the methodological decisions were implemented in order to reach the research goal were motivated. An analysis of the narratives of the adolescent drug users were provided in Chapter Four, in the form of the metaphor of a journey. In Chapters Five and Six, the contributions of the four sample groups were presented, complemented by a literature control and excerpts from the participants’ narratives. Chapter Seven provided a summary and conclusions derived from the empirical study and the participants’ recommendations for drug prevention interventions. The latter section of Chapter Seven culminated in a description of the co-constructed practice guidelines for culturally sensitive drug prevention interventions. The present chapter shifts the focus to presenting the summary, conclusions, limitations and recommendations for the research methodology, followed by recommendations for practice, policy, training and education, and lastly, for future research.
8.2.1 Summary: Research methodology implemented in study

A narrative tradition of inquiry, embedded in a qualitative research approach and a constructivist research paradigm, was implemented to answer the research question. The study was conducted in two phases. The first phase comprised an exploration of the research problem and involved four distinct participant groupings. The second phase comprised the co-construction of the practice guidelines for culturally sensitive drug prevention interventions. Phase one started with the informal exploration of community stakeholders’ views on the identified research problem and the process of gaining access to the research population. The process of negotiating access and the actual recruitment of a research sample proved to be challenging, since this coincided with a spate of drug-related gang violence in the research community, which contributed to parents’ reluctance to consent to their children’s participation in the study. The inclusion of four sample groups was a challenging and time-consuming process, as it involved preparing numerous gatekeepers (i.e. social workers, school teachers, community volunteers, lay counsellors and a minister of religion) about the sampling criteria and the ethical procedures to follow in recruiting research participants. The dire need for professional counselling services in the research community became evident during engagements with the gatekeepers. This resulted in the abandonment of the researcher role on a few occasions, to arrange the screening and referral of adolescents for professional addiction counselling.

A non-probability purposive sampling method was employed to recruit 29 adolescent non-drug users and ten adolescent peer mentors (via the TADA Programme at one school). The same sampling method, followed by a snowball sampling technique, was employed to recruit ten adolescent drug users (in the recovery process) and nine social workers and social auxiliary workers respectively. The sample sizes were determined by the principle of data saturation.

The data generation method used in respect of the non-users took the form of semi-structured written narratives, administered in a group context during school time, instead of the originally planned individual interviews. This amendment was implemented to enhance the participants’ anonymity and to yield to the parents’
resistance against the audio recording of the individual interviews. The following questions served as prompts to elicit the written narratives:

- What does the word ‘Coloured’ mean to you?
- What do you think is the reason for the alcohol and drug abuse amongst adolescents from your community?
- How can alcohol and drug abuse be prevented amongst adolescents from your community?

A second round of data generation was implemented after the analysis of the written narratives revealed thin, narrow descriptions to the first and third questions listed above. Nineteen of the original 29 non-users participated in the second round of data generation. The two questions that were purposefully constructed to thicken the participants’ socio-cultural meaning constructions and to promote the potential for resilience and resistance against the dominant internalised stereotypes of cultural identity follow below:

- What do you appreciate about ‘Coloured’ identity and residing in the Northern Areas?
- What has enabled you to not become involved in alcohol and drug use?

The life-grid (Wilson et al., 2007:144), a qualitative visual tool for mapping important life events, was employed to guide the co-construction of the biographical narratives generated during the individual semi-structured interviews with the sample of adolescent drug users. The participants had the choice to either produce their story in written form as a drawing or in oral form. After the life-grid was explained to the participants, and the stationery and drawing/writing paper pointed out, the following prompt was provided as the invitation for participants to tell their stories:

‘I want to invite you to imagine that we are writing your life story and you can choose what you include in that story and what you leave out. The life-grid is merely a guideline
to help you along, but where you start and what you talk or write or draw about is up to you.’

Focus group interviews were used to enhance an understanding of the peer mentors and social service practitioners' views on the construct ‘Coloured’ and their existing drug prevention programmes. The following questions guided the qualitative focus group interviews:

- **What comes to mind when you hear the word ‘Coloured’?**
- **Can you share with me the drug prevention services that you render to adolescents from the Northern Areas communities? (in your school)**
- **Can you reflect on your experiences of being involved in these drug prevention programmes? (in terms of the responses of the adolescents; resources available to you; and the specific challenges that you encounter in rendering this service).**
- **What are your views regarding your current programmes and their impact on drug prevention to adolescents from the Northern Areas communities? (in your school)**

Each of the individual and focus group interviews were audio-recorded, transcribed and complemented by the field notes. Informal data gathering occurred through participant observation of two drug prevention programmes, attendance of a FAD Support Group meeting, and interviews with community volunteers and the SAPS Youth Development Forum.

Both the content and the context of the narratives were analysed to arrive at the themes, sub-themes and categories. The content of the narratives was analysed by employing categorical content analysis, whilst the form of the narratives (i.e. how the stories were told) was analysed by using narrative analysis. The socio-cultural approach to narrative analysis was employed to gain insight into the context of the adolescent drug users' narratives. The journey metaphor emerged from the adolescent drug users' narratives. The trustworthiness of the data and the verification of the research process were achieved by subscribing to the four characteristics of qualitative
research (Yardley, 2000). These entailed remaining sensitive to the context, employing commitment and rigour, transparency and coherence and, lastly, enhancing the impact and importance of the findings.

Four philosophical principles guided ethical conduct in the research, namely, autonomy and respect for the dignity of participants, nonmalifecence (avoidance of harm), beneficence, and justice.

Phase two of the research process entailed the co-construction of the practice guidelines. This phase was informed by comparing the empirical findings with existing drug prevention programmes and literature on cultural sensitivity. This resulted in the emergence of functional elements inherent in culturally sensitive drug prevention programmes, which formed the premise of the practice guidelines.

8.2.2 Conclusions relating to research methodology

The conclusion drawn from the summary of the research methodology and empirical findings was that the qualitative research approach, and in particular the narrative tradition of inquiry, would be an appropriate approach and design to use given the nature of the research goal. The qualitative approach enabled me to consult with the parents of parents of potential participants (refer to Section 3.6.2 in Chapter Three), resulting in an amendment of the data generation method for the one sample group. The qualitative approach furthermore permitted the involvement of the research community as experts on what they really need, thus endorsing the extensive engagement with various community stakeholders during the process of negotiating entry to the research population. The flexibility of the qualitative research approach further enabled me to alter the data generation method with the one sample group in order to accommodate parents’ concerns about the safety of their children. The research design not only facilitated the construction of participants’ stories in a non-threatening manner, it also ignited the development of a transformative agenda, which was achieved in two ways. Firstly, as a co-constructor of the participants’ narratives, I was able to employ the construct ‘Coloured’ in an evocative manner (Chase, 2005). Secondly, the iterative process of data generation and analysis allowed me to return to
the one sample group of adolescent participants when it became evident that further data generation was necessary to enlist an alternative story of hope and resilience (Miles & Hüberman, 1994 cited in Monette et al., 2011:433).

The inclusion of four different sample groups (and different methods of data generation) enhanced the richness and triangulation of the narratives (Creswell, 2007) and illustrated sensitivity to the data (Denzin & Lincoln, 2003). The analysis of the content, context and how the story was told, achieved the illumination of the differences and similarities in the participants’ meaning constructions of the same constructs.

8.2.3 Limitations relating to research methodology

Several limitations were inherent in the deployment of a qualitative research approach. The first one was linked to the time-consuming nature of qualitative research, which proved true in the present study. Enlisting the assistance of gatekeepers with a large load of additional responsibilities, delayed the research process. The pressure exerted by the gatekeepers to gain access to the researcher’s professional expertise instead of research skills required setting boundaries and adherence to the ethical guidelines. However, the value added by the gatekeepers surpassed and mitigated these limitations.

The dominant number of males in the sample group of drug users represented a largely male voice, which created an unbalanced picture, especially in a field where the extent of drug use amongst adolescent girls is rapidly increasing. The female voice therefore requires further investigation. Similarly, the number of females in the non-user group outweighed the males, making it imperative to explore the social constructions of a larger male adolescent contingent.

Two of the three samples of adolescent participants were recruited primarily through the school, hence omitting the voices of out-of-school adolescents on non-use and drug prevention.
The variable found to be common amongst the sample of drug users comprised learning problems at school. This could explain why all but one participant from this sample group chose to not write or draw their life stories, casting some doubt on the applicability of the life-grid as a data collection tool. The field notes, however, revealed that all the participants from this sample group utilised the life-grid guide as a positive conversation stimulant and to lend structure to their telling of their stories. The observation notes further revealed that the participants fixed their eyes on the life-grid as a guide whilst relaying difficult episodes or uncomfortable parts of their life story. The visual tool therefore served as a point of reference and a valuable self-management tool.

*The reader’s attention is drawn to the fact that the summary and conclusions relating to the empirical findings were presented in Sections 7.5 and 7.6 in Chapter Seven.*

8.3 Summary: Theoretical perspectives and models from literature relating to drug prevention

The literature review (Chapter Two) provided a detailed overview of the drug prevention approaches dating back to the 1930s along to the 21st century. The different models for experimental drug use and addictive drug use were reviewed with specific emphasis on their advantages, disadvantages and implication for drug prevention. The different levels and targets for drug prevention were reviewed and revealed the importance of taking into account the environmental and social contextual determinants of drug use when developing drug prevention interventions. This approach is in synergy with South Africa’s National Drug Master Plan and is particularly relevant to the context of the research community where drug use has been normalised and associated with community and cultural identity. Drug prevention interventions embedded in one or both conceptual frameworks, i.e. Social constructionist and Ecological systems risk/protective resilience frameworks were reviewed. This review was undertaken with the focus on cultural sensitivity in drug prevention, targeting each of the different ecological systemic layers, i.e. individual, family, peer, school, community and society. Drug prevention programmes (incorporating cultural sensitivity) that were empirically supported were reviewed in terms of their strengths, weaknesses and core functional
elements. These included the following: The Strengthening Families Programme 10-14 (SFP 10-14) (Kumpfer et al., 1989); Familia Adelante (Cervantes et al., 2011); Preparing for the Drug Free Years Programme (PDFY) (Kosterman et al., 1997); and The Strong African American Families Programme (SAAF) (Brody et al., 2004); The Healthwise Programme (Wegner et al., 2008:1056); and the Ke Moja (AYDF) drug prevention programme. The review specifically highlighted task-related activities that could be implemented to enhance positive youth development and resilience at family and community levels.

- **Conclusions relating to theoretical perspectives and models**

The conclusion derived from the literature review was that there had been a drastic shift in drug prevention over the years, from information sharing approaches, based on scare tactics and advocating abstinence, to more interactive methods, incorporating harm reduction approaches. Similarly, the value of comprehensive and multi-focused drug prevention interventions as opposed (and in addition) to individual focused drug prevention interventions has been recognised. The majority of these programmes, however, have remained focused on preventing the onset of drug use or reducing the harmful use of drugs, as opposed to focusing on the enhancement of individual, family and community resilience as building blocks to effect positive health promoting alternatives. Whilst the importance of cultural sensitivity in drug prevention has been recognised, there is inconsistency in how the concept ‘culture’ is applied in these programmes. Furthermore, the literature review revealed that there was insufficient empirical research on cultural sensitivity in drug prevention, especially in the South African context.

8.4 **Summary: Practice guidelines for culturally sensitive drug prevention interventions**

The empirical study and literature review culminated in an enhanced understanding of the socio-cultural constructions of ‘Coloured’, drug use, non-use and drug prevention of the research participants. These new insights formed the basis for the construction of
the practice guidelines for culturally sensitive drug prevention interventions. The focus of the practice guidelines was located in the domain of primary or universal drug prevention, aligned with that of the National Drug Master Plan (2012-2016) (South Africa, 2012a), namely to have a drug-abuse free South Africa.

The practice guidelines, embedded in a comprehensive multisystemic drug prevention approach, were founded on two goals: i) To promote the development of prosocial, health promoting behaviours and social competencies in adolescents; ii) To promote protective peer, school, family, community and societal processes which, through collaborative interaction, will contribute towards the delay and reduction in the onset of drug use and culminate in the development of stronger, supportive and cohesive systems. The four strategies that were developed to direct the accomplishment of these goals were as follows: strategy 1: co-construction of information; strategy 2: promoting positive youth development; strategy 3: promoting family, peer, school, community and environmental protective processes, and strategy 4: problem identification and referral.

- Conclusions: Practice guidelines for culturally sensitive drug prevention interventions

Based on the findings of the empirical study, as summarised and concluded in Chapter Seven, the literature review and the participants’ own recommendations for drug prevention (refer to Chapter Seven), the practice guidelines emanating from this study, foreground that drug prevention interventions must be informed by the social constructions of the participants whom the intervention is aimed at. The practice guidelines take the form of a comprehensive multisystemic prevention approach and makes provision for the involvement of multiple stakeholders. The strategies clearly reflect that the practice intervention ensues from the point of co-construction of information pertaining to the participants’ socio-cultural contexts and needs and ends with the referral for secondary prevention. The practice guidelines have clearly formulated goals for each strategy, as well as a reflection on inhibiting and enabling factors for goal attainment. The guidelines furthermore focus the attention of social service practitioners on the practice principles underpinning the guidelines, as well as the pre-requisites in terms of knowledge, skills and attitudes. Each strategy contains
practical suggestions for the implementation of the practice strategies, a reading list, and a list of existing community resources.

8.5 RECOMMENDATIONS

The ensuing recommendations are presented in three subsections:

8.5.1 Recommendations relating to research methodology employed

- The design of a qualitative study of this nature should ideally culminate in the implementation, evaluation and refinement of the practice guidelines. This will serve as justification for the amount of energy and time devoted to the study (by all the stakeholders) but, most importantly, ensure that the product emanating from the study is refined for implementation (refer to Section 8.5.2 below).
- Gatekeepers should be screened and carefully selected to ensure that they have the capacity and time to fulfil the role of gatekeepers amidst all their other life roles.
- The sampling criteria could be revised to ensure that a larger female sample of drug users and larger male sample of non-drug users are included. This will facilitate the inclusion of different voices in terms of gender and drug use.
- The structure of the narratives of the adolescent drug-users could be analysed in terms of the genre of the story, to further enrich the understanding of the participants’ stories.

8.5.2 Recommendations relating to practice, policy, professional training and continuing education

- Since drug prevention is regarded as a specialist field, it is recommended that the powers and duties of the Central Drug Authority and its supporting structures (i.e., the Provincial Substance Abuse Forums and Local Drug Action Committees) be expanded to ensure the coordination and implementation of training of prevention practitioners, the implementation of programmes, and especially the cultural adaptation and evaluation of prevention interventions (refer to the Prevention of and
Harker et al. (2008:34-35) emphasise the importance of ongoing supervision for all presenters of drug prevention programmes. It is further recommended that prevention workers stay informed about new developments in the field, especially given the degree of innovation and creativity by drug suppliers.

It is further recommended that the legislated bodies (referred to in the preceding bullet) focus on reducing the piecemeal or fragmented approach to drug prevention interventions, as different stakeholders could collaborate and combine their interventions. This will not only enhance the judicious utilisation of scarce resources, but will also reduce the competition for funding amongst the organisations and structures involved in prevention interventions.

The amendment of the Prevention of and Treatment for Substance Abuse Act 70 of 2008: Chapter 10 is recommended to ensure the inclusion of community representatives on the LDAC. This would not only strengthen the LDAC, but also offer an opportunity for community members to assume ownership for drug prevention and positive development interventions in their communities, as outlined in the practice guidelines (refer to Chapter Seven).

The research findings and practice guidelines should be disseminated at conferences and in professional journals, with the focus on:

- advocating for the promotion of comprehensive, multi-systemic culturally sensitive drug prevention approaches,
- adolescent peer-led interventions, and
- the review of strength-inhibiting social work practice approaches, with particular emphasis on the powerful influence social service practitioners have to either reinforce or contest social constructions of inferiority and powerlessness in the communities that they serve.

Social service practitioners can benefit from continuous professional development in reflective practice through which they can develop increased awareness to confront and review internalised stereotypes and restrictive approaches to practice.

Continuous professional development should also include more conscious training in asset-based approaches and strength-based approaches.

Most undergraduate social work training programmes have at least one module on drug abuse of which some component is normally devoted to drug prevention. It is
therefore recommended that undergraduate social work students receive more exposure to the field of drug prevention and that the development of post-graduate training programmes in drug prevention be explored, considering the seriousness of the drug scourge in South Africa. The re-curriculation of the Postgraduate (Masters) Programme at NMMU affords the opportunity to incorporate modules on drug prevention and health promotion, embedded in cultural sensitivity theories.

- Short learning programmes can be developed from the evaluated practice guidelines. This would be particularly relevant, as a short learning programme can incorporate a professional audience as well as community stakeholders.

- The rationale for reporting surveillance statistics of drug use (and other social problems) according to racial categories should be weighed up against its power to reinforce racial stereotypes (refer to Section 1.9 in Chapter One).

8.5.3 Recommendations related to future research

- It is recommended that an intervention research study be undertaken as further research, constituting a post-doctoral study. This would start with consultation with an expert panel (of drug prevention practitioners and community stakeholders). The practice guidelines can be reviewed in terms of feasibility, as well as the gaps ‘left by a research base of limited breadth and generalisability’ (Howard & Jenson, 1999:348). This should be followed by the refinement, subsequent implementation and evaluation of the practice guidelines.

The following research areas are recommended as further exploration and follow up to the topic under investigation:

- Parents’, teachers, social service practitioners and adult mentors’ perspectives about how they have been promoting positive cultural and community identity in children growing up in growth limiting socio-cultural contexts.

- Adolescent non drug-users’ perspectives on positive peer influence strategies.
Community role-players and volunteers' narratives of how they have been effecting positive adolescent development as alternative to drug use in growth limiting socio-cultural contexts.

8.6 CONCLUDING REMARKS

The findings of the present study provided insight into the socio-cultural constructions adolescents' have of the constructs 'Coloured', drug use, non-use and drug prevention. The conclusion derived from the study is that drug prevention interventions are more likely to succeed when it is co-constructed with members from the target community, tailored to their socio-cultural context. Such an intervention should take the form of a comprehensive, multi-systemic intervention that is culturally sensitive and contextually relevant, and actively defies narrow community and cultural identity constructions. Research shows clearly that regardless of the type of risk factors an individual or communities are exposed to, strengthening internal and external protective factors can diminish such risks and culminate in stories of resistance and resilience (Shochet et al., 2009:23). Moreover, harnessing a culture of positive development as a way of life at individual, family, peer, school, community and societal level, will result in a social construction of drug use as a health inhibiting and strength limiting behavior.


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543
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APPENDIX A

LETTER FROM THE Research Ethics Committee-Human

Chairperson of the Research Ethics Committee (Human)
NMMU
Tel. +27 (0)41 504-2538 Fax. +27 (0)41 504-2778
Ref: N 01/11/03/07 [H10-HEA-SDP-008/Approval]

Contact person: Mrs U Spies
11 January 2011
Dr B Pretorius
NMMU
Department of Research Capacity Development
Summerstrand South Campus

Dear Dr Pretorius

NARRATIVES OF ADOLESCENTS FROM URBAN COLOURED COMMUNITIES AS GUIDELINES FOR SUBSTANCE ABUSE PREVENTION PROGRAMMES

Your above-entitled application for ethics approval was round robin ed to members of the Research Ethics Committee (Human).

We take pleasure in informing you that the application was approved by the Committee.

The ethics clearance reference number is H10-HEA-SDP-008, and is valid for three years. Please inform the REC-H, via your faculty representative, if any changes (particularly in the methodology) occur during this time. An annual affirmation to the effect that the protocols in use are still those for which approval was granted, will be required from you. You will be reminded timeously of this responsibility, and will receive the necessary documentation well in advance of any deadline.

We wish you well with the project. Please inform your co-investigators of the outcome, and convey our best wishes.

Yours sincerely

[On behalf of] Chairperson: Research Ethics Committee (Human)

cc:   Department of Research Capacity Development

      Faculty Officer, Faculty of Health Sciences
APPENDIX B:

Letter and Informed consent form for the parents of adolescent participants

Dear Parent

Request for your child to participate in research on Narratives of adolescents regarding substance use, abuse and non use as guidelines for drug prevention programmes in the Northern Area communities

My name is Veonna Goliath and I am currently studying towards a Doctoral degree in Social Work at the Nelson Mandela Metropolitan University. I am conducting research amongst adolescents from the Northern Area communities and drug prevention practitioners with the view of contributing to the development of guidelines for more effective drug prevention interventions to adolescents from these communities.

In order for the study to proceed, I require participants from the coloured community who meet the following criteria:

* Should be between the ages of 16-18 years
* Live in the Northern Areas of Port Elizabeth
* Have used/abused any form of drug
* Have considered or started some form of intervention to stop the use/abuse of the drug

I will appreciate it if you would allow your son/daughter to participate in the study. If you choose to allow your son/daughter to participate in this research, he/she will be invited to participate in a semi-structured interview of approximately 60-90 minutes at a time and at a venue convenient to your child. Participation in the research is completely voluntary, and you have the right to withdraw your son/daughter (and your son/daughter has the right to withdraw in person) at any time. Confidentiality and anonymity will be maintained at all times throughout the process of data collection, analysis of the data and the completion of the doctoral degree.

A summary report of the findings will be made available to the participants. If you would like any further information or are unclear about anything, please feel free to contact me on (041) 5042197 or cell 072 1968 083. Your cooperation and your son/daughter's participation is valued and appreciated.

Kind regards

Veonna Goliath  
Doctoral student

Dr BML Pretorius  
Research Supervisor
DECLARATION BY PARENT OF PARTICIPANT

I, _________________________ (I.D. number ______________________________)

in the capacity of parent/guardian of

__________________________ (I.D. number ____________________________)

hereby confirm as follows:

(Please initial against each paragraph)

1 My child was invited to participate in the above mentioned research project, which is being undertaken by Veonna Goliath of the Department of Social Work in the Faculty of Health Sciences, Nelson Mandela Metropolitan University.

2 This research aims to help other researchers to develop and implement meaningful drug prevention strategies. The information will be used as part of the requirements for a doctoral degree in Social Work. The results of the study may be presented at scientific conferences or in specific publications.

3 I understand that I will need to complete the consent form and return it to the researcher on completion. In addition, my child will be required to share significant experiences they have had across their life span. (see the attached life grid that will be used as data collection tool)

4 My child’s identity will not be revealed in any discussion, description or scientific publication by the researcher.

5 My child’s participation is voluntary. My decision whether or not to allow my child to participate, or my child’s decision whether or not to participate, will in no way affect his/her present or future school career or lifestyle.

6 No pressure was exerted on me to consent to my child’s participation and I understand that I may withdraw my child, or he/she may withdraw at any stage without penalization.
Participation in this study will not result in any cost to my child or myself.

I CONSENT VOLUNTARILY TO ALLOW MY CHILD TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT.

Signed at __________________ on _________________________ 2012.

Signature of parent or guardian of participant: ____________________________
APPENDIX C

C1: Information letter to adolescent participants

Dear …………………………

My name is Veonna Goliath and I am a registered social worker and doctoral student at the Nelson Mandela Metropolitan University. As part of my studies I am conducting research on the stories (biographical narratives) of adolescents from the Northern area community regarding the use, abuse and non use of substances with the aim of helping to develop more effective drug prevention programmes for adolescents.

I want to talk to young people between the ages of 16-18 years so that I can learn more about their experiences of life from birth to present date in relation to this topic, and in particular their views on how substance prevention programmes should be altered to reduce the onset of substance use and abuse amongst adolescents.

I have chosen to interview a few young people your age and would like you to be one of those people. If you wish to participate, this is what will happen:

- You will have to sign a form to say that you want to be a part of the research. This is your choice; no one will be let down if you do not want to participate.
- I will then consult with your parents to obtain their permission for your participation in the study
- During the interview I will present you with a life grid (see attached copy) with the request that we talk about those different aspects of your life. You can fill this life grid in yourself during the interview and can make any drawings/ symbols that will illustrate your narrative (story). At the end of the interview you are also welcome to tell me what information you would like to retain, which information you think was omitted and what you would still like to add.
- I will use an audio recorder, which means that your answers during the interview will be taped. This is so I can remember everything that you say. You can listen to the tape if you wish to. I will make sure that no one else will be allowed to listen to the tape.
- Your identifying details, as well as those of your parents and your school’s will be kept private. This means that your name will not be mentioned anywhere. The form you will be asked to fill in will contain your details for me to be able to contact you to schedule an interview appointment, and to mail you the outcome of the study, but will not be used anywhere else.
- You have the right to choose to withdraw from the study at any time you wish, by merely informing me.

I thank you for your time and ask that you sign the assent form, if you wish to participate.

If you have any questions during the process please do not hesitate to call me or to request that I call you.

_________________________  _______________________
Ms Veonna Goliath    Dr Blanche Pretorius
Doctoral student/Researcher  Research Supervisor
(041) 5042197            (041) 5042309
C2: Informed assent form for the adolescent participants

<table>
<thead>
<tr>
<th>Paragraph Number</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>I was invited to participate in the above mentioned research project, which is being undertaken by Veonna Goliath of the Department of Social Development Professions in the Faculty of Health Sciences, Nelson Mandela Metropolitan University.</td>
</tr>
<tr>
<td>2</td>
<td>This research aims to help other researchers to develop and implement meaningful substance prevention strategies. The information will be used as part of the requirements for a doctoral degree in Social Work. The results of the study may be presented at scientific conferences or in specific publications.</td>
</tr>
<tr>
<td>3</td>
<td>I understand that I will need to complete the assent form and return it to the researcher on completion. In addition, I will be required to share significant experiences I have had across my lifespan.</td>
</tr>
<tr>
<td>4</td>
<td>My identity will not be revealed in any discussion, description or scientific publication by the researcher.</td>
</tr>
<tr>
<td>5</td>
<td>My participation is voluntary. My decision regarding participation (or non-participation) in the study will in no way affect my present or future school career or lifestyle.</td>
</tr>
<tr>
<td>6</td>
<td>No pressure was exerted on me to consent to my participation and I understand that I may withdraw from the study at any stage without penalization.</td>
</tr>
<tr>
<td>7</td>
<td>Participation in this study will not result in any cost or financial gain for me or my parent (caregiver).</td>
</tr>
</tbody>
</table>

Signature: __________________________
C3: Data gathering protocol: Life grid Interview

Thank you for agreeing to participate in this research study. The purpose of the study is to establish what meaning adolescents from the Northern Areas communities give to substance use, abuse and non use. This (show A3 page) is called a life grid and is a tool that will help us to talk about your own experiences from birth to the present. The top line of the grid represents the various age periods/stages in your life. The lines underneath resembles the different facets of your life, e.g., the first line ask you to reflect on your experiences of attending school, the second line about your friends/peer group, etc.

You can choose to start anywhere on the grid and as you remember significant times in your life; try to think of a name (metaphor) that you would give to describe this period or specific experiences. You are welcome to draw if that will help you to illustrate the point you will be sharing with me.

Afrikaans: Baie dankie dat julle ingestem het om deel te neem aan die navorsing. Die doel van die studie is om vas te stel watter betekenis adolesente van die Noordelike Areas heg aan middel (alkohol/dwelm) gebruik, misbruik en nie gebruik. Hierdie bladsy wat ek hier het noem ons ‘n lewensriglyn. Dit is ‘n hulpmiddel wat jou help om oor jou ervaringe te praat of dit te skets met betrekking tot jou lewe tot dusver. Daar is spesifieke temas (onderwerpe) waaroor ons kan gesels en jy kan kies oor watter een jy eerste wil praat, en ook oor hoeveel detail jy oor elkeen wil deel (indien enige). Die idée is dat jy dink aan ervaringe wat vir jou uitstaan as besondere goeie of minder goeie tye vir enige van die lewensfases. Jy kan ook dink aan ‘n metafoor wat jy kan gebruik om die spesifieke tyd in jou lewe uit te beeld. Jy is welkom om te teken (skets) op die bladsy en jy ook self aantekeninge maak/skryf op die bladsy wat jou gaan help om oor die spesifieke ervaringe te praat.

<table>
<thead>
<tr>
<th>Facets of life</th>
<th>0-6 years</th>
<th>6-10 years</th>
<th>10-12 years</th>
<th>12-14 years</th>
<th>14-16 years</th>
<th>16-18 years</th>
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<td>School</td>
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<td>Friends/peers</td>
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<td>Where you live</td>
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<td>Home/family life</td>
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<td>Home and care</td>
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<td>Responsibilities</td>
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<td>Interest, sports,</td>
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<td>Hobbies</td>
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<td>Interaction with other</td>
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<td>race groups</td>
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<td>Substance use, non</td>
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<td>use, abuse</td>
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<td>Prevention of</td>
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<td>substance abuse</td>
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</table>
APPENDIX D

Written narrative guideline (in Afrikaans)

Ouderdom: __________
Graad: _____________
Manlik/Vroulik __________

Beste _____________________

Baie dankie dat jy bereid is om van jou tyd op te offer om my te help met die navorsing. Die belangerikste doel van die studie is om riglyne te ontwikkel vir die voorkoming van alkohol en dwelmmisbruik onder adolescente in die Noordelike Areas. Kan jy jou gedagtes met my deel omtrent die volgende onderwerpe:

1. Wat beteken die woord KLEURLING vir jou?

2. Wat dink jy is die rede vir die groot mate van alkohol en dwelmmisbruik onder adolessente in die Noordelike Areas?

3. Hoe kan alkohol en dwelmisbruik onder kleurling adolessente VOORKOM word?

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

BAIE DANKIE VIR JOU DEELNAME AAN DIE STUDIE
APPENDIX E

E1: Information letter to service providers of drug prevention services

Dear Social Work/Social Auxiliary Work practitioner/TADA member

Request to participate in a FOCUS GROUP INTERVIEW

Title of the study: Narratives of adolescents regarding substance use, abuse and non use as guidelines for drug prevention interventions in the Northern Area communities of Port Elizabeth (Revised title: Practice guidelines for culturally sensitive drug prevention interventions)

My name is Veonna Goliath and I am a registered social worker and doctoral student at the Nelson Mandela Metropolitan University. As part of my studies I am conducting research on the stories (biographical narratives) of adolescents from the Northern area community regarding the use, abuse and non use of substances with the aim of helping to develop more effective drug prevention guidelines for adolescents in these communities. An important part of the study entails consulting with social work and social auxiliary work practitioners and TADA members who render drug prevention services to adolescents from these communities. The purpose of this letter is hence to request your participation in the study. Should you consent to sharing your valuable inputs, this is the process that will be followed:

- You will be required to sign an informed consent form indicating your voluntary participation in the project with the knowledge that your personal identity and that of your organization will be kept confidential; Furthermore that the privacy and intellectual property of your material is guaranteed and that it will not be reproduced in any form;
- You will be requested to avail yourself for at least 60-90 minutes for a focus group research interview where information about your experiences and views on drug prevention services will be explored (see the attached interview guide). The focus group interview will be recorded to ensure that none of the information gets lost;
- You can withdraw from the study at any point and there will be no consequences attached to such a withdrawal

I thank you for your time and request that you sign the informed consent form if you wish to participate. If you have any questions during the process please do not hesitate to call me or to request that I call you.

Ms Veonna Goliath
Doctoral student/Researcher
(041) 5042197

Dr Blanche Pretorius
Research Supervisor
(041) 5042309
E2: Informed consent form for the social work/social auxiliary work/TADA service provider

I, _________________________ (I.D. number___________________________)

(Please initial against each paragraph)

1 I was invited to participate in the above mentioned research project, which is being undertaken by Veonna Goliath of the Department of Social Work in the Faculty of Health Sciences, Nelson Mandela Metropolitan University.

2 This research aims to help other researchers to develop and implement meaningful substance prevention strategies. The information will be used as part of the requirements for a doctoral degree in Social Work. The results of the study may be presented at scientific conferences or in specific publications.

3 I understand that I will need to complete the consent form and return it to the researcher on completion. In addition, I will be required to share my experiences and views on drug prevention services to adolescents from the Northern Area communities

4 My identity will not be revealed in any discussion, description or scientific publication by the researcher.

5 My participation is voluntary. My decision regarding participation (or non participation) in the study will in no way affect my present or future career or lifestyle.

6 No pressure was exerted on me to consent to my participation and I understand that I may withdraw from the study at any stage without penalization.

7 Participation in this study will not result in any cost or financial gain for me or my employer.

Signature: ___________________________ Date: ______________________
E3: Data gathering tool for focus group interview with social work and social auxiliary work practitioners/TADA members

- What comes to mind when you hear the word “Coloured”
- Can you share with me the drug prevention services that you render to adolescents from the Northern Area communities?
- What promotes and hampers your presentation of the drug prevention services?
- Can you reflect on your experiences of being involved in these drug prevention programmes? (into the response of the adolescents; resources available to you; challenges, etc)
- What are your views regarding drug prevention services to adolescents from the Northern Area communities?
- How are they different or similar to programmes that you render in other communities?
- If you were to compile practice guidelines for social workers/social auxiliary workers who render prevention services to adolescents from the Northern Area communities what would you include?
TIGER by Katy Perry

I used to bite my tongue and hold my breath
Scared to rock the boat and make a mess
So I sat quietly, agreed politely
I guess that I forgot I had a choice
I let you push me past the breaking point
I stood for nothing, so I fell for everything

You held me down, but I got up (hey!)
Already brushing off the dust
You hear my voice, your hear that sound
Like thunder, gonna shake the ground
You held me down, but I got up
Get ready 'cause I had enough
I see it all, I see it now

I got the eye of the tiger, the fire
Dancing through the fire
'Cause I am a champion, and you're gonna hear me roar
Louder, louder than a lion
'Cause I am a champion, and you're gonna hear me roar!

Oh oh oh oh oh oh oh oh
Oh oh oh oh oh oh oh oh
Oh oh oh oh oh oh oh oh
You're gonna hear me roar!

Now I'm floating like a butterfly
Stinging like a bee I earned my stripes
I went from zero, to my own hero

You held me down, but I got up (hey!)
Already brushing off the dust
You hear my voice, your hear that sound
Like thunder, gonna shake the ground
You held me down, but I got up
Get ready 'cause I've had enough
I see it all, I see it now

I got the eye of the tiger, the fire
Dancing through the fire
'Cause I am a champion, and you're gonna hear me roar
Louder, louder than a lion
'Cause I am a champion, and you're gonna hear me roar!

Oh oh oh oh oh oh oh oh
Oh oh oh oh oh oh oh oh
Oh oh oh oh oh oh oh oh
You're gonna hear me roar!
You're gonna hear me roar!

I got the eye of the tiger, the fire
Dancing through the fire
'Cause I am a champion, and you're gonna hear me roar
Louder, louder than a lion
'Cause I am a champion, and you're gonna hear me roar!

You're gonna hear me roar!

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**TIK MONSTER**

*Written and performed by Local Rap Artist from the Northern Areas, Port Elizabeth, Shaido*

Pas Op Pas Op Hier Kom die Tik Monster/ and Klop aan jou deur soos n Wilde Renoster/ Hy wil jou aan Neem nd jou Lewe. Regeur/ Jou n Plak Gee om jou Ma se Purse Te Steel/

Hy's op soek na elke. Ras kullid. Swart of wit/ hy is n pragtige drug nd wil jou lewe verwis/ jou. Vernietig nd jou bring tot binne in jou kus/ bt eers speel hy saam jou nd wys jou hoe lekker die lewe is/

Hy maak jou baie lus nd gee jou oneindige rus/
Dit is n lekker plesier wat duur meer as n uur/
Hy is crystal wit nd sal jou maak loop deur die vuur/
Jy sal verbaas wees hoe hy nou jou lewe bestuur/

Hy sal jou baas raak dinge lat doen nd maak/ jy sal kwaad raak nd die mense rob met woede nd wraak/ nd al loop jy langs jou skoene jy sal hom nooit verlaat/ van die dag as jy jou by val dan is dit klaar te laat

Kyk Nou Kyk Nou Hier Kom Hy Weer/
Try hom Een keer nd jy sal Weer/
Try n Noge Keur nd dan voel jy verlee/
Nd die Derde Mal sal hy jou lewe oor neem/

Op Elke hoek nd Draai sal jy hom op soek/ Hy is we'll bekend nd almal ken hom as sjtoef/ Tik, Crystal Meth in n pakkie Toe Gewrap/ hy is die Beste Ja nd maak van die mooiste Ger n Slet/

Die Prys is Reg bring enige iets wat jy Het/ Hom lus is so diep nd dit lat water jou bek/ Ja hy is
jou laanie nd maak van al sy monster n gek/ Jy sal al jou besittings verkoop tot even jou buite Hek/

Dink Nou Dink Nou Voor jy dit Kom Try/ Hy sal jou Klap lat jy waai nd almal sien jy is die py/ Ja hy is die Tik Monster nd Wag Op Elke Draai/ Hy sal Jou Lewe Destroy nou net met en swaai

Daar was n oulike Meisie vol Lewe nd Beroep/ Net 16 jaar oud nd deur die monster besoek/ syt die bulpie geroek ja sy het gesjoef/ nd haar lewe verwoes toe sy half kaal le nd Roep/

Niemand was daar om ha aan te raak/ net die wrede draak met n pakkie in sy hand/ and offfer haar help uit har moeg gesukkelde hell/ van ha pa is n addict nd ma bly suip nd skel/

Syt verlief geraak op die monster die wrede draak/ van as sy ge choef het dan voel sy hy is altyd daar/ om haar uit te help van soggens tot laat/ nd sex te had nd saam verskillende manne te gan slaap/

N paar maande Later toe stoot sy die Kruipwa/ 9 maande pregnant nd sy weet nie wie is die Pa/ syt gesit nd gehuil nd gedink wat gan sy mak/ van n Bulbie nd n pakkie was altyd ha Beste Bra.

Wat gan an in die wereld vandag/ My Boeties kan nie slaap nie nd dwaal rond in die nag/ van almal bly so hoog hoog hoog hoog/ Van almal bly so hoog hoog hoog hoog/ Die ouens op die hoek bly n bulpie soek/ nd die Gere wil net choef hulle kry nie genoeg/ Pas Op Va die Tik Tik Tik Tik Monster
Pas Op va die Tik tik Tik Tik Monster`