# AUDIT OF PREVENTION PROGRAMMES TARGETING SUBSTANCE USE AMONG YOUNG PEOPLE IN THE GREATER CAPE TOWN METROPOLE: TECHNICAL REPORT

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MRC SOUTH AFRICA

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# EXECUTIVE SUMMARY

A cross sectional audit of prevention programmes targeting substance use among young people in the greater Cape Town Metropole was conducted in 2007. The study rationale was based on the fact that at present there is little known about alcohol and drug prevention services in the country. In addition, there are concerns about the quality of prevention services as (i) there is no legislation that regulates and oversees the training, qualification and competencies of prevention service providers and (ii) there are no minimum norms and standards to guide prevention interventions (SMART, 2007). As a result, prevention programmes are designed and implemented with little empirical evidence for what works. The information gathered in the audit starts to address this gap in current knowledge and may inform prevention service planning and delivery at local and provincial levels.

A questionnaire containing 47 questions was designed for the purposes of the audit. This questionnaire collected information on the types of prevention programmes offered and described the focus of prevention activities, skills levels of prevention workers, and evaluation methods.

The audit found that the majority of prevention services in Cape Town are provided by the non-profit sector. Most of the organisations rendering prevention services offer services on an ad hoc basis and as a secondary activity. This is partially attributable to a lack of funding for prevention services targeting substance use.

Prevention programmes offered to young people in the Cape Town metropole mostly target youth between thirteen and eighteen years of age. Only a few organisations target primary school children. The study further found that very few programmes target youth with a high number of developmental and social risk factors for substance use.

With regard to the types of programmes provided, the majority of organisations surveyed continue to provide education/information-based programmes. Although information-based programmes are useful in certain situations they do not necessarily meet criteria for best practice interventions. Only a small proportion of organisations offer skills-based prevention programmes, of which the majority are life skills programmes.

Although many organisations indicated that they used methods that are culturally sensitive, few were able to provide examples of such practices. As a result, findings regarding the use of culturally sensitive methods in prevention programmes should be interpreted with caution. Similarly, many organisations indicated that they address risk and protective factors in their prevention programmes. This implies the use of programmes that have a life skills focus, yet the majority of organisations did not offer skills-based prevention programmes.

The audit also focused on the extent to which organisations monitored and evaluated their prevention programmes. Organisations indicated that outcome and process evaluations were conducted on a regular basis, yet some discrepancies were noted. Specifically, they were unable to provide evaluation reports and they were unable to describe the findings from these evaluations.

From the study findings, a number of recommendations relating to policy, practice and further research can be made. First and foremost is the need for the national regulation and accreditation of prevention providers and prevention programmes in the field of substance use disorders. Related to this, minimum norms and standards for the prevention of substance use need to be developed and implemented. Thirdly, prevention programmes need to be implemented in a coordinated and efficient manner as opposed to the fragmented, ad hoc fashion in which programmes are currently being offered.

Taking into consideration the escalating levels of substance abuse in Cape Town, it is further recommended that funds be injected into prevention activities. Funds specifically allocated for prevention would encourage organisations to adapt and expand existing programmes to fit the needs of diverse age groups and allow organisations to reach all levels of the community, particularly those that are more susceptible and exposed to substance related harm. Funding, however, should be contingent, on organisations following evidence-based practices for prevention among young people and targeting those most at risk for developing substance use disorders. Funding should also be contingent on evidence of the effectiveness and impact of prevention activities. The routine evaluation of prevention programmes should be a minimum condition for the receipt of state funding. As such, organisations should be capacitated to conduct routine and systematic evaluations of prevention programmes.

# PART 1: BACKGROUND

## 1.1. WHY FOCUS ON PREVENTION IN SOUTH AFRICA?

South Africa has experienced escalating levels of substance use during its transition from apartheid to democracy (Central Drug Authority 2006; UNODC, 2004). Since 1991, the number of young people treated for substance-related problems in South Africa has increased significantly (Parry et al, 2004). The high proportion of adolescents who use alcohol and other drugs (AODs) is particularly evident in the Western Cape. The 2002 National Youth Risk Behaviour Survey of 10 699 school-going adolescents reported prevalence rates of 23% for past-month binge-drinking and lifetime prevalence rates of 13% for cannabis use, 6% for cocaine, 12% for heroin, and 16% for the inappropriate use of over-the-counter and prescription medicines (Reddy et al., 2003). Pettifor, Rees and Stevens (2004) reported lifetime national prevalence rates of 56% for alcohol use and 9% for cannabis among 15 to 24 year olds (N = 11904). In contrast, Shisana et al. (2005) reported lower lifetime prevalence rates of 7% for risky drinking, 2% for cannabis and less than 1% for the use of other drugs (N = 23 572). Treatment data obtained through the South African Community Epidemiology Network on Drug Use (Plüddemann et al., 2006) indicates similarly high proportions of individuals under the age of 20 receiving treatment from 19% in Bloemfontein to 28% in the Western Cape.

South African research has demonstrated that significant proportions of school-going adolescents misuse substances (Parry et al., 2004a). Recent school surveys, for example, reported that more than a third of male students in Cape Town and over half of male students in Durban reported binge drinking episodes in 1997 (N = 2930) and 1998 (N= 3030) respectively (Parry et al., 2004a). This is cause for concern, not only because heavy drinking by school-goers is significantly associated with absenteeism, academic failure, risky sexual behaviour (Flisher, Parry, Evans, Muller & Lombard, 2003), increased risk for sexual victimisation (King et al., 2003; Morojele & Brook, 2005), and increased likelihood of other drug use (Grossman, Chaloupka, & Sirtalin, 1998), but also because these adolescents represent the country's future workforce. These findings together with findings from the 2002 Youth Risk Behaviour Survey (Reddy et al., 2003) suggest that a significant proportion of South African adolescents require, if not formal AOD treatment then at the very least, brief interventions to reduce their risk of developing AOD problems (Parry et al., 2005). It also raises questions about the success of efforts to prevent or delay substance use and its associated negative consequences among young people.

Compared to other sites in South Africa, the need for effective interventions targeting substance use among young people is particularly evident in Cape Town. Findings from national household surveys reflect higher prevalence rates for risky drinking in the Western Cape Province (of which Cape Town is the capital) relative to the other provinces. For example, the 2002 Youth Risk Behaviour Survey reported that 34% of school-going adolescents binge-drink in the Western Cape, which is significantly greater than the national average of 23% (Reddy et al., 2003). Shisana et al. (2005) also found that compared to other provinces, the Western Cape had the highest prevalence of risky drinking (16%), followed by the North West Province (13%) and the Northern Cape (12%). The remaining six provinces had risky drinking prevalence rates below 10%.

The incidence and prevalence of substance use among young people highlights a worrying trend and raises the need for various interventions to curb the use of substances, particularly prevention activities. Researchers and policy makers have identified a clear need for comprehensive prevention programmes for youth in the Western Cape (Morojele, Knott, Myburg & Finkelstein, 1998). The field of substance abuse prevention however, lacks the organisational framework through which prevention services can effectively and efficiently be delivered (Central Drug Authority 2006). Without this infrastructure, assuring quality, monitoring performance, and diffusing new ideas and technologies becomes difficult (Merrill, Pinsky, Killeya-Jones, Sloboda & Dilascio, 2006).

## 1.2. WHAT IS PREVENTION?

Prevention activities can facilitate change in

substance abuse trends within community and other social networks. Prevention is most often defined as any activity designed to prevent or delay the onset of substance use and reduce its health and social consequences (World Health Organisation (WHO), 2002). Specifically, prevention activities focus on (i) preventing the use or uptake of psychoactive substances, (ii) delaying the age at which substance use begins and (iii) preventing problem use of legal substances such as alcohol (DiClemente, 1999; WHO, 2002). In its narrowest sense, it targets individuals and their peers, and at the broadest level it takes the form of international treaties, conventions and other structural interventions.

**Universal, selective and indicated prevention interventions**

Preventative interventions can be classified as universal, selective or indicated (Medina-Mora, 2005). *Universal prevention interventions* target the general public or a whole population. School-based prevention programmes are a popular form of universal prevention among youth as schools facilitate easy access to a large part of this population (Burkhart, 2007). These prevention activities can be educational or psychosocial in focus (Foxcroft, Ireland, Lister-Sharp, Lowe & Breen, 2003). Educational interventions are aimed at preventing the onset of substance abuse via awareness raising and information-sharing activities. In contrast, psychosocial interventions are aimed at developing psychosocial skills (for example to resist peer pressure and to enhance self-esteem). Educational interventions are the most common form of prevention activity in South Africa.

*Selective preventive interventions* are aimed at subgroups of the population whose risk of developing substance use disorders is significantly higher than the general population. Among young people, such interventions are mainly focused on truants, young people at risk of leaving school early, dropouts, young offenders, and youth from neighbourhoods with difficult socio-cultural conditions (Burkhart, 2007). Identifiers for increased risk include falling school grades; consumption of alcohol and other gateway drugs; conduct disorders; and alienation from parents, school, and positive peer groups (Burkhart, 2007; Medina-Mora, 2005).

*Indicated interventions* target individuals who are exhibiting early signs of problematic substance use and/or other problem behaviours. This problematic substance use is then targeted through focused interventions. Early interventions for substance misuse fall into this category of intervention.

**Addressing risk and protective factors in prevention programmes**

One of the generic principles of effective substance use prevention among young people involves reducing the factors that place young people at *risk* for initiating substance use and enhancing factors that *protect* young people from starting to use substances (NIDA, 2003). Risk factors have been defined as those that increase an individual's risk of taking drugs (UNODC, 2004). Evidence suggests that early initiation into substance use is most clearly predicted by the cumulative number of elevated risk factors, rather than by any specific risk factor (Loxley et al., 2004). Young people with high scores on risk scales and low scores on protection scales are more likely to drink in a risky fashion, smoke, use illicit drugs, experience mental health problems, and have conduct disorder. As such, it is important to target both risk and protective factors in substance use prevention programmes. Table 1 depicts some of the specific risk and protective factors that should be targeted.

**Table 1: An overview of risk and protective factors for the initiation of substance use**

| PROTECTIVE FACTORS: | RISK FACTORS: |
|---|---|
| Strong, positive family bonds | Chaotic home environments, especially where parents abuse substances. |
| Parental monitoring of children's activities and their peers | Ineffective parenting, especially of children with difficult temperaments or conduct disorders and lack of parent-child attachments. |
| Clear rules of conduct that are consistently enforced within the family | Failure in school performance |
| Involvement of parents in the lives of their children | Poor social coping skills |
| Success in school performance and strong bonds with institutions such as schools and religious organisations. | Liaisons with peers who display deviant behaviour. |
| Adoption of conventional norms regarding drug use. | Mental health issues. |
| Life skills | Seeking short term versus long term gratification |

## 1.3. STUDY RATIONALE

Drug prevention work in South Africa was historically based on opinion rather than evidence of effectiveness (UNODC, 2004). Scare tactics, which employed the use of extremely visual material, were frequently used to reinforce the message that drugs were dangerous. This was largely based on the philosophy that if individuals saw the negative consequences of drug use they would choose not to use drugs. In more recent years, emphasis has shifted to information-based programmes with a strong life skills component, covering a variety of topics such as decision making skills, self-esteem and peer pressure (UNODC, 2004). Concerns have also been raised about the quality of substance use prevention in the country. Although prevention programmes are amended on a regular basis, there is presently no legislation that regulates and oversees the training, qualifications, and competencies of primary prevention service providers. There are also no minimum norms and standards to guide prevention interventions (SMART, 2007).

In general, little is known about the structure and content of South African substance use prevention services. A review of the literature on substance abuse interventions in South Africa revealed that very little is known about (i) prevention programmes aimed at addressing substance use among young people, and (ii) the effectiveness of such programmes in curbing substance use. This study begins to address this gap by auditing existing prevention services for substance use among young people in Cape Town. This audit provides evidence on the characteristics, scope and content of prevention programmes.

**Why focus on Cape Town?**

The prevention audit was piloted in the greater Cape Town metropole due to the large burden of harm substance use places on this city (Parry et al., 2004). The decision to conduct the pilot in Cape Town was also partially linked to the escalating methamphetamine problem in the area, and the need to intensify efforts to prevent methamphetamine use in Cape Town (Plüddemann et al., 2006).

# PART 2: METHOD

## 2.1. THE STUDY PURPOSE

The overall purpose of the pilot study was to investigate the feasibility of conducting a national prevention audit by pre-testing the methods and instrument to be used in a national prevention audit. In addition, this study hoped to provide preliminary data on the structure and content of prevention programmes in the Cape Town metropole.

## 2.2. STUDY AIMS

- To describe the characteristics of prevention programmes targeting substance use among young people in Cape Town.
- To describe the types of services offered, the target audiences, resources utilised, programme intensity, and the skills levels of prevention service providers.
- To describe the use of monitoring and evaluation tools within prevention services.
- To use this information to inform current prevention service planning and delivery at local and provincial levels.
- To disseminate the information collected to local, provincial and national stakeholders.

## 2.3. METHODS

**Study Design**

A cross-sectional survey of prevention programmes targeting substance use among young people was conducted in Cape Town in 2007.

**Sample**

The sample comprised all directors or unit heads of organisations in the greater Cape Town Metropole that provide prevention programmes targeting substance use among young people in Cape Town. For the purposes of this audit, the term "young people" refers to the population aged 10-21 years of age. This age range was chosen as it was felt that this group would benefit most from prevention services and because this group has been used in previous research studies (Nkowane, Rocha-Silva, Mbatia, Ndubani & Weir-Smith, 2004).

All organisations providing prevention services, either as a primary or secondary focus, were included in the study. The sample frame was constructed from a list of known prevention services. These services were extracted from the MRC database of substance abuse service providers and other agencies identified from key informant interviews. Snowball sampling was used to expand this list. That is, key informants acted as gatekeepers and provided the researchers with the names of other prevention service providers that were known to them. This sampling continued until saturation occurred and no new service providers were identified.

**Questionnaire**

Data for the audit were collected by means of a structured questionnaire. The primary prevention audit questionnaire is a 10-page instrument that contains 44 questions, some of which required multiple responses. The questionnaire was divided into 4 focus areas which included questions on the characteristics of the organization, the types of prevention programmes offered, staffing characteristics and monitoring and evaluation methods. The first draft of the instrument was based on the Treatment Services Audit (TSA) questionnaire used for the purposes of auditing substance abuse treatment facilities in South Africa. Modifications made were based on inputs from 5 local key informants and an international expert in the drug prevention arena.

**Procedures**

The primary prevention facilities in the sampling frame were contacted via telephone and asked to participate in the study. This was followed by a letter confirming participation in the study. The letter provided a brief description of the audit as well as a consent-to-participate form. The questionnaire was either posted or faxed to participating centres in April 2007. Participants were requested to complete the forms within two weeks. The initial response rate was poor and the date for submission was extended three times to ensure a response rate of at least 65%. The investigators made regular follow-up telephone calls with participants to determine if there was a need for assistance in completing the forms. Completed questionnaires were returned to the investigators between July and September 2007. The response rate for the questionnaire was 74%, with 35 of the 47 organisations completing the questionnaire.

## 2.4. DATA ANALYSIS

Statistics for this study were computed using the Statistical Package for the Social Sciences (Norusis/SPSS Inc., 1988). The focus was on descriptive data and no hypothesis testing took place.

## 2.5. ETHICAL ISSUES

The data collected in this study relate to organisations offering prevention programmes rather than the individual clients of these services. Data on individual clients were not collected. Organisations were assured that no data would be reported that could identify individual organisations. Each participating organisation completed an informed consent form which has been filed and treated as confidential. Ethics approval for conducting the study was granted by the Committee for Human Research at Stellenbosch University.

# PART 3: RESULTS FROM THE AUDIT OF PREVENTION PROGRAMMES TARGETING SUBSTANCE USE AMONG YOUNG PEOPLE IN THE CAPE TOWN METROPOLE

## 3.1. PROFILES OF ORGANISATIONS AND TARGET POPULATIONS

This section describes the characteristics of the organisations rendering prevention services as well as their target populations.

**Proportion (%) of organisations rendering prevention services by type of organisation**
Generally, prevention services in South Africa fall into one of four business categories: state or public sectors, non-profit organisations (NPOs), private for profit, and community based organisations (CBOs). State/public organisations refer to those organisations that are owned, managed and overseen by government. Non-profit organisations' (NPOs) primary objective is supporting an issue or matter of private interest or public concern for non-commercial purposes, without concern for monetary profit (Wikipedia, 2007). In contrast community based organisations (CBOs) provide social services at local level, are often non-profit organisations but are based primarily on volunteer efforts and rely on volunteer contributions for labour, material and financial support (Chevetto-Salles & Geyer, 2006). Of the 34 organisations that participated in the study, the majority (57% (20)) were NPOs. CBOs comprised 11% (4) of the sample, with private for profit and state facilities comprising 17% (6) and 14% (5) of the total sample (Figure 1).

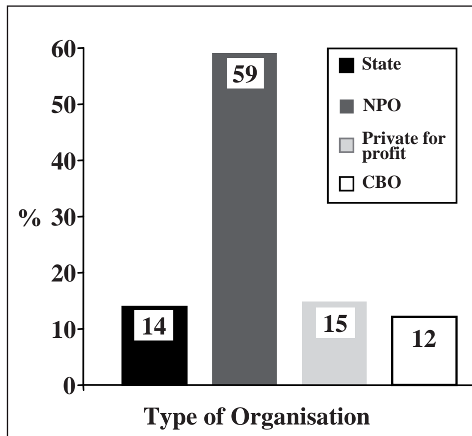


*Figure 1. The proportion of organisations rendering substance abuse prevention services by type of organisation*

**Organisational profile by substance abuse prevention focus**
Primary prevention activities in South Africa have generally been conducted on an ad hoc basis mostly because official funding for prevention activities is limited (UNODC, 2004). As a result most treatment centres offer substance abuse awareness and education programmes as part and parcel of treatment services to the community. This study found that of the 35 organisations sampled, 51% indicated that substance abuse prevention is a secondary and not a primary focus (Figure 2).

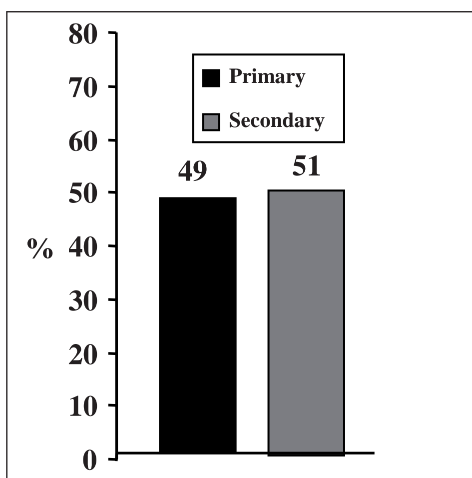


*Figure 2. Proportion (%) of organisations offering substance abuse prevention programmes as a primary or secondary focus*

For those organisations where substance abuse prevention was a secondary activity, the most frequently reported primary activity was the provision of substance abuse treatment followed by crime prevention and homeless shelters (Table 2).

*Table 2: Types of primary services offered by organisations*

| Primary Service | N | % |
|---|---|---|
| Adolescent training and development | 1 | 3 |
| Child Protection and counseling services | 1 | 3 |
| Crime Prevention | 2 | 6 |
| Family preservation | 1 | 3 |
| Health Promotion | 1 | 3 |
| Substance abuse treatment services | 7 | 20 |
| Life skills and AIDS awareness | 1 | 3 |
| Faith-Based | 1 | 3 |
| Shelters | 2 | 6 |

**Proportion of total budget allocated to prevention services**
Of the organisations sampled, 48% allocated money to their prevention budget. Of these, a quarter (22%) indicated that 50% or less of the budget was allocated to prevention activities whilst 11% of respondents indicated that their entire budget was spent on prevention activities. A further 23% indicated that no budget was allocated for prevention services and 29% of the respondents did not answer the budget related questions. It seems that despite the extent and gravity of the substance abuse problem in Cape Town, very little money is invested in prevention programmes (UNODC, 2004). No significant difference was found in the allocation of budgets on the basis of whether prevention services were a primary or secondary service.

**Number of years in operation and provision of AOD services**
Forty-five percent of organisations were in operation for more than 10 years. Only 3% of the sample has been in operation for less than 1 year. More specifically, 31% of organisations indicated providing substance abuse prevention services for more than 10 years and 26% for 3-5 years. Two organisations who have been in operation for more than 10 years reported introducing substance abuse prevention services in the last three to ten years.

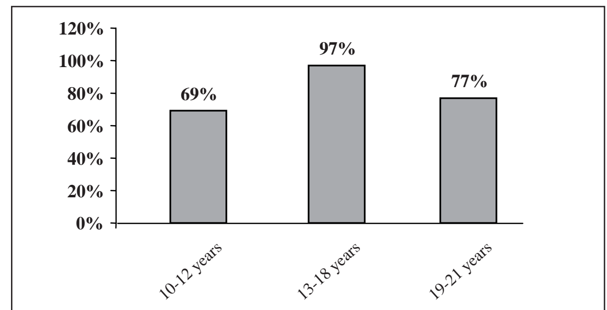


*Figure 3: Length of years in operation and services offered*

**Age distributions of persons targeted for substance prevention programmes**
A large proportion of organisations (97%) target young persons between 13 to 18 years of age. Sixty-eight percent of organisations target people between 10 and 12 years of age (see figure 4).

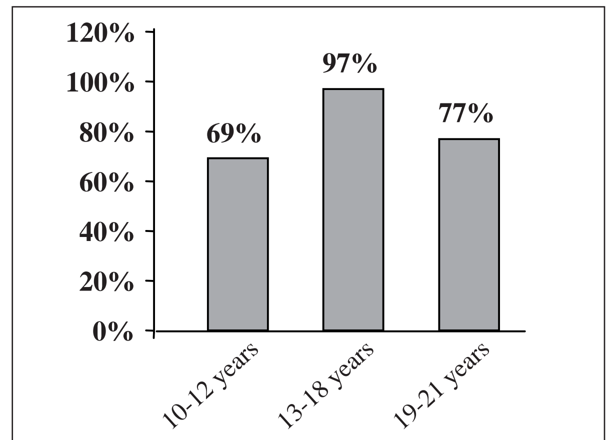


*Figure 4: Age groups targeted by organisations (%)*

**Targeting young people**
The findings (see Figure 5) show that prevention programmes are more likely to target young people in primary (71%) and secondary (88%) schools than in other institutions. Schools tend to be a logical place to (i) introduce prevention activities as part of a universal prevention approach and (ii) for the early identification of substance-related problems (Halfors & Van Dorn, 2001). However, this excludes young people who are not in the school system and who may be most at risk for substance use disorders. More specifically, this study found that less than half of organisations target youth offenders (that is youth under the age of 18 who are presently within the criminal justice system) (40%);

gang members (31%), street children (34%) and children in state institutions (45%).

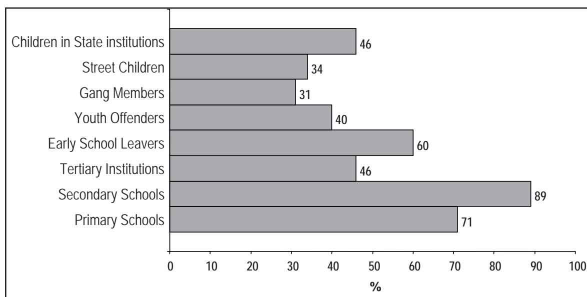


*Figure 5: Targeting young people- places for prevention activities*

**Targeting parents and communities regarding substance use among young people**
Most organisations (85%) target parents in their prevention programmes (Figure 6). Although the content, depth and scope of these parent-centred programmes is unknown, this is in keeping with the prevention principle of addressing familial risk factors such as family disruptions, poor supervision, criminal behaviour and parental drug use.

Community education happens to a lesser degree, with only 59% of organisations targeting community leaders. There is strong evidence that public education campaigns can contribute to reductions in smoking and risky alcohol use, if other reinforcers such as law enforcement and tax increases are also in place. One organisation reported targeting shebeen owners and another organisation reported prevention efforts targeting pregnant women.

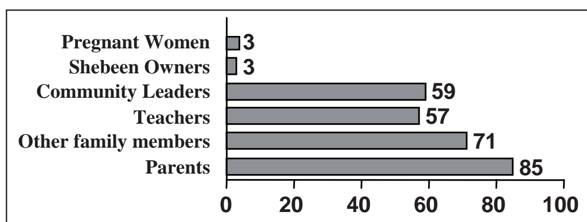


*Figure 6: Proportion (%) of the adult population targeted by organisations offering primary prevention services*

The study also shows that 57% of organisations direct their prevention efforts towards teachers. This is in keeping with the South African policy framework for addressing drug use within educational institutions. This policy recommends that teachers are given drug awareness training as part of systemic prevention efforts.

**Racially defined social groups**
The findings show that all racially defined social groups are targeted in prevention programmes. From the total sample, 88% of organisations target the black African population; 100% target Coloured communities; 73% target Asian communities and 82% target white communities (Figure 7). While these findings seem to contrast with findings related to the representativeness of treatment programmes (Myers, 2002), the actual proportion of Black/African and Coloured young people served by prevention services is unknown.

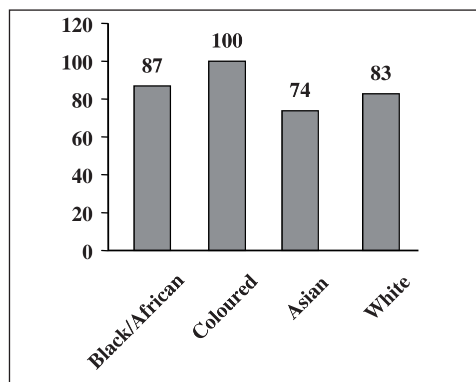


*Figure 7. Proportion of racially defined social groups targeted by organisations*

## 3.2. PROFILE OF PREVENTION PROGRAMMES

This section describes the characteristics of prevention programmes that participated in the audit.

**Type of prevention programmes provided**
The audit found that 91% of all prevention programmes are education programmes (Figure 8). For the purpose of this study, education programmes are defined as those that raise awareness of substance use by providing knowledge about substances and their consequences, with the overall aim of preventing young people from misusing substances (Foxcroft, Ireland, Lister-Sharp, Lowe and Breen, 2003). A smaller proportion of services offer skills-based prevention programmes, with life skills programmes only

offered by 57% of services (Figure 8). These programmes aim to develop psychosocial skills (such as coping skills and peer pressure resistance skills) that will enable young people to avoid the use of alcohol and other drugs. Fifty-one percent of organisations report offering both education and life skills programmes depending on the request from the consumer. A further 6% share their personal experiences of drug use as a means of preventing substance use. On average, the length of each prevention session ranges from 45 minutes (for once-off educational sessions) to 3 hours (life skills sessions).

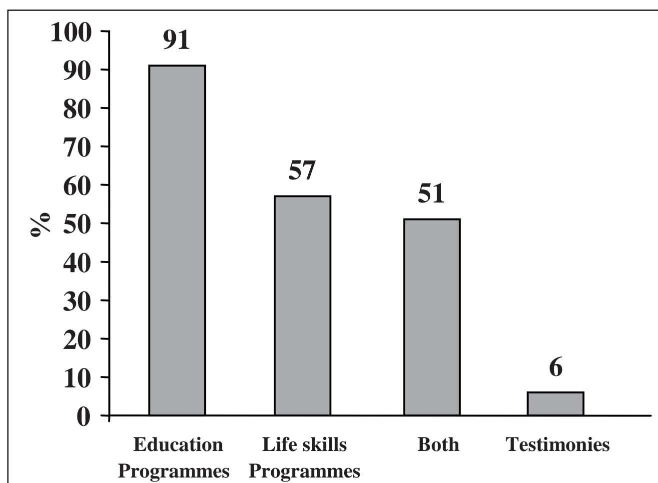


*Figure 8: Proportion of organisations offering education, life skills or other primary prevention programmes*

Organisations were further asked to comment on the *kinds of substances* their prevention programmes focused on. In recent years, the tendency has been to focus prevention programmes on illicit drug use only with very little focus on the use of alcohol and tobacco products by youth. This is ill-advised considering that drugs, both legal and illegal, cause an immense amount of illness, disruption and distress (Loxley et al, 2003). The organisations participating in the study, however, placed equal focus on both legal (91%) and illegal drug (97%) use.

With regard to *key programme objectives,* 97% of organisations aim to raise awareness of the consequences of substance use, 79% aim to prevent initiation of use among those not yet using alcohol and drugs, 85% address specific risk factors related to substance abuse, and 53% aim to mobilise community action against substance use.

**Use of cultural sensitive methods in substance use prevention**

Cultural sensitivity, is "the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of a target population as well as relevant historical, environmental and social forces are incorporated in the design, delivery and evaluation of targeted health promotion materials and programmes" (Resnicow et al., 2000). Cultural sensitivity is one of the most widely accepted principles of public health. All public health initiatives should emphasise the importance of integrating community needs with evidence-based practices in a manner that respects cultural diversity and promotes sustainability (Rand Health 2007). For instance all prevention projects should be appropriate to the age group targeted to ensure comprehension. Primary prevention programmes for use within particular groups should also take into account trends in local drug use, religious needs, cultural norms and values, physical diversity, children with special needs who may require special medication, and gender differences. These programmes should also cater for the needs of people from different socio-economic groups (MentorUK, 2006).

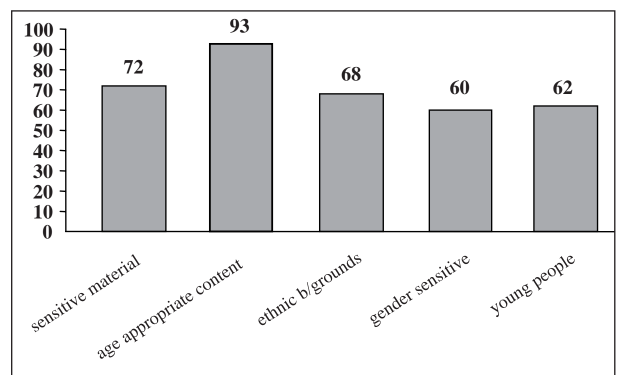


*Figure 9: Use of culturally sensitive methods by organisations offering primary prevention services in Cape Town*

Although, the majority of organisations responded in the affirmative to the questions on the use of culturally sensitive methods (Figure 9), these data should be interpreted with caution as most organisations could not describe the specific culturally sensitive practices they employed. More specifically, in this study, 93% of organisations indicated the use of age appropriate content and 72% reported the use of culturally sensitive material

(Figure 9). However only 14% of organisations provided examples of the culturally sensitive methods used. Sixty percent of organisations reported making use of material that is gender sensitive, but could not provide examples of such methods.

### Use of interactive methods in prevention programmes

The use of interactive teaching methods rather than didactic approaches and the active involvement of young people in programmes are generally considered to be principles of effective prevention programmes (UNODC, 2004). Active discussions assist in challenging misconceptions that children hold about the normative use of drugs among peers (UK Mentor, 2006). In this study, most organisations make use of discussions (77%) and group feedback (77%) as interactive teaching methods. The use of peer counsellors has been cited as useful in engaging youth in discussions, yet only 3% of organisations make use of peer educators or counsellors. Peer educators are powerful resources because they model normative attitudes - but only when implemented well and with the backup and management skills of professionals (Loxley et al 2003).

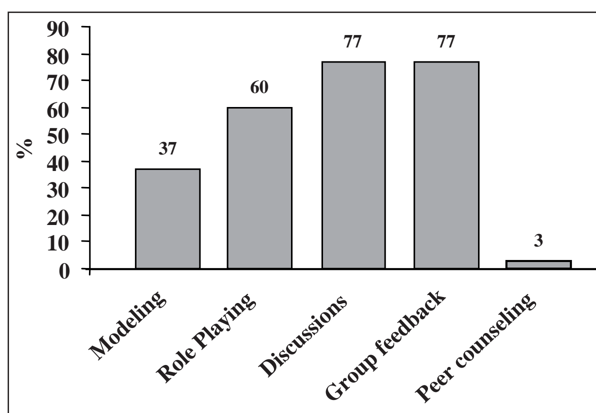


*Figure 10: Proportion of organisations using interactive methods as part of primary prevention programmes.*

### Proportion of prevention facilitators with a history of AOD use and length of abstinence

The findings show that 65% of all facilitators involved in prevention work have a history of substance use and 71% have been abstinent for less than 3 years. This is contrary to the Alcoholics Anonymous (AA Guidelines) guidelines for people employed in the alcohol use disorder field. These guidelines recommend at least 3-5 years of uninterrupted sobriety before tackling a paid job in the substance abuse field (AA Guidelines).

### Proportion of prevention facilitators with relevant qualifications and training

The complexity of substance use, its impact on public health, advances in treatment and prevention research as well as an escalating demand for services suggests that the manner in which prevention initiatives are conducted should be based on the best possible evidence (CARBC, 2006). Evidence based interventions are based on evidence of what works and what works most effectively, to bring about the best possible outcomes for the client and target population (CARBC, 2006). This evidence is derived from scientifically sound evaluations of interventions such as randomised controlled trials (RCTs) and meta analyses of RCTs. In order to ensure that prevention programmes are evidence based and meet best practice standards, prevention workers should be trained in both the theory and practice of prevention. Also, prevention workers should be proactive in up-skilling themselves in their chosen field. Study findings, however revealed that half of all respondents had no specialised training in the prevention of risky behaviours, less than a quarter had any training in substance use disorders, and roughly a third of all organisations had no training in working with young people.

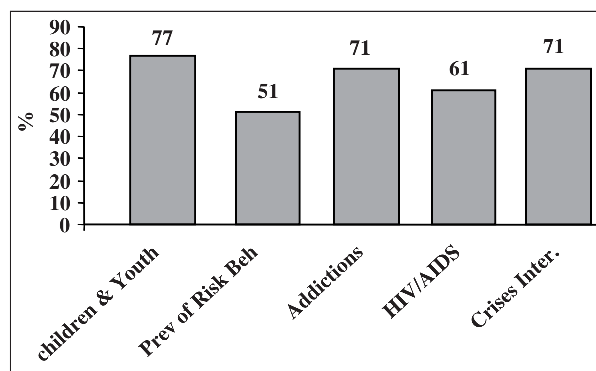


*Figure 11: Proportion of organisations providing prevention facilitators with specific training in various fields*

These findings highlight the need for capacity development within these organisations. Related to this, 71% of organizations provided some form of capacity development to staff. Overall, 62% of organizations provide supervision to their prevention workers either

on a daily (9%), weekly (35%) or monthly (18%) basis. The quality and content of these capacity development initiatives and the quality of supervision, however remains unclear and requires further investigation.

## 3.3. TYPES OF PREVENTION SERVICES OFFERED

This section describes the types of prevention services offered by organisations. Prevention services within schools, communities and the media will be examined separately. This section also examines the extent to which risk and protective factors for substance use are addressed and how prevention programmes were developed.

**School- based prevention programmes**

In South Africa school-based prevention is the most popular form of universal prevention among young people, as schools facilitate easy access to a large part of the target population. Sixty percent of organisations working in schools offer substance use interventions with follow-up sessions and 69% have short-term, once-off awareness-raising activities and interventions within school settings (Figure 12). The reality is that the latter constitute a big part of what is reported as drug prevention in South Africa.

The audit also examined the provision of vocational and academic training as part of prevention among young people. According to NIDA (2001), the provision of these services is central to addressing risk factors for substance use. Only a small percentage (18%) of organisations had vocational training as part of their prevention services. In contrast, a large proportion (83%) of organisations provides referrals for treatment as part of their prevention activities. This is done to encourage early detection of substance use disorders and help-seeking behaviour among adolescents (UNODC, 2002).

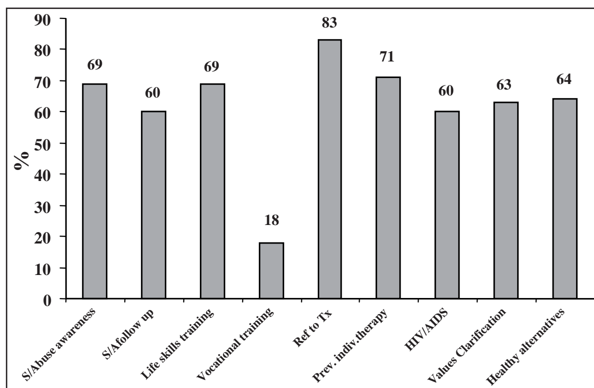


*Figure 12: Types of school- based substance abuse prevention programmes (%)*

The study also found that about a third of all organisations participating in the study did not provide healthy alternatives to substance use as part of their prevention services. The provision of healthy alternatives reinforces local values, and provides young people with attractive alternatives and choices to substance use (UNODC, 2002). Sixty percent of organisations incorporate HIV/AIDS education and the linkages between risky sexual behaviour and substance use into their programmes (Figure 12).

**Community-based prevention programmes**

Community prevention initiatives target drug use directly (Loxley, Toumbourou & Stockwell, 2003) through attempting to change adult behaviour and by addressing structural issues that support and maintain drug consumption (such as drug availability). There are sufficient theoretical reasons to suggest that these initiatives enhance protective factors - especially when the prevention messages are *consistent and community-wide* (Loxley, Toumbourou & Stockwell, 2003; NIDA 2002). In this study, 70% of organisations reported offering community-based drug education services and 40% drug education services for parents. Life skills programmes, vocational training services, youth sport and recreational activities, HIV/AIDS education and the link between HIV/AIDS and substance use remains under represented at the community level (Figure 13). In addition, none of the organizations surveyed reported working to address the structural issues that support and maintain alcohol and other drug use in communities.

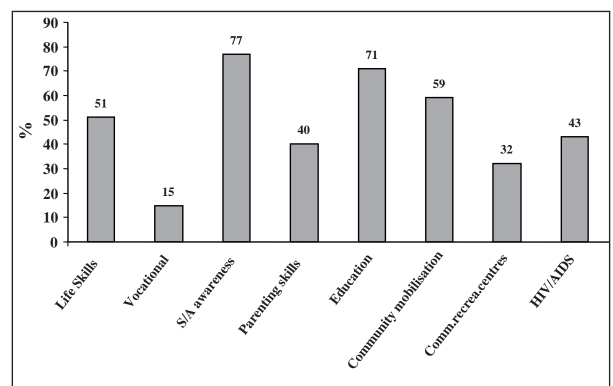


*Figure 13: Types of community-based substance abuse prevention programmes (%)*

**Prevention through mass – media marketing and advocacy**

Most organisations reported circulating printed items as a means of creating awareness (65%)(Figure 14). Marketing on the television and radio was pursued to a lesser degree, with 21% and 50% of organizations reportedly being involved in these activities respectively.

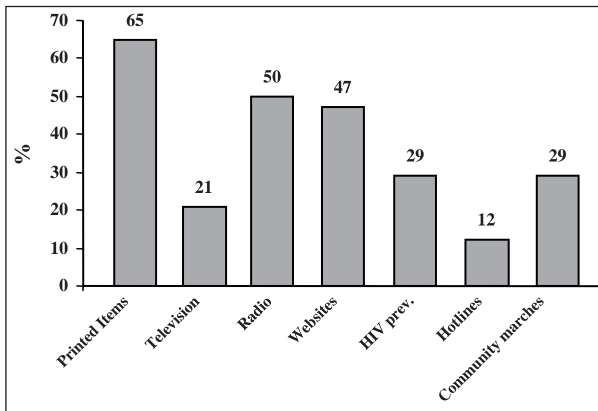


*Figure 14: Proportion (%) of mass media awareness campaigns targeting young people*

**The use of shock tactics as a prevention strategy**

The graph shows that 39% of organisations make use of shock tactics as a means of preventing early initiation into substance use. According to the UNODC (2002), shock tactics involve exaggeration and a focus on the extremely negative (but often rare) impacts of substance use, such as death due to overdose. Research has shown that such methods are unhelpful and rarely influence behaviour positively.

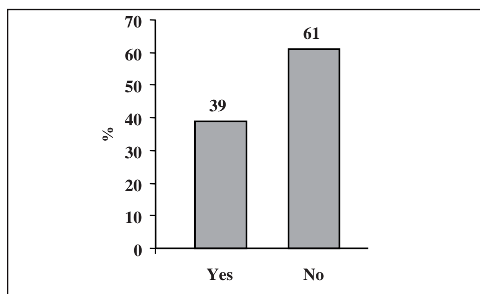


*Figure 15: Proportion of organisations using shock tactics as a means of deterring substance use*

**Addressing risk and protective factors in prevention programmes**

In terms of addressing the risk factors for the initiation of substance use, 71% of organisations report addressing substance abuse among adult role models during prevention programmes and 63% report addressing poor parenting skills. Only 37% of organisations address learning difficulties. Similarly, only 37% of organisations address mental health promotion and drug-related harm (Table 3). Loxley et al. (2003) emphasize that mental health promotion and drug-related prevention rest on the same principles namely, reducing risk and increasing protective factors.

*Table 3: Proportion (%) of organisations addressing specific risk factors*

| Risk factors addressed in prevention programmes | % |
|---|---|
| Substance abuse among adult role models | 71 |
| Poor parenting skills | 63 |
| Poor family relations and bonding | 77 |
| Membership to deviant peer groups (gangs, etc.) | 54 |
| Learning difficulties/poor school performance | 37 |
| Peer pressure | 80 |
| Mental health problems | 37 |

In terms of protective factors, while most organisations surveyed report enhancing parental involvement, positive peer relations and a range of psychosocial skills (for example coping and goal setting skills), only a small percentage (57%) encourage parental monitoring, involvement in prosocial institutions (41%), and conduct health promotion activities (39%)(Table 4). A few organisations indicated involvement in health days, condom demonstrations, and distributions, yet there remains tremendous potential for existing health services to contribute to broader community agendas in preventing or reducing harmful drug use by young people.  This can be done through forming collaborations with organisations offering these prevention services.

*Table 4: Proportion (%) of organisations enhancing specific protective factors*

| Protective factors addressed | % |
|---|---|
| Parental involvement | 83 |
| Parental monitoring | 57 |
| Adopting healthy social norms | 85 |
| Decision making skills | 77 |
| Conflict negotiation | 66 |
| Life skills | 74 |
| Coping | 74 |
| Goal setting | 77 |
| Self-efficacy | 77 |
| Positive peer relationships | 91 |
| Pro-social institutions e.g. Church; sports, volunteering | 41 |
| Health promotion | 39 |

**Program development and gaps in programmes**

It is important that prevention agendas be guided by sound theoretical rationales and models of prevention and behaviour change. This study found that 41% of programmes were developed by health professionals; less than a quarter were adopted from an international model; 12% were developed by health promotions managers; 3% were unstructured, life story type programmes; and 6% were faith-based programmes. Eleven percent of organisations were unsure about the origins of their programmes.

Numerous programme gaps were identified by organisations. Fifteen percent of respondents were concerned about the lack of programme evaluation within their organisations, while 3% stated that their programmes required updating. Financial concerns (15%) and the need for more prevention staff were also cited as challenges to the delivery of services. Twenty-one percent of organisations did not complete this section of the questionnaire.

## 4.4. PROGRAMME MONITORING AND EVALUATION

This section describes the extent to which monitoring and evaluation (M & E) tools were used by organisations offering prevention services.

Organisations were asked to indicate whether they conduct process and outcome evaluations. Process evaluations focus on describing the nature and extent of the programme activities (including the number of individuals reached). Outcome evaluations aim to describe the impacts or effects of a project in relation to its objectives. More than half of all prevention service providers reported conducting process evaluations and 52% had conducted an outcomes evaluation. Seventy-five percent of organisations evaluate client satisfaction or obtain user feedback (this type of evaluation solicits straightforward yes/no type answers) though the use of feedback forms (MentorUK, 2006) (Figure 16).

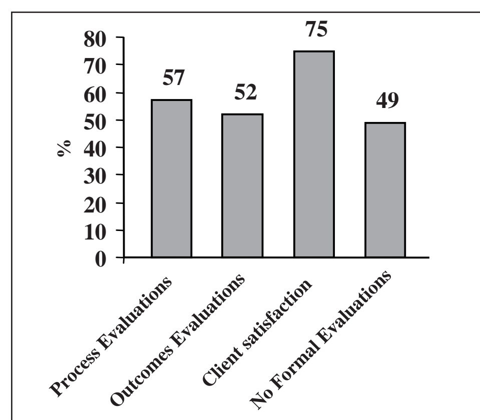


*Figure 16: Proportion (%) of substance abuse prevention facilities evaluating their programmes*

These findings should however be interpreted with caution due to discrepancies in the data. When asked if a formal evaluation of prevention services had ever been conducted, many facilities replied in the affirmative. Yet service providers who indicated they had evaluated their programme generally were unable to describe the evaluation design or findings. On telephonic follow-up, respondents displayed a poor understanding of evaluation; with few providers understanding the difference between outcome and process evaluations. For instance, some respondents categorised ad hoc feedback and anecdotal responses from service recipients, information on the number of people reached and the types of services provided as outcome evaluations. Six percent of organisations did indicate the use of pre and post test measures.

A major concern is that (49%) of organisations have not had formal evaluations conducted on their prevention services. A further 12% of the respondents did not complete this section of the audit. Of the organizations that

conducted some form of evaluation, 18% reported internal evaluations and 15% external evaluations.

For organisations making use of client satisfaction forms, a second question covered the type of measurement tools used to determine whether their targeted population has been reached. Fifty percent of the sample responded to this question, and responses included the use of attendance registers and feedback forms, anecdotal responses, surveys, referrals after presentations and feedback forms. Forty four percent of organisations produce formal results captured in annual reports, newsletters and other reports.

# PART 4: CONCLUSIONS AND RECOMMENDATIONS

This section highlights key findings and offers recommendations for service providers and policy makers to help inform current primary prevention service planning and delivery at local, provincial and national level. Despite some limitations (to be discussed later in this section), the main objectives of the audit were achieved. We were able to pretest and refine our questionnaire and we obtained a better understanding of the characteristics, strengths and limitations of prevention programmes targeting substance use among young people in Cape Town.

## 4.1. CONCLUSIONS AND RECOMMENDATIONS RELATING TO LIMITED FUNDING FOR PREVENTION

Despite the growing wave of substance use problems in Cape Town, prevention efforts that could possible reduce or avert many of the harms associated with substance use remain unfunded or poorly funded. Most organisations offer prevention programmes on an ad hoc basis as a secondary focus, largely due to limited funds for prevention activities. Although government and the private sector over the last few years have become positively oriented towards prevention efforts, a lot of money remains spent on ineffective programmes that do not really have an impact on the behaviour of young people (Brewin 1995, Twala, 2005) and often lack structure and a sound scientific base. An infusion of funds into evidence-based substance abuse prevention programmes would likely lead to savings of thousands of Rands annually in healthcare, criminal justice, and child welfare system costs as well as regained work productivity (Merrill et al, 2006).

Seeing that most organisations offering prevention programmes fall into the non-profit sector, it is further recommended that funds should be specifically allocated to these organisations. This will assist in ensuring that services are evenly dispersed among organizations. NPOs should direct their efforts towards areas where service gaps have been noted, such as the lack of services to young people with more and higher risk factors for substance use.

Considering the variations noted in programme content, models and duration as well as the limited number of evidence-based approaches, it is further recommended that publicly-funded training courses in effective prevention be initiated. This will help ensure consistency, maintain best practices and sound ethical standards. However it is also essential to conduct a systematic review of what works in the context of substance use prevention prior to designing and implementing such training programmes.

- *If the hope is to decrease the demand for illicit and licit substances of abuse through successful prevention programmes, there should be the commitment to inject the needed funds into sustainable interventions.*
- *This funding should be allocated to the non-profit sector specifically*
- *The funding should be contingent on prevention services having demonstrated efficacy (via evaluations) and being evidence-based*
- *Publicly funded training courses in effective prevention among young people should be initiated as a matter of urgency*

## 4.2. CONCLUSIONS AND RECOMMENDATIONS RELATED TO THE ACCESSIBILITY OF PREVENTION PROGRAMMES.

The study showed that organisations are making a concerted effort to target young people. This is partially attributable to the recent rise in substance use in Cape Town, specifically methamphetamine use, among those under 20 years of age (Pluddemann et al., 2007). Secondly, adolescence is a time of experimentation when young people become increasingly independent and mobile, and are subject to a "widening range of social influences" (Loxley et al., 2003).

**Target Groups**

The findings indicate that during adolescence, young people are often exposed to prevention activities in Cape Town. However, effective

interventions to prevent drug use and harm should begin at an early age (Loxley et al., 2003). International research organisations strongly recommend the introduction of prevention strategies from birth through the pre and primary school years (Loxley et al., 2003), including health service orientation; parent education; school preparation; and basic life skills development, such as self-esteem development, delaying of gratification, impulse control and behaviour management. There is increasing evidence that preventive programmes targeting young people between 4 and 12 years of age can prevent and reduce harmful drug use in later years. Although some of the organisations participating in the study did conduct interventions at these ages, prevention experts suggest continued multi-level interventions are needed for younger children including: family interventions, parent education, school-based drug education, and individual behaviour management.

The study also found that most primary prevention programmes do not target individuals with a high number of developmental and social risk factors. Targeted interventions, for adolescents with a high risk for substance abuse, should be initiated early in the developmental pathway to assist in building positive connections or attachments to family, school and community therefore promoting positive educational, health and social outcomes. It is recommended that programmes should seek to extend to all levels of the community (Morojele et al, 1999), especially those groups most at risk for developing substance use disorders.

Notwithstanding the difficulty associated in getting parents of school going children involved in activities, organisations are encouraged to engage parents in substance abuse education. This remains a useful resource to support families particularly in the primary school and adolescent phases of their children's life. Encouraging parents to participate in devising prevention programmes for their children and providing referral services for parental substance abuse problems are key aspects of family intervention (MentorUk, 2007).

- *Organisations should continue to target adolescents in their prevention services but should also be encouraged to expand their focus to include young people between 4 and 12 years of age*
- *Organisations should target young people who are most at risk for developing substance use problems. These high risk groups are often ignored in broad based prevention campaigns*
- *Organisations should be encouraged to involve parents in prevention initiatives. This involvement should include assisting parents in implementing prevention within the home, referring parents to substance abuse treatment where needed, and educating parents about strategies to prevent substance use among their children.*

**Geographical Spread**

Despite the findings that all race groups and geographical areas in the greater Cape Town metropole are covered by existing prevention services, few organisations mentioned the name of the areas to which they render services. The tendency was to list the area of service as the 'Western Cape' or Cape Town, with few organisations providing a complete breakdown of target areas. The geographical coverage and dispersion of prevention services is therefore unknown at present.

- *To gain a more complete picture of the geographical spread of prevention services and for future roll-out of the audit, it is recommended that geographical mapping technologies be employed.*

## 4.3. CONCLUSIONS AND RECOMMENDATIONS RELATING TO THE TYPE AND CONTENT OF PREVENTION SERVICES.

The type of prevention service offered by organisations varies in approach and duration. A large percentage of organisations offer educational programmes that provide information only and are mostly once-off sessions with no follow-up. The findings in this audit indicate that 40% of organisations do not conduct long term repeated interventions. This is contrary to the broad principles of effective prevention which clearly state that long-term repeated interventions are encouraged and more effective than once-off interventions (Medina-Mora, 2005, Twala,

2005, Mentor UK, 2006). The emphasis appears to be on quantity of people reached as opposed to the quality of programmes provided. Medina-Mora (2005) & UNODC (2002) further suggest that information given as a form of prevention in itself is insufficient. They concluded that such sessions have to some degree changed attitude and modified knowledge, but sustained behaviour change has been more difficult to achieve. For organisations that include skills training methods in their programmes it must be emphasized that such programmes should be grounded in theory (Medina Mora, 2005)

- *Where possible, prevention programmes should be extended to include multiple years of intervention and should not be conducted on an ad hoc basis.*
- *Prevention programmes should not only be information-based but should include a skills-building component that is grounded in theories of behaviour change.*

## 4.4. CONCLUSIONS AND RECOMMENDATIONS RELATING TO PREVENTION WORKERS

A small percentage of prevention work included the sharing of personal testimonies. This involves people in recovery retelling the story of their addiction, and their life whilst using substances as well as their rehabilitation. Personal testimonies draw the attention of young people but have short term effects that diminish soon after the presentation. As such, they are not really useful. In some instances, presenters use what appear to be shock tactics as a form of discouraging drug using behaviour. An alternative is using a personal testimony as a case study/activity/discussion point in a programme that meets other criteria for best practice which is more likely to have a long term impact on young people.

Results from the audit found that the majority of prevention workers who have a history of previous substance abuse have been clean or sober for less than 3 years. There is cause for concern given the AA guidelines which suggest a time frame of at least 3 -5 years of uninterrupted sobriety before an individual begins prevention work. For prevention workers, training in specialised fields (such as substance use disorders and working with young people, and childhood development) relevant to prevdention work among young people was low. Questions relating to the supervision of prevention workers indicated that slightly less than half of prevention workers receive supervision. Regular and ongoing supervision of prevention workers is a form of monitoring outputs and organisations are recommended and encouraged to provide such supervision.

- *In instances where an individual has been clean for less than the stipulated number of years and renders prevention services, it is recommended that this individual receive regular, ongoing aftercare support,* ***not*** *as a monitoring measure but rather as a supportive measure.*
- *It is recommended that organisations provide workers with the necessary training, especially given the scientific complexity of these services.*
- *It is recommended that prevention workers receive accredited training in substance abuse prevention as well presentation skills.*
- *Prevention workers should also be kept abreast of new research and programme developments within the substance abuse field and other related fields.*

## 4.5. CONCLUSIONS AND RECOMMENDATIONS RELATING TO CULTURALLY SENSITIVE METHODS

The section of the audit pertaining to cultural sensitivity yielded some inconsistencies. While organisations reported using methods that were culturally sensitive, respondents were unable to provide examples of the culturally sensitive methods that they employ. This raises doubts about the validity of the findings. This is cause for concern as programmes that attempt to impose values, practices or judgements 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 (Gullotta & Bloom, 2003). Adolescents are easily alienated by programmes that are not developmentally and culturally synchronized (Barth et al., 1991). We recommend that:

- *Awareness and understanding among prevention workers and organisations about the importance of using methods that are culturally sensitive is created.*
- *This section of the audit questionnaire be expanded to include open-ended questions. This will allow the research team to explore respondents' perceptions of cultural and gender sensitive practices.*

## 4.6. CONCLUSIONS AND RECOMMENDATIONS REGARDING RISK AND PROTECTIVE FACTORS

There are a number of factors that place young people at risk of initiating drug use. There are also factors that protect them and shield young people from harm. Incorporating these risk and protective factors into prevention programmes not only positively influences developmental pathways but is evidence-based approach to prevention (Loxley et al., 2003). Although organizations all indicated the use of risk and protective factors within their programmes, programmes should take into account factors that may place some youth more at risk than other youth and adapt their programmes accordingly instead of using generic programmes or a one-size fits all approach (MentorUK, 2006). Consideration should be given to the socio-economic circumstances of the target group, the local/community drug trends, religious and cultural needs of the target group. We recommend that:

- *The extent to which and the specific activities that programmes use to target these risk and protective factors remains unclear and requires further examination in future audits.*

## 4.7. CONCLUSIONS AND RECOMMENDATIONS REGARDING SCHOOL-BASED PREVENTION

Schools-based drug education that aims to reduce drug-related harm among young people is to be encouraged by education departments and should involve school teachers and parents. The Western Cape Department of Education already urges schools to have drug awareness programmes in place particularly during international drug awareness week. Drug abuse topics are also included in the life orientation learning area of the school curriculum to aid in reducing the chances of drug misuse (WCED, 2007). Whether this addition to the school curriculum has resulted in changes in attitude and behaviour among young people is unknown. It is essential that such education not remain information based only, as this is necessary but not sufficient to change the behaviour of young people. Schools that offer life skills programmes should be consistent in their implementation of such programmes throughout the primary and high school career of the young person.

- *It is therefore recommended that life orientation programmes should include a focus on skills development and be extended over many years*
- *An emphasis should be placed on prevention programmes that incorporate vocational aspects, drug information (without employing shock tactics), provision of healthy alternatives, harm reduction aspects, referral to treatment, living a healthy lifestyle, values clarification exercises, HIV/AIDS, pro-social activities and other life skills.*
- *Programmes should include interactive teaching methods (including role modeling) and engagement strategies and stay clear from didactic teaching methods.*
- *School-based prevention should be delivered through a standard programme (contrary to uncoordinated ad-hoc delivery of prevention services).*
- *Programme content should be based on theoretical models of behaviour change*
- *The intensity and impact of prevention measures should be monitored and evaluated regularly.*

## 4.8. CONCLUSIONS AND RECOMMENDATIONS REGARDING COMMUNITY-BASED INTERVENTIONS

Community-based interventions should include family and environmental strategies as important subsets and important target groups within community prevention initiatives (Burkhart, 2007). This implies active community involvement in prevention activities and can include family-based interventions, school-based interventions, as well as broader environmental strategies

aimed at the immediate cultural, political and social environment of people. Individuals using drugs do not only do so based on personal susceptibility, but are also influenced by a complex set of factors in the environment such as the norms in the community, the accessibility of substances and rules and regulations of social institutions (Burkhart, 2007).

- *Engaging and mobilising community structures and local authorities into actions that aim to prevent substance abuse is encouraged.*
- *A useful community structure is a community-driven one-stop help centre which operates from a multi-agency approach and acts as a referral base for person's experiencing substance abuse problems.*
- *Community prevention programmes can be run from such a resource and should use peer educators in conjunction with prevention professionals as a means of reaching young people.*

## 4.9. CONCLUSIONS AND RECOMMENDATIONS REGARDING MASS MEDIA INTERVENTIONS

The mass media is a powerful vehicle for the promotion and marketing of alcohol and tobacco products (Loxley, Toumbourou & Stockwell, 2003 & Kilburn 2007). As part of a wider community based strategy which includes activities such as community development and education, community mobilisation, health education and promotion, policy development and political lobbying, the mass media should be used to market competing prevention messages that discourage the use of licit and illicit substances. The mass media can also be used to increase community awareness of availablde intervention services for those young people displaying early signs of problematic substance use.

## 4.10 CONCLUSIONS AND RECOMMENDATIONS REGARDING KNOWLEDGE GAPS AND PROGRAMME WEAKNESSES

A concern emanating from the study was that slightly more than a quarter of organisations indicated that there were no gaps in their programmes. This seems unrealistic.

- *Organisations are encouraged to have their programmes evaluated for effectiveness, identify potential shortcomings in their programmes and adapt programmes where needed.*

## 4.11. CONCLUSIONS AND RECOMMENDATIONS RELATED TO THE LACK OF A NATIONAL SUBSTANCE ABUSE PREVENTION REGULATORY REGIME

In addition to insufficient funding, the field of substance abuse prevention in South Africa lacks an effective regulatory regime in the form of minimum norms and standards for effective practice and the accreditation of individual prevention workers and specific prevention services. Through this regime, prevention services can be efficiently offered, coordinated, organised, delivered, and paid for. Such a regulatory body should be responsible for assuring quality, monitoring performance, and diffusing new ideas and technologies. As indicated, prevention services for substance use are under-funded and lack a central organising body. This has numerous unintended consequences on service coverage, service effectiveness and service quality. The study further found an increase in the number of new institutions (churches, crime protection services, adolescent centres) offering prevention services. These do not fall in to the traditional realms of organisations offering substance use prevention services. There are also individuals offering substance abuse prevention programmes in their personal capacities as ex-substance abusers.

- *The possibility of introducing a body to regulate and accredit prevention service providers and the quality of their services, to coordinate funding allocation and the dispersal of services, and to disseminate new ideas and technologies in the field of prevention should be explored and made a priority.*
- *Minimum norms and standards should be developed for the field of prevention*
- *Accreditation of prevention workers is needed. This will help ensure that*

*programmes are monitored so that they meet best practice criteria.*

## 4.12. CONCLUSIONS AND RECOMMENDATIONS REGARDING THE EVALUATION & MONITORING OF PREVENTION PROGRAMMES

Research has emphasised the importance of monitoring and evaluating substance abuse prevention programmes, not only because this helps identify areas in which services can be improved, but also because evidence of service effectiveness can inform decision-making around the allocation and distribution of prevention resources. Despite the widespread use of prevention programmes worldwide, evaluations seldom if ever take place (Gulotta & Bloom, 2003). Many organisations did indicate that outcome and process evaluations were conducted yet discrepancies in the evaluation and monitoring aspects of the organisation were noted. These discrepancies could be attributable to the poor understanding of monitoring and evaluation or the terminology used in the questionnaire. Successful interventions depend on comprehensive programme evaluations (Brewis 1995) and with this lacking in organisations we recommend that:

- *Attempts should be made to increase the capacity of organisations to conduct routine evaluations. The World Health Organisation (2002) has developed a framework for programme evaluation within substance abuse prevention and treatment services that could serve as a useful starting point for such an initiative.*
- *Another solution may be for organisations to partner with academic institutions that specialise in monitoring and evaluation (CCSA, 2007).*
- *In addition, policy makers in South Africa should consider making the regular evaluation of all substance abuse prevention programmes a condition of registration, accreditation, and funding.*

## 4.13 CONCLUSIONS AND RECOMMENDATIONS RELATING TO STUDY LIMITATIONS

The audit in itself has a few limitations due to a failure to access information from all organisations that render prevention services and also problems relating to the questionnaire used and lack of understanding by the participants of certain sections of the audit. There may also have been a possible social desirability bias on the side of the participants, as the questionnaire was a self-report questionnaire. The study would have benefited from a mixed method approach. A qualitative section would have provided some insight into the inner workings of the organisations and their programmes and would have afforded the investigators the opportunity to follow-up on questions that required clarification. Face to face interviews and observations of prevention services would also have provided further reassurance of the reliability and validity of the findings.

- *It is recommended that the study design and data collection tool for the prevention audit be reassessed with these limitations in mind.*
- *It is further recommended that a national audit of prevention programmes be conducted on a regular basis so that changes in provision, coverage and reach of prevention services can be monitored.*

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