**UNIVERSITY OF CAPE TOWN**

Division of Occupational Therapy

# Research Report

**In partial fulfilment of Bachelor of Science in Occupational Therapy**

## Substance use amongst school-aged young people in Ocean View: A pilot study

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**Year:** 2019

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The UCT Knowledge Co-op facilitated this collaborative project between Living Hope and UCT Department of Occupational Therapy.

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HREC REF: 2018/0823

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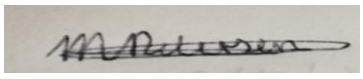

**Date:** September 2019

# Acknowledgments

We would like to acknowledge the Living Hope organisation and thank them for all their input. We are immensely grateful for their involvement and for all their efforts in liaising with stakeholders and community members and for assisting in the recruiting of participants for our study. An enormous thank you is due to Nathan Panti and Avril Thomas for all their assistance, contributions and efforts. We are so grateful for your partnership and truly wish you all the best with the hope of future research taking place in your community. From an Occupational Therapy perspective, we would also like to thank them for all they are doing to help the children of Ocean View.

Secondly, we would like to acknowledge UCT Co-op for partnering us with Living Hope and your involvement in the logistics of the process. We are also so thankful for your willingness to cover the costs that exceeded our budget. A special thank you to Barbara Schmid for all your efforts and communications.

Thirdly, we would like to thank UCT for this opportunity to be able to complete this research and for the faculty's financial contribution.

We would also like to thank our eager and willing participants as well as the greater community of Ocean View.

We would also like to thank our panel of experts including Lisa Wegner, who assisted this research process by reviewing our questionnaire, and to Anke Theron and Marieke van Zyl, who helped with the translation of the questionnaire into Afrikaans.

Finally, we would like to acknowledge our supervisor, Sophia Allie, lecturer and Occupational therapist, for all her help throughout this lengthy process. Thank you for communicating with the relevant stakeholders and suggesting solutions along the way. Thank you for your input and problem-solving strategies. Thank you for facilitating our growth in this process and for your constant support. We humbly appreciate all your help.

Thank you to our team of researchers for all your hard work and tiresome efforts over the past year.

# Abstract

**Introduction:**

Substance use among adolescents is a major problem worldwide and specifically in Cape Town communities within South Africa. Using substances from a young age results in multiple developmental delays, educational difficulties, emotional distress and other harmful effects. There are organisations within communities that have identified these issues and are attempting to offer alternative options for children to engage in after school so that they do not fall into peer pressure and engage in substance use. The initial issue raised to the researchers was that the extent of the substance use problem is unknown and NGOs are unable to fundraise and raise accurate awareness without current statistics. Thus, this research started out by aiming to uncover the prevalence of substance use among young people in Ocean View. After ethical considerations and various community dynamics, the study changed to a pilot study in order to test the formulated questionnaire.

**Method:**
Nine male participants who were part of a local soccer club, between the ages of 15-17, completed the questionnaire. Results were then analysed and interpreted relating to how well the questionnaire was answered
**Findings:**
Of all substances investigated, alcohol was reported as the most common substance used and Tik was reported as being the least common substance used. On average participants began using substances when they were 14 years old. Results revealed that 9% of the questions in the questionnaire answered by all nine participants were answered in a way that contradicted previous answers given by a participant. In total, 27% of all questions were answered poorly, due to ambiguity around which questions required an answer. This uncertainty may have been perpetuated by confusion in the layout of the questionnaire. Most of these inappropriate answers, were found in the section of the questionnaire which enquired around the participants' history of substance use (Section C).
Due to the small sample size, the results of the questionnaire are not generalizable to the sample population and can only be used to make inferences around the nine participants' substance use, personal and contextual factors. Therefore, findings revealed that adaptations need to be made to the questionnaire in order for it to be utilized as a valid and reliable research tool.
**Conclusions and recommendations:**
Recommendations for amendments to the questionnaire were made and if followed, will allow for improved face validity of the research tool and overall research in the future. Future researchers need to establish a relationship with potential participants in order to reassure them of the anonymity of the process and to aid recruitment. Recommendations were also made to the existing NGOs after furthering their aftercare programs in order to broaden the occupational possibilities of the young people in the community. The prevalence of substance use still needs to be uncovered; urgent and extensive future research is recommended.

*Keywords: Substance use, prevalence, Ocean View, age, age of onset, adolescents, young people, occupational engagement, commonly used substances, pilot study, questionnaire*

# Table of Contents

# List of Tables



# List of Figures



# List of abbreviations

DALYS- disability-adjusted life-years

HREC - Human Research Ethics Committee

NGO – Non-Governmental Organisation

NPO - Non-profit Organisation

OT - Occupational Therapy

SA- South Africa

UCT- University of Cape Town

WC - Western Cape

WCDoE – Western Cape Department of Education

WHO – World Health Organisation

# Definition terms

**Adolescents/adolescence:**

A period between childhood and adulthood; specifically, individuals between 13 and 18 years of age (Erikson, 1998). In this study, the term adolescents will be used in the literature review to describe individuals aged 13-18 and in the study specifically to describe individuals aged 15-17.

**Young people:**

Anyone who falls within the age range of 15 – 24 years (Department of Economic and Social Affairs, 2014). The terms 'adolescents' and 'young people' will, therefore, be used interchangeably in this study.

**Substance use:**

The act of inappropriately consuming prescription or over-the-counter medicines, alcohol, tobacco, or any other off-the-street psychoactive substances (Saunders, 2003).

Substance use can be viewed across a spectrum, which ranges from using, to abusing, to depending on a substance, which results in addiction (Pasche & Stein, 2014). This term will be used in the study to describe the consumption of alcohol or any other psychosocial substances.

**Legal guardian:**

The Duhaime Legal dictionary defines a legal guardian as "an individual who, by legal appointment or by the effect of a written law, is given custody of both the property and the person of one who is unable to manage their own affairs, such as a child or mentally-disabled person" (2000). In this study, only biological or legally appointed guardians of minors may provide consent for the child participant. This term will be defined in the consent form to ensure that consent is given from legal guardians.

**Occupation:**

Chunks of goal-directed activities or tasks that hold meaning, are performed within a particular context, and that can be named when considering culture(s) (Christiansen & Baum, 1997).

In this study, the term 'occupation' will be used to describe the groups of tasks and activities that adolescents take part in, within the context of Ocean View, in order to achieve goals and generate meaning.

**Occupational engagement:**

The extent to which an individual has an established and balanced pattern between taking part in activities and resting, a range of meaningful occupations that they are able to take part in, and an ability to engage with the social environment (Bejerholm & Eklund, 2006b). Occupational engagement is determined by factors related to the individual, who has their own set of skills, abilities and interests, and the context, which either provides opportunities or barriers for taking part in meaningful occupations (Law et al.,1996). The term will be used in this study to describe how the ability (afforded on both individual and environmental levels) to take part in meaningful occupation is affected by substance use.

**Occupational performance:**

The ability to understand, remember, plan and carry out roles, tasks, activities and routines, so that one can achieve self-maintenance, productivity and leisure, and is determined by internal and external environmental demands (Chapparo & Ranka, 1997). In this study, this term will be used when describing how substance use affects the nature and manner of engagement in tasks, activities, roles and routines, and how the various areas of performance

are impacted through the internal and external environmental demands within a context where substance use is prevalent.

**Participation:**

Participation is defined as being involved or taking part in a life event (World Health Organization, 2001). This term will be used in the study to frame, from an Occupational Therapy perspective, how taking part in meaningful activity is affected through substance use.

**Productivity:**

Productivity refers to the tasks and activities that are done to enable the person to provide support to the self, family and society through the production of goods and services (Canadian Association of Occupational Therapists, 1995). It the case of young people, it would include occupations that relate to their identities such as learner, son/daughter, sibling and others.

# CHAPTER 1: Introduction

## 1.1 Introduction to chapter

In this chapter, the extent of substance use as a contributor to the global burden of disease will be explored. The chapter will also relate substance use as a global issue to substance use specifically within South Africa and the Western Cape, which is the context in which this study took place. This chapter highlights the gaps in recent existing literature on substance use within under-resourced contexts of the Western Cape. The specific aim and objectives of this study speak to its quantitative design, as prevalence relating to the issue, specifically amongst young people living in Ocean View, is explored.

## 1.2 Background to study

Disability-adjusted life years (DALYs) measure the number of years of life lost, due to ill health, an early death or disability. Therefore, one DALY reflects one year of life lost. The total DALYs for a given population reflects its burden of disease (World Health Organization, 2015). Alcohol and substance use disorders are responsible for 1.14% and 1.20% respectively of the global population's DALYs ("Alcohol and drug use disorders: Global Health Estimates", 2017). 10% of global DALYs reflecting alcohol use disorders arose from Africa, and of the DALYS attributed to substance use disorders, 8% arose from South Africa ("Alcohol and drug use disorders: Global Health Estimates", 2017). Substance use is becoming an increasingly widespread problem in South Africa, and within the Western Cape (Parry et al., 2004). Previous studies express a concern for a high prevalence of substance use, within under-resourced Western Cape communities (Harker et al., 2008; Flisher et al., 2003; Wechsberg et al., 2006; & Plüddemann et al., 2010). However, these studies are outdated and fail to explore every unique context. It was also found that there is a lack of research on cannabis use within rural areas of the Western Cape (Harker et al., 2008).

Focusing on a few communities, Masitsa (2007) found that among 828 secondary schools in South Africa, the most commonly used substance was alcohol. This was followed by tobacco Snuff, tobacco inhaled through the nasal cavity; and cannabis. This study showed that the most commonly used substances by young people in townships at secondary schools in the Western Cape are those which contain alcohol (Masitsa, 2007). (Other studies done with

young people, conducted within a similar context in the Western Cape, showed that alcohol was the second most used substance, following tobacco products (Plüddemann et al., 2010, Wechsberg et al., 2006; & Flisher et al., 2003). Thereafter, cannabis was most used (Plüddemann et al., 2010, Wechsberg et al., 2006; & Flisher et al., 2003), and then methamphetamine (Plüddemann et al., 2010). These show that tobacco, alcohol, cannabis and methamphetamine were the most used substances within Western Cape townships amongst young people. It was also revealed that alcohol is a commonly used substance in South Africa, and that there are many unreported consumption cases that should be considered when looking at statistics (Freeman & Parry, 2006).

Adolescence is the primary risk age group for substance use and this often begins with using alcoholic substances (Masitsa, 2007; Oshodi, Aina & Onajole, 2010). In the Western Cape, many begin using substances in primary school when they are under the age of 13 years indicating that substance use is becoming a more prevalent problem in the population of young adolescents (Schronen, 2002). As each context is unique, there is no research covering all Western Cape communities; particularly the context of Ocean View.

Ocean View is an impoverished, under-resourced township in the Western Cape. The township was established under the Group Areas act in 1968 (Wilkinson, 2000). Due to the Apartheid system under which the Group Areas Act was legislated, areas such as Ocean View were not well resourced through various infrastructure and services including healthcare and education – the effects of which are still evident today (Benninger & Savahl, 2016). With a population of around 30000 people living in a 1.72m² sized area, unemployment rates are high, and the substance use culture is the norm ("Ocean View – Living Hope", 2019). The context of Ocean View is rife with crime, gang violence, and substance use (Woolard, 2002). These negative contextual features adversely affect the individuals residing in Ocean View - limiting their opportunity for occupational engagement (Masitsa, 2007).

Living Hope is a Non-Governmental Organization (NGO) based in the community of Ocean View. Living Hope aims to improve the community of Ocean view through health-related, educational, social and economic development programs (Ocean View – Living Hope, 2018). As an organisation working within Ocean View, Living Hope has observed children and

adolescents using substances. They have noticed the negative effect that substances have on individuals, particularly adolescents. Living Hope has obtained no empirical data that reveals the extent of the problem.

Living Hope, approached the Knowledge Co-op at the University of Cape Town (UCT) for assistance with research. The Knowledge Co-Op makes UCT's skills, resources and professional expertise easily accessible to the community partners ("Knowledge Co-Op", 2019). They do this by linking community groups i.e. Living Hope, with academic partners. These partners would need to meet the identified needs for research or practical support that is formulated by the community group. The Knowledge Co-op collaboratively worked with Living Hope, linking Living Hope to a group of undergraduate researchers (fourth-year Occupational Therapy students) studying at UCT. The undergraduate researchers were provided with the opportunity to meet with and interview Living Hope, because they work in the community, about the number of adolescents who use and are affected by substances. Living hope stated that children as young as eight years old use substances.

Various key stakeholders involved in this research study include the undergraduate students, their supervisor, the NGO Living Hope, Knowledge Co-op, community leaders and learners involved.

As mentioned above, literature has revealed that there is a high prevalence of substance use amongst adolescents within South Africa and the Western Cape (Parry et al., 2004). However, the researchers have found that there is a gap in literature. Since each context is unique, the high prevalence of substance use in the Western Cape cannot be generalised to the specific needs of every community. There is minimal available literature, (and limited documented evidence), identifying the prevalence of substance use among school-aged young people (aged 15 to 17) living in Ocean View. The statement made by Living Hope that substance use is a pressing problem in Ocean View is based on anecdotal evidence. Therefore, in order to determine whether an adolescent patient-based substance use clinic needs to be set up in Ocean View, research needs to target young individuals living in the community. Accordingly, the focus of this research will be on school-aged young people (between the age of 15 to 17) - within the context of Ocean View.

## 1.3 Rationale

This research formed part of a two-part research study (one research study being quantitative, the other being qualitative) in order to understand substance use among young people within the context of Ocean View. This research study focused on the extent of substance use by young people in Ocean View, while the qualitative study focused on exposure to substance use among young people in the community.

Substance use has a detrimental effect on an individual's occupational and social functioning – thereby limiting their occupational performance (Crouch & Wegner, 2014). As future occupational therapists, the researchers are concerned about the impact of substance use; particularly in impoverished, vulnerable contexts such as Ocean View. Understanding the impact of substance use in Ocean View will provide knowledge and understanding of how significant the substance use problem is. This study was conducted to gather data that can assist organizations such as Living Hope, to provide appropriate services for young people living in Ocean Vie

Through this, the research findings will work towards reducing dysfunction in occupational performance that arises due to substance use. This will be achieved by creating opportunities for meaningful occupational engagement and participation, for individuals within the community of Ocean View. Furthermore, the research findings may help to reduce the negative implications that arise from substance use, such as barriers to learning and overall impairment of physical, cognitive, emotional and/or social development (Crouch & Wegner, 2014).

## 1.4 Problem Statement

Although substance use is a recognized problem in this community, a gap in literature and evidence contributes to the uncertainty of the extent of the problem; making it difficult for stakeholders to know where the focus should be for effective intervention. Therefore, this research will inform the community of the extent of the problem, and create awareness in order to implement preventative measures, which will benefit the community as a whole. This research aims to contribute to the existing body of knowledge about substance use

amongst adolescents; particularly with regards to knowledge about substance use in school-aged young people living in Ocean View. Additionally, the research has added benefits to all the various stakeholders involved.

Substance use is associated with health, wellbeing and social implications (Crouch & Wegner, 2014). Substance use among school-aged adolescents across low socioeconomic South African communities has found to be elevated (Parry et al., 2004; Harker, et al, 2008). However, there is little known research around the prevalence of substance use in school-aged young people in Ocean View. This gap in research means that the extent of this problem in Ocean View (a low socioeconomic area), and its implications for the community's health and quality of life, is not well understood. This means that no intervention around the wellbeing and social implications within this community can occur, to improve the quality of life of those residing in Ocean View. The proposed research, therefore, seeks to bridge this gap in knowledge.

## 1.5 Purpose

The results from the proposed study may benefit the NGO, Living Hope with strategies to more effectively meet the needs of the young adolescent individuals residing in Ocean View, benefitting the community as a whole. Furthermore, this study on substance use among young people will provide opportunities for future research on substance use in Ocean View. Additionally, the research will benefit the researchers and their UCT supervisor. The undergraduate researchers will be able to attain their degree through this research, and their supervisor will gain experience in managing or overseeing undergraduate Occupational Therapy research. For the Ocean View community as a whole, receiving feedback at the end of the study will create awareness about the extent of the problem, and possibly provide them with the first step towards addressing the substance use within their community. Additionally, Knowledge Co-op will benefit from the research process; the research conducted will create opportunities for more NGOs (such as Living Hope) to approach UCT Knowledge Co-op, knowing that they are a reliable organization involved in research collaboration. This body of research will allow Knowledge Co-op to establish relationships, and become actively involved in research processes across SA - laying the foundation for

future research projects. This research, having allowed the opportunity to administer an adapted questionnaire, will provide a guide for future researchers about helpful items to include as well as where the gaps lie in the questionnaire.

### 1.6 Research question

What is the prevalence of substance use among young people in Ocean View?

### 1.7 Aim of the study

The aim of the study is to establish the extent to which young people living in Ocean View are using substances.

### 1.8 Objectives

1. To establish which substances are most commonly used by school-aged young people in Ocean View.
2. To establish at what age substance use is most prevalent amongst school-aged young people in Ocean View
3. To determine the age of onset of substance use amongst school-aged young people in Ocean View

## 1.9 Chapter summary

It is clear that substance use has detrimental effects worldwide and specifically in Cape Town communities, South Africa. Working with Living Hope, an organisation already established in the community of interest, the aim of the study is to uncover the extent of substance use among adolescents. Focusing on the ages of young people as well as which specific substances they use, the purpose of this study is to gain access into the community and begin the process of uncovering information, allowing future research to have some direction in this field. With the background of the study outlined, the researchers set out to review existing literature.

# Chapter 2: Literature Review

## 2.1 Introduction to chapter

Extensively exploring past and current literature on various elements of substance use, this chapter describes all the relevant literature found for this research. This chapter speaks to the effects of substance use, substance use in South Africa and the Western Cape, substance use in relation to age, peer pressure and patterns, as well as contextual factors influencing substance use in this age group. Additionally, upon completion of a comprehensive literature review, this chapter highlights certain gaps in literature, especially regarding the context of Ocean View.

Literature was obtained by firstly accessing the UCT Health Sciences Library Home page. Databases were then accessed from this page through the search and find tab. Databases accessed included EBSCOHost, Google Scholar, OT Seeker and CINAHL.

To find words and phrases that could be used to refine the search the acronym PICO was used. This acronym is used in evidence-based practice to formulate an answerable question and to make sure that all required information is included in the search. The acronym translates into “P” being population, “I” as intervention, “C” is comparison and “O” is the Outcome of interest. Additional manners of searching included using Boolean operators such as “AND” and “OR”. The Boolean operator “AND” combines two or more words, while “OR” is used to indicate synonyms that may relate to the searched word. Examples of search items that were used include: Substance Use AND Effects, Substance Use AND South Africa.

Literature was also obtained by searching for books within UCT’s Health Sciences Libraries. This was done by searching on the computers in the library for any relevant books, related to this research, within the library.

## 2.2 Substance Use and its Effects

Substance use is generally defined as the intake of drugs that have the possibility of becoming addictive to the user (Bryant, Fieldhouse & Bannigan, 2014). Substance use is often brought

on by experimentation or curiosity and is characterised by individuals beginning to use alcohol or other substances, despite knowing the dangerous consequences and harmful side effects (Crouch & Wegner, 2014). Substance use can be limited to this initial encounter or individuals may only use substances occasionally. Using certain substances in this manner has effects that are short-term and have not been shown to have significant physical or psychological consequences (Lasser & Schmidt, 2009). Drugs alter perception and they have a relaxant effect on the body (Khantzian, 1997). Therefore, they are often used as a coping mechanism. In a way of self-medicating, individuals use substances to gain relief from or alter their state of pain or distress.

According to the DSM-IV, substance abuse or "harmful use", as referred to by the ICD-10, is when an individual is under the influence of one or more substances and presents with behavioural changes that negatively affects them socially, psychologically, legally, physically or their occupational engagement and performance. The ICD-10 terms "substance abuse" as "harmful use" and has fewer specific criteria than the DSM-IV. The ICD-10 requires criteria to be present for at least a month or have regular occurrences within a 12-month period. The DSM-IV has four criteria that need to be identified in the involved person before it can be termed substance use. The DSM-IV terms the persistent use or chronic use of a substance, as abuse (Ellis et al., 2012). Substance abuse is characterised by an individual using the substance more frequently, resulting in an interference with the individual's occupational functioning including education and relationships. Furthermore, an increased sense of subjective distress or suffering as well as feeling overwhelmed, are motivating factors for substance use (Lasser & Schmidt, 2009). Therefore, the term that will be used in this thesis will be *substance use*, as this includes general substances and is the term most often characterised as the use of substances.

Substance use is said to lead to substance dependence, or substance use disorder (Crouch & Wegner, 2014). Individuals who use substances are at a greater risk of becoming dependent on said substance (Lasser & Schmidt, 2009). These effects are perpetuated when individuals consume alcohol or other substances to avoid, enable or enhance their occupational engagement. Substance dependence occurs when individuals build up a tolerance; starting to use a substance more frequently and in greater quantities. Individuals then experience

cravings and withdrawal effects, which eventually results in addiction and impaired functioning even without taking the substance (Crouch & Wegner, 2014).

Substance use is also associated with psychiatric conditions such as mood, anxiety, personality disorders, depression, and suicide (Pasche & Stein, 2012). Physical implications resulting from substance use may include gastrointestinal or liver problems, pancreatitis and hypertension. Certain substances also require the use of hypodermic needles and sharing these needles among substance users increases the risk of contracting HIV and certain types of hepatitis. Additionally, the disinhibiting effects of some substances resulting in increased sexual activity which also increases the risk of contracting HIV and other sexually transmitted diseases (Columbia Electronic Encyclopedia, 2019).

The psychiatric and physical symptoms mentioned above, which accompany substance use, result in significant implications on one's occupational engagement and occupational performance. When substance use affects an individual's ability to function in daily life, it can be defined as a substance use disorder. A substance use disorder has serious consequences and the individual is often unable to fulfil their various roles, through a decline in occupational participation (Crouch & Wegner, 2014). For example, individuals may start neglecting responsibilities such as childcare and household maintenance. Additionally, substance use can cause acts of aggression, and unlawful behaviour that has far-reaching legal consequences. It is further stated that a substance use disorder results in a decline in occupational performance, as daily activities can become centred around engaging in the occupation of substance use. Substance use may lead to decreased participation in various occupational performance areas such as social participation or leisure and individuals may withdraw from family and friends (Crouch & Wegner, 2014).

Participation in occupations relating to productivity, such as the activities required to fulfil the role of a learner, are also negatively impacted by one's substance use (Masitsa, 2007). This can be apparent through a compromised quality of occupational performance, a decline of schoolwork results, as well as an increase in absenteeism and eventually, dropping out. As one's occupational engagement diminishes, and meaning attached to school-related activities falters, occupational performance is compromised which

has negative effects on one's health and well-being (Chapparo & Ranka, 1997). Furthermore, substance use can result in the development of other co-morbid mental health conditions (Ellis et al., 2012). These effects are evident worldwide, and the following section will focus on substance use within the South African (SA) context.

## 2.3 Substance Use in South Africa and the Western Cape

Substance use is a pressing problem within S.A. Research has revealed that substance consumption in SA is double the average world consumption, with over 15% of the country living with a substance use addiction (Tshitangano & Tosin, 2016). Parry et al. (2004) stressed that within the SA context, there has been a notable increase in the negative effects of adolescent substance use. The current reality in many South African communities is that adolescent substance use adds burdens to the healthcare, social welfare and criminal justice systems (Freeman & Parry, 2006). Research by Matzopoulos et al. (2014) states that the costs resulting from alcohol-related damage, within SA, outweigh the income generated by the country's alcohol sales. Alcohol and other substance use in SA have caused detrimental effects on the health, social and economic sectors- details of which will be elaborated on within this chapter.

In a study investigating the prevalence of substance use in SA, substance use is shown to be prevalent amongst individuals between the age of 18 and 29 years (Van Heerden, Grimsrud, Seedat, Myer, Williams, & Stein, 2009). The findings revealed that of the participants aged 18 to 29; 89.4 % had used alcohol, and 80% had used tobacco or cannabis, before age 20 (Van Heerden, Grimsrud, Seedat, Myer, Williams, & Stein, 2009). 60% of participants aged 18 to 29 had used other drugs (such as stimulants and cocaine), by age 17. However, an epidemiological study conducted in S.A by Ramlagan, Peltzer & Matseke (2010), revealed that alcohol, tobacco and dagga are being used by *younger* individuals between the ages of 10 and 14, with more harmful drugs (such as cocaine or heroin) being used between the ages of 16 and 17.

Within SA, the prevalence of substance use is particularly high within the Western Cape (W.C.) (Peltzer, Ramlagan, Johnson, & Phaswana-Mafuya, 2010). Harker, et al. (2008) conducted a

review of trends of substance use from 2000 to 2008 by collecting and collating substance use data from the South African Medical Research Council, the Human Research Council, and University of Cape Town's psychiatry department (previous research reports, theses, and dissertations). The review aimed to look at the prevalence and the patterns of substance use in both rural and remote areas of the W.C. Harker, et al. (2008), go on to explain that substance use is a common problem amongst adolescent individuals within the Western Cape – particularly the use of alcohol, methamphetamine, cannabis, tobacco, and other opiates. According to the Youth Risk Behaviour Survey, 34% of school-going adolescents within the Western Cape binge-drink (Harker, et al., 2008). From a sample of 139 patients under the age of 20 presenting in hospital trauma units within Cape Town, 31.8% had a positive breath alcohol level, and 26.9% of patients positively tested for cannabis (Parry, 2004). Urgent prevention and immediate intervention measures are required to address the problematic use of substances within the Western Cape (Flisher, 2003; Harker et al., 2008).

A study conducted by Watt et al. (2013), investigated the impact of Tik on personal, interpersonal, and community levels, within a township called Delft which is situated within the Western Cape. This study showed that Tik consumption had negative personal impacts on a mental, physical and economic level and that it affected one's opportunities for personal growth or improved occupational performance, in work and school settings. It also showed that on an interpersonal level, Tik use is associated with violence and sexual risks. Lastly, on a community level, Tik use was found to be associated with crime, violence and corruption. These consequences all negatively affected the cohesion and overall well-being of the Delft community.

Through exploring incidences of how substances affect individuals on a personal level, it is evident that the severity of substance use has significantly influenced school-going adolescents, resulting in increased school drop-outs. This has consequently leads to effects on a community level, in the form of heightened crime rates, as well as a rise in poverty (Griffin, Lowe, Acevedo & Botvin, 2015). Townsend et al. (2004) and Oshodi, Aina & Onajole (2010), emphasize that there is a correlation between substance use and dropout rates. 55% of students, who were attending school mid-way through Grade 9, had dropped out two years later. Furthermore, Valkov (2018) suggests that the greater the severity of the

substance use, the worse the impact on academic performance, and therefore, the higher the risk for school dropout. Additionally, Masitsa (2007) found that overall, substance use during or before school hours is linked to poor school attendance and discipline. All this evidence raises major concern for the effects of substance use on school-going adolescents, on a personal, interpersonal and community level.

With a focus on the adolescent age group, Oshodi, Aina and Onajole (2010) raise another matter of interest, specifically, the gender difference in the prevalence of substance use. Previous studies have discovered that higher prevalence rates occurred among males for all substances (Oshodi, Aina and Onajole, 2010). Harker et al. (2008), also highlight gender differences in substance users, concluding that amongst grade 8 students within the Western Cape, 25.9% of males and 14.8% of females use alcohol. Plüddemann (2008) states that 13.3% of males and 11.9% of females use methamphetamine in the WC, indicating that males are more likely than females to use methamphetamine. Masitsa's (2007) findings also show that substance use was more prevalent within the male population compared to the female population.

## 2.4 Substance use in relation to age, stage and development

### *2.4.1 Age and stage: Substance use in adolescents*

Research by multiple authors corresponds with statistics on Substance Use in the Western Cape (Harker et. al., 2008) and Cape Town (Parry, 2004) suggesting that the rate of substance use is increasing amongst the adolescent population. With concern for the younger population, a study completed by Flisher (2003) looked at the prevalence of substance use in adolescents attending grades eight and 11 at public schools in Cape Town. The findings revealed that the prevalence of substance use increased among this age group (Flisher, 2003). When comparing their findings to a similar study previously done in Cape Town, they found that the rate of substance use, specifically the use of cannabis, had doubled (Flisher, 2003). Multiple authors concur that the use of substances is highly prevalent in the population of young adolescents (Armstrong and Costello, 2002; Oshodi, Aina and Onajole (2010); Young et al., 2002.)

A study conducted in Northern Cape showed that there was a prevalence of illicit drug use of 52 (12%) participants who were adolescents. They also found that the use of drugs increases as the grades of the participants increases that grades of the participant's increases. The author did note that their statistics were lower than that of the participants' counterparts in the US and affiliated with this being that Northern Province is a province that is rural and has values that do not encourage the use of drugs (Madu & Matla, 2002). Studies by Tshitangano and Tosin (2016), and PlüDdemann et. Al (2008) further emphasizes that individuals begin using substances within the adolescent period. Research carried out in low-income settings in South Africa by Tshitangano and Tosin (2016), focused on the use of alcohol, methamphetamine and cannabis (the main substances found to be used by young adolescents). Methamphetamine has become a widely used drug in recent years, amongst young individuals living in Cape Town (PlüDdemann et. al, 2008). Statistics gathered from rehabilitation facilities, reveal an increased number of methamphetamine users in individuals under the age of 20 (PlüDdemann et. al, 2008). The research overall heightens the concern for the at-risk population in Cape Town.

Drawing upon Erikson's psychosocial stages of development, adolescence is primarily associated with the psychosocial task of identity formation (Erikson, 1968; Erikson & Erikson, 1998). Young individuals between the ages of 13 to 18 years, fall into this psychosocial life stage of identity versus role confusion. During this stage of identity development, adolescent individuals go through the process of identity formation; they begin to develop a sense of who they are, explore who they would like to become, and consider how they can contribute to society (Erikson, 1968; Erikson & Erikson, 1998; McLeod, 2008). Identity refers to a sense of who a person is as an individual, as well as how one contributes to society (Sokol, 2009). There are various factors that contribute to identity formation (Erikson, 1968). Increased independence and autonomy leads greater exploration of new occupations, roles, and relationships within their community and school (Sokol, 2009); they begin to think about families, careers, housing, etc. (McLeod, 2008). As adolescents mature, they begin to form ideologies and moral values (Sokol, 2009), their expectations and responsibilities are increased, and they come to understand their role as emerging adults (McLeod, 2008). Multiple authors emphasise that young individuals are therefore vulnerable to substance use during this adolescent period, and are in agreement that substance use

negatively impacts the development of adolescent identity (Erikson, 1968; Erikson & Erikson, 1998; Sokol, 2009; McLeod, 2008; Crouch & Wegner, 2014).

Substance use can have detrimental consequences to an adolescent's development, particularly in relation to their identity (Erikson, 1968; Erikson & Erikson, 1998). The onset of puberty during adolescence leads to newfound cognitive skills (Sokol, 2009). When the individual is unable to manage the task of assessing their personal attributes and expressing them, the individual experiences an 'identity crisis' and role confusion occurs (McLeod, 2008; Erikson, 1968; Erikson & Erikson, 1998). This role confusion can lead the individual to question their personality and altering how they view themselves which can result in a sense of loss, confusion and unhappiness (McLeod, 2008; Sokol, 2009). Multiple authors correspond with Erikson's identity development theory, and agree that lack of identity development or role confusion, is suggested to be associated with an increased risk of engaging with alcohol and other substances, as a means to cope with this life stressor (Erikson,1968; Erikson & Erikson, 1998; Reed & Rountree, 1997; Amoateng, Barber, & Erickson, 2006; Schwartz, Mason, Pantin & Szapocznik, 2008.)

If substance use is present in communities and schools, adolescents between the ages of 13 and 18 years are more likely to experiment with these substances (Reed & Rountree, 1997).Amoateng, Barber, & Erickson (2006), and Schwartz, Mason, Pantin & Szapocznik (2008), found that negative changes to family structure or function (such as family stress), is another mechanism responsible for identity confusion and the increased likelihood of substance use, during the adolescent period. Multiple authors confirm that in addition to the negative impact on identity development, substance use during adolescence has detrimental occupational effects impacting an individual's health and well-being (Crouch & Wegner, 2014; Flisher, 2003; Masitsa, 2007).

The negative impact on the identity formation described by Erikson (1968) and Erikson & Erikson (1998), leads to problems relating to self-esteem, which in turn, impairs occupational performance and engagement (Crouch & Wegner, 2014). Poor identity development and role confusion has a negative effect in relation to activities of daily living (such as self-care), resulting in a decrease in one's self-esteem (Erikson, 1968; Crouch & Wegner, 2014). A

decline in engagement in restorative leisurely occupations may present as role diffusion results in negative cognitive and psychosocial effects, and maladaptive coping strategies (Crouch & Wegner, 2014). Various authors confirm the occupational effects described by Crouch & Wegner (2014). Multiple research findings reveal substance use negatively impact adolescents' occupational engagement or performance in school-related activities, resulting in poor scholastic attendance, and increased high-school drop-outs (Flisher, 2003; Masitsa, 2007). All these risks and consequences have made researchers wonder whether peer influence has an effect on substance use.

### *2.4.2 Substance use and peer pressure*

A common assumption is how peer pressure and peer influence are strong determinants of adolescent substance use (Reed & Rountree, 1997; Goliath & Pretorius, 2016; Mason, Mennis, Linker, Bares & Zaharakis, 2014; Masitsa, 2007.). In the study conducted by Masita (2007), it was found that peers have the most significant influence on young people who use substances. From the sample 24.6% used alcohol, 10.5% used tobacco, 4.3% used snuff and 3.5% used dagga (Masitsa, 2007). Santor, Messervey, and Kusumakar (2000) confirm that peer pressure is a strong predictor of risk-taking behaviours, and potential psychosocial difficulties. The degree to which young people feel pressured by friends, in general, correlates with alcohol, cigarette and drug consumption (Santor, Messervey, and Kusumakar, 2000). However, it is unclear to what extent peer pressure predicts the actual use of drugs or alcohol. Van Ryzin, Fosco & Dishion (2012) uncovered that the probability of tobacco, marijuana and/or alcohol use in adolescents between the ages of 15 and 17 years, regardless of race or gender, greatly increased when their friends used a certain substance. Conversely, in the study conducted by Reed and Rountree (1997), it was found that peer pressure does not influence substance use significantly, rather the influences of socialization, rationalization and social selection play a significant role.

According to a longitudinal study conducted on a sample of 12 to 15-year olds by Osgood et. Al. (2013), it was found that the likelihood that an individual would begin drinking alcohol increased by approximately 55.1% of their friends consumed alcohol is slightly higher qualities than the average. Furthermore, adolescents who drank alcohol were discovered to have an

increased probability of gaining and maintaining friendships, thereby increasing an adolescent's prospect of exposure to peer-influence around alcohol use (Osgood et. Al., 2013). Additionally, Osgood et. Al. (2013) discovered that young adolescents were more inclined to choose friends who shared comparable alcohol use to themselves. This phenomenon contributes to the positive correlation between adolescents and their friends' alcohol use (Osgood et. Al., 2013).

Adolescents between the ages of 12-14 years that presented with poor social skills when confronted with peer deviant behaviour, are more susceptible to perceived peer pressure, and had a higher probability of adapting their substance use to equate to that of a close friend (Allen, Chango, Szwedo, Schad & Marston, 2012). Furthermore, adolescents whose close friends were more popular in the context of their larger peer group showed a greater prospect for emulating their close friend's extent of substance use (Allen, Chango, Szwedo, Schad & Marston, 2012).

From the ambiguous literature findings, the exact influence that peer pressure has on substance use seems uncertain. However, it is still evident that peer pressure is, to some extent, a contributing factor, which indicates the need for more research to be completed.

### ***2.4.3 Common substance use patterns***

Whilst investigating the effects of peer pressure and looking at habitual norms, Masitsa (2007) found that most students in their sample used substances during the weekend. The most preferable time to use substances was when they were around their peers, and this time-period allowed them to engage in substance use without the looming presence of teachers or parents (Masitsa, 2007).

Goncy & Mrug (2013) investigated cigarette, alcohol, and cannabis use in adolescents aged 10-19 years, and found that their chosen time and location to engage in substance use differed according to factors such as age and gender. The number of adolescents who reported consuming alcohol, and smoking cigarettes or marijuana, was found to be higher on the weekends, and when they were around their friends (Goncy & Mrug, 2013). Whilst no

gender differences in time or location of cigarette use were noted, it was found that more males than females in the 15-19-year age range, reported consuming alcohol prior to, and after school (Goncy & Mrug, 2013). An increased number of males of the same age range reported using marijuana before, during and after school, compared to females; whilst more 15-19-year-old females reported using marijuana on weekends, in comparison to males (Goncy & Mrug, 2013).

Mhlongo (2005) and George (2005) noted findings that school-going adolescents tend to use substances more commonly in the mornings before school, or during their lunch break. With substance use patterns being looked at it, it is important to discover what else impacts the use of substances.

## 2.5 Contextual factors influencing substance use

Alcohol (and other substance) consumption has proven to have a detrimental effect on health and wellbeing; with around 3.8% of global deaths and 4.6% of global disability-adjusted life-years (DALYS) being attributed to alcohol use (Rehm et al., 2009). This burden of disease was found to be correlated more highly with the volume consumed among marginalised groups, and people with a low socioeconomic status (such as those in the community of interest; Ocean View). Specifically studying the global substance use burden, substance dependence was the largest of the four causes (68%) resulting in premature morbidity and mortality (Degenhardt & Hall, 2012). Aside from the burden of disease, other adverse effects of substance use include stigma, peer pressure and discrimination increased criminal behaviour, and decreased safety in a community (violence threatens consumers and the larger society). Substance use adds to social detriment health costs; accounting for over 1% of the gross national costs for middle-income countries like SA (Rehm et al., 2009). Multiple studies conclude that substance use is an avoidable risk factor adding to the burden of disease, and urged measures to be put in place with the attempt of reducing this burden. Therefore, in line with the study's aim; determining the prevalence of substance use will provide information needed to highlight areas for intervention.

High incidences of crime and violence are noted to occur across South Africa (Meth, 2016). Within the Western Cape, gang violence is explained to be the largest cause of crime and is associated with the selling and use of substances. Crime is a common occurrence within the adolescent population (Su, Supple & Kuo, 2018). Adolescents are becoming increasingly involved in 'drug running' (where gang members use young people to handle substances) and gang violence. Consequently, this population of young people has greater access to substances. Shields, Nadasen and Pierce (2008) explain that being exposed to any form of violence results in noteworthy psychological distress. Shields, Nadasen and Pierce (2008) suggest that the amount of violence witnessed by an individual, is directly proportional to their subjective experience of distress. Therefore, there may be a possibility that the high levels of violence witnessed by individuals in Ocean View, and the correlating distress they experience from this, could be a contributing risk factor for the increased prevalence of substance use in this area.

South Africa has notably high unemployment rates which contribute to high incidences of crime, violence and idleness. These negative contextual factors are exacerbated by a lack of occupational engagement opportunities within this context (Woolard, 2002). A lack of opportunities and supportive environmental factors (such as infrastructure) which facilitates leisure occupational engagement, is strongly, positively correlated with increased substance use by individuals in the community, with specific reference to young adolescents (Masitsa, 2007).

Lastly, adolescents often model behaviour that they observe within their home or immediate context (Masitsa, 2007). High incidences of violence and drug use within the area, and within an individual's observable range, could be a contributing factor to substance use within this population. Parents or their parenting style can also play a role in adolescents' use or exposure to substance use (Matsumoto & Juang, 2016). Parents may use substances themselves, and thus can create an environment that exposes adolescents to drug use, often from a very young age (Matsumoto & Juang, 2016). This literature review reveals the global, national and provincial burden of substance use, and its harmful effects amongst school-aged adolescents. Much of this evidence dates years back, and there is a need for more research to be carried out. The impact of substance use is clearly felt by under-resourced communities

in South Africa and the Western Cape, but there is limited research on the extent of substance use in these communities, such as Ocean View.

## 2.6 Chapter Summary

Based on all the above-conducted research, the main findings indicate that substance use is a pressing problem in South Africa and the Western Cape. Substance use rates have increased drastically, especially amongst the adolescent population. Looking at the most prevalent types of substances used within a South African context, it was found that the most commonly used substances were alcohol, methamphetamine, and cannabis. It is also evident that there are gender differences in substance use.

Additionally, the prevalence of substance use specifically in relation to the development stage of adolescents was explored. Children between the ages of 13 to 18 are likely to use substances; during this time of identity formation, peer pressure often leads to experimentation.

However, upon conducting this research, it was found that there are gaps in the literature. There is limited research available on substance use in adolescents of school-going age, within South Africa and the Western Cape. There is also limited research specifically on substance use, and contextual factors influencing substance use, within the context of Ocean View itself. Therefore, this study aims to investigate the prevalence of substance use in school-aged adolescents in Ocean View with the aim to address the gaps evident in the current literature. Chapter 3 outlines the methodology in an attempt to address this research gap.

# Chapter 3: Methodology

## 3.1. Introduction to chapter

The following chapter outlines the step by step process and procedures followed in order to address the gap in literature. All details are given, starting with how the research process was designed, which participants were included, the reliability and validity of the questionnaire, to the details of how researchers went about collecting and analysing data. Throughout this research process, researchers strived to uphold ethics and thus, the end of the chapter outlines which ethical considerations were adhered to.

## 3.2. Research Approach and Design

### *3.2.1 Research approach*

A quantitative approach was chosen in order to answer the research question. Quantitative research involves the use of inquiry strategies to measure and observe phenomena in order to describe and contextualise a frequency of occurrences, thereby developing knowledge about a certain phenomenon (Creswell & Creswell, 2017).

### *3.2.2 Research design*

A suitable design chosen for this study was a descriptive cross-sectional design. A descriptive cross-sectional design portrays and explains an existing phenomenon, whilst simultaneously collecting data from participants at a point in time using a cross-sectional survey method to depict a current occurrence (Brink, van Der Walt & van Rensburg, 2006).

## 3.3. Population and Sampling

### *3.3.1 Population:*

The impact of the problem of substance use in Ocean View is multi-layered. Violence and gang exposure in the community has resulted in PTSD, depression, attempted suicides, and substance use, and other mental illnesses ("[Video] “In Ocean View, we are too far away from mental health facilities” | Live Mag", 2018). Degenhardt and Hall (2012) agree that the use of

substances and especially dependence, has a detrimental effect on health; contributing to the cause of mental illness. Ocean View residents face many socioeconomic challenges, including exposure to a culture of alcohol and drug use (crystal methamphetamine is sold for R5) ("Ocean View – Living Hope", 2018). This alcohol and drug use norm means affordable and easy access to substances for adolescents. Gangs and violence are said to result from drug problems; making the community unsafe for its inhabitants ("Ocean View – Living Hope", 2018). These issues are directly and indirectly affecting individuals within the Ocean View community and to determine the population for this study, participant who were in some way affected needed to be selected

When determining the sample population, the aim was to have participants that represented the overall population of Ocean View that encountered these issues related to substance use. The population is the members of a certain set or class of people that are the focus of research (Payton, 1988). The study population included school-aged adolescents in Ocean View. This population was males between the ages of 15 and 17 years and could be participants of any race. These participants were either fluent in English or Afrikaans. Exclusion criteria were those participants who were either above or below the abovementioned age group.

### *3.3.2 Sampling Method and Sample size*

This study made use of convenience sampling was used, where participants who volunteered and available were selected (Polit & Beck, 2017). Recruitment of participants was carried out by Living Hope specifically identifying a group of possible participants. Once the researchers gave information about the study, recruiting participants involved word of mouth and snowballing as adolescents share the information with each other.

All students attending the Living Hope homework club programme or sports teams were invited to participate in the study through a brief presentation (summarising key details around the study, procedure and purpose as a synopsis of the information sheet which was distributed), where information sheets, consent and assent forms were distributed to each potential participant. All potential participants who returned signed consent and assent forms (by the previously agreed date) and thus meet the outlined inclusion criteria were included in the sample for this study. The sample size consisted of nine participants.

## 3.4. Instrumentation

The instrument used was a non-standardised questionnaire developed by the researchers. The research objectives, literature review and the youth risk behavior survey, which is a standardized tool, were used in order to develop the questionnaire (Morojele et al., 2013). The questionnaire was adapted from the youth risk behavior survey, questions that apply to the proposed study were chosen, and the language was simplified. The questionnaire was translated into Afrikaans. The questionnaire was self-administered and provided both categorical and numerical data with close-ended questions.

Reliability can be defined as the degree to which the measurement instrument (questionnaire) produces reproducible results (Polit & Beck, 2017). The data collection instrument was developed with the intention of ensuring reliability. The researchers did this by ensuring inter-rater reliability.

Inter-rater reliability can be described as the extent of agreement amongst raters or interviewers, whereas intra-reliability is the consistency of the measurement over two or more occasions completed by the same person (Polit & Beck, 2017). The same set of instructions was given to each participant, and standardised ways of answering common potential questions were used, thus ensuring the consistency of the questionnaire, and consistency in the administration process of the questionnaire. Identical questionnaires were administered to each participant at the same time on the same day, in the same venue, with researchers present to answer any questions they may have, in order to ensure reliability.
The simple structure of the self-administered questionnaire where participants ticked or answered close-ended questions means that inter-reliability can be ensured as there is no room for interpretation; thus, the same results will be achieved regardless of who the researcher is.

The utilised measurement instrument needed to provide high validity. This was achieved through considering face, content and construct validity.

Face validity can be defined as the degree to which the questions make sense to the participants (Polit & Beck, 2017). In this study, face validity was ensured by having both English and Afrikaans versions of the questionnaire (taking into account language barriers). The researchers used a simple format for the questionnaire, and ensured that all the questions were relevant and easily understood by the participants in the study.

Construct validity refers to the extent to which the indicator of a concept represents the concept of interest (Polit & Beck, 2017). This study's construct was the questionnaire that was used to indicate and correctly represent the concept of the research question. A relevant questionnaire was developed, in order to address the research question and achieve the objectives. Thus, each question presents in the questionnaire pertained to the research question and/or objectives, and the answers to these questions gave the necessary information for the research question and objectives to be answered, without gaining information unrelated to the research question and objectives.

Content and construct validity were also established through the use of consultation with relevant experts in substance use and quantitative research, who provided input regarding whether information included in the instrument was relevant and valid to the sample group, and was representative of all current content that is applicable to the study. The feedback that they provided was used to adapt the questionnaire where necessary, in order to more adequately cover all aspects of substance use in the age group (the questions asked to encompass all facets of the research question and objectives), and to ensure that the questions provided the correct information, in order to answer the research question and objectives. The research question and objectives were closely used to formulate the questions, thus ensuring a higher construct validity, as the questions provided the required information to answer these. Additionally, questions related to the research question and each of the objectives were developed to better ensure content validity, and the questionnaire encompasses all aspects of the construct.

The questions taken from the questionnaire used in Morojele et al.'s (2013) survey were relevant to age and substance use, and adapted these to fit the criteria of individuals between the age of 15 and 17 gender, substance use of alcohol, methamphetamine and cannabis

(which were identified as more frequently used substances in the indicated population through a review of literature around substance use( W.C. Harker, et al. 2008, Tshitangano and Tosin, 2016). This was done in order to ensure content validity, which entails the instrument accounting for all elements relevant to the concept being investigated, including the research question and the objectives (Polit & Beck, 2017).

## 3.5. Procedure

The research proposal was submitted to the Human Research and Ethics Committee (HREC) at the University of Cape Town (UCT), Faculty of Health Sciences for ethical approval. Once ethical approval had been granted, the researchers assembled a panel of experts who were asked to review the compiled questionnaire in order to ensure its validity. After which the appropriate amendments were made to the questionnaire prior to the commencement of the study.

Once ethical approval had been granted, the researchers began the process of obtaining permission from the relevant stakeholders. Firstly, the Western Cape Department of Education (WCDoE) was contacted for permission to gain access to Ocean View Secondary School. After obtaining this permission, a written request was sent to the principal at the School. Permission from Ocean View Secondary was not granted. The principal explained that in the past, learners have passed on false information resulting in the community of Ocean View being incorrectly represented. The NGO, Living Hope, was approached in order to assist with community entry (requesting permission from community leaders) as they are already an existing organisation working within the community of Ocean View.

An information meeting was held on a negotiated evening in 2019 in Living Hope's facilities, where relevant community leaders were invited to attend. This meeting was hosted by the researchers, where information around the study and its purpose was set to be introduced, and a space was provided to answer any questions that arose. No community stakeholders attended this meeting.

The researchers made two further visits to Ocean View in an attempt to recruit research participants. These attempts also failed as no one was willing to take part

Participants were then recruited through Living Hope and Ocean View community members by word of mouth. The researchers visited Living Hope and the local soccer club on a negotiated day in 2019; to introduce the study and its purpose to the participants (the Living Hope Aftercare Programme and local soccer club were invited to participate). On the same day, a brief presentation summarising key details around the study was held with all the participants, this included: the procedure to be followed, the purpose, a synopsis of the information sheet, explanation about voluntary participation, and information regarding information on the assent and consent and assent forms. An incentive was offered to all willing participants; a R20 voucher would be given to them if they are willing to participate. Information sheets, consent and assent forms (double-sided and stapled pages) were then distributed by the researchers to each participant. The participants were informed that if they wanted to participate, they could read the information sheets for more information. Each participant had the choice of either an English or Afrikaans translation of the questionnaire. The participants were notified that participation in the study was voluntary, and if they would like to participate, they would need to sign the assent form, and ask their parents to sign the consent form and return it. The participants were requested to return relevant documents (signed or not), on a given date after the first visit. The adolescents from the holiday club were unwilling to participate but members from the local soccer club were willing and the Living Hope handed consent and assent forms to those who did not meet the supervisors. All consent and assent forms were returned to the Living Hope facilities by placing said forms in a sealed box (with a slit on the top). This box was collected by the researchers on the agreed date of return.

The researchers returned to the local soccer club on the negotiated day to distribute and administer questionnaires to those who have handed in completed consent and assent forms. All the participants were gathered in an allocated private space at the same time. Once all the participants are seated, the researchers explained the questionnaire to the participants and handed them out to be completed. Voluntary participation and withdrawal were reiterated. Participants were reassured that the goal of this study was to test the questionnaire and not to judge them on their substance use patterns. If the participants had any questions, they were answered by the researchers. Nine male participants handed in

completed and signed consent and assent form and they each completed the questionnaire. Completion of the questionnaire took between 10 to 15 minutes, depending on the participant answering it. Once all participants had completed the questionnaire, the questionnaires were deposited by the participants in a sealed box which was collected by the researchers. Each participant received a R20 airtime voucher to thank them for their participation. Anonymous questionnaires, consent and assent forms were stored in a locked cabinet in the supervisor's office. Once all the questionnaires had been retrieved, they were handed over to one of the researchers who manually collated the data and then researchers began data analysis.

## 3.6. Data Collection

Data was collected using a non- standardized self-administered questionnaire comprising of three different sections (personal information, schooling and substance use), which required the respondents to fill in the questions by themselves. This required the participants to answer 15 questions around demographical aspects in section A and B, and between four and 44 questions in section C on drugs, depending on whether the participant used said drug or not. Section A and B comprised mainly of multiple-choice answers. Section C included yes/no answers, as well as fields that required the participants to fill in information such as their age when they first used the drug, as well as naming/listing other drugs they have used. The questionnaires were available in both Afrikaans and English which the participants were given the chance to choose which one they preferred to answer in. The researchers were present during the administration of the questionnaire and were available to help assist if the need had arisen. The questionnaire can be found in Appendix D.

## 3.7. Data management

Questionnaires were completed and collected whilst the researchers remained on site. The hard copies of the questionnaires were kept on the researchers' person at all times. The data collected was recorded on an excel spreadsheet and stored on google drive, which only the researches had access too. Each participant was allocated a number at random, and the data collected from each participant was recorded in a numerical table format, on Microsoft Excel. Once information was transferred to online, digital information; it was kept on a document

that was secured with passwords only known by the researchers. The hard copies were handed over to the UCT supervisor to be preserved for six years. The hard copy data was locked up securely in a cabinet, in the UCT supervisor's office. Access to research information will be solely granted to researchers and the research supervisor.

## 3.8. Data Analysis

Data was interpreted through the use of Microsoft excel. The data collected from the questionnaire was both categorical and numerical with a focus being on descriptive statistics. Data were analysed according to how each question was answered, how various sections were answered, how well they were answered and what questions were not answered. Additionally, reasons for confusion and misunderstandings were analysed. Measures of central tendency (mean, median and mode), as well as frequency measures, were used to analyse the collated data. Pie charts and bar graphs were constructed, representing certain patterns of how questions were answered. These results were then interpreted and explanations and recommendations were given.

## 3.9. Ethical Considerations

The study was conducted according to the principles outlined in the Declaration of Helsinki (Millum, Wendler & Emanuel, 2013). Data collection commenced only once ethical approval had been obtained from the HREC at UCT. The ethical processes outlined above were adhered to wherever possible. However, some of the ethical principles were not able to be fully addressed and will be detailed in the discussion and limitations section.

**Respect**

Respect for the participants of this study as well as the members of the Ocean View community and relevant parties consulted during the research process. Measures were taken to ensure the confidentiality and protection of collected data from participants. Researchers informed all participants that they were allowed to withdraw from the study at any time during the research, and not be penalized for this (in accordance with informed consent and assent forms). Efforts were made to consult members of the community, involved organizations and participants were prior to and during the research process and were given

the study results upon completion of the research study. If any new information arose during the study, participants were informed.

**Beneficence**

Beneficence refers to doing the most good. Drawing on the principles of scientific validity and fair participant selection in the declaration of Helsinki, participants in this study were sampled or chosen for scientifically valid reason. This study offered no individual benefits; the benefits of this study lay within the context of Ocean View as a whole.

Drawing upon the ethical principle of social value; this research had social value within the community of Ocean View, and for the Living Hope Organization. The research study was conducted in order to understand the depth of the problem of Substance Use within Ocean View and aimed to reduce the impact of substance use in Ocean View. This research was useful within the context of the health problem; it highlighted the problem for the community, as well as assisted the Living Hope Organization develop effective, socially and culturally relevant intervention strategies to alleviate the increasing prevalence of substance use and reduce the impact of substance use in Ocean View. Referral mechanisms for participants who reported substance use of their own, or within their families were put in place. After the questionnaires were handed out, the researchers gave a brief talk to the participants about what support services are available within Ocean View, and surrounding areas. Pamphlets and flyers summarizing the information regarding support services were handed out to the participants.

**Non-maleficence**

Non-maleficence refers to doing no harm. The participants recruited to take part in the study were vulnerable due to their age and developmental stage as adolescents, as well as their socio-economic environment. Upholding the ethical principle of fair participant selection, considering the participants' vulnerability; precautionary measures were taken to ensure that they do not come to any harm through participating in the study. Participants were protected through informed consent (given by a parent or legal guardian) and confidentiality; they had the freedom to choose whether to participate or not. In line with the ethical principle of favorable risk-benefit ratio, this research had a favorable risk-benefit ratio within the community of Ocean view; the study did not bear any harmful risks on the community.

Additionally, drawing on the ethical principle of fair participant selection, the study design reached the objectives of the research, without denying participants access to health services. Data was collected in a realistic, reasonable timeframe by using quick, efficient, comprehensible method of convenience sampling. Finally, this research study did not cause participants harm to their identity or reputation, because everything that they shared was kept confidential. There was an emotional risk associated with the study. However, the participants were adequately informed about the emotional implications associated with the study beforehand. The participants could decide not to participate in it they felt like it will be too emotionally taxing. All researchers were taught basic counselling skills during the course of their studies and were therefore equipped to contain the participants if they become distressed while completing the questionnaire. The researchers also made sure the participants aware of the referral process that will be followed, should they require further support after the researchers had left the site. This included providing the participants with numbers of various organisations such as Childline South Africa, Lifeline and the South African Depression and Anxiety Group (SADAG). Any substance use reported within the questionnaire could not undergo a referral mechanism, as the questionnaires were anonymous. However, if participants disclosed to the researchers directly about their own or a family member's substance use, the researchers provided them with relevant referral mechanisms that they could choose to make use of. This included information about Alcoholics Anonymous (AA), Narcotics Anonymous and the City of Cape Town's 24/7 toll-free alcohol and drug helpline on 0800435748.

**Informed consent**

Informed consent involved the method of ensuring the autonomy of all participants was preserved, by allowing each individual to make the decision of whether and how they wished to participate in the study. This decision was made with the participants knowing all possible risks and benefits before the research was conducted, (information was provided to the participants in the information sheet - see in appendixes). There were no physical risks involved in participating, but this study did provide the risk of emotional triggers to participants who had experienced trauma relating to substance use. The acknowledgment of emotional risk was clearly stated in the informed consent and assent forms. Participants were informed of the emotional risk of the study. Parents or guardians were well informed of the

potential risk of the study on their child's emotional well-being when deciding whether or not to allow their child to participate. The informed consent and assent forms also clearly stated that this study would offer no individual benefits and that the benefits lay solely on a community level.

Informed consent and assent forms needed to be given by the individual's legal care guardian prior to participation in the study. The consent and assent forms were sent home with each potential participant to be given to their legal guardian. The consent and assent forms were adapted to match the literacy level of each of the age groups of the study's participants. Both the consent form and assent forms had to be signed in order for the potential participant to take part in the study. This was done in order to protect the rights of the participants, who, aged between the ages of 15 and 17, were considered to be vulnerable persons.

**Justice**

In upholding the ethical principle of justice for the duration of the study, all school-aged adolescents in the population sample had an equal chance of participating in this study. This ensured that the first of the three aspects of justice were upheld. Questionnaires were handed to all interested participants, and all participants faced equal risks and benefits. If participants could not read or understand questionnaires, the researchers explained it to them, allowing them a fair opportunity to take part. In maintaining reciprocity; the results of the study were explained to participants, to the community and to stakeholders; ensuring that the study was mutually beneficial. By upholding impartiality, numbers allocated to participants ensured that none of their findings were analysed unfairly or differently. By implementing the inclusion criteria for participant selection, no one was excluded unfairly.

**Autonomy**

As mentioned, the autonomy of all participants was preserved by allowing each individual to make the decision of whether and how they wished to participate in the study. Participants were also given the choice of withdrawing their participation at any time during the study, without experiencing any consequences. Not only were the participants respected by being treated as autonomous agents, but those with diminished autonomy were entitled to protection (Ehrlich & Joubert, 2014).

**Confidentiality**

To ensure confidentiality, data collection was achieved through participants filling in a questionnaire anonymously. A number was assigned instead of having the participants write their name on the questionnaire. Researchers ensured that the participants answered the questionnaires in solitary fashion, by providing separate workspaces for each participant to fill their questionnaire in. Sealed boxes were provided for the participants to place their completed questionnaires in, ensuring complete anonymity.

**Truth-telling**

Veracity is the principle of truth-telling, based on respect for individuals and the concept of autonomy (Bennett-Woods, 2005). Without truth-telling, the participants would not have all the information to make their decision. Truth-telling was ensured by making sure no deliberate, incorrect information was given or withheld and/or omitted when explaining the purpose of the study, and using the questionnaire (Bennett-Woods, 2005). The principle of truth-telling was also ensured by not cloaking any of the information in language which the participants did not understand. Providing participants and the community with any information that arose during the research study, as well as the end results, assisted in respecting all those who participated (Millum, Wendler & Emanuel, 2013).

## 3.10. Chapter Summary

These principles outlined in the Declaration of Helsinki (Millum, Wendler & Emanuel, 2013) were adhered to, wherever possible, in this study. These included respect, beneficence, non-maleficence, informed consent, justice, autonomy, confidentiality and truth-telling.

The principle of *beneficence*; ('doing the most good') was upheld in this research process. Participants were recruited on the basis of a scientifically valid reason. This study had a favourable benefit to risk ratio, and social value within the context of Ocean View, in relation to addressing the problem of substance use in school aged-young people.

These principles of *respect* and *non-maleficence*; ('doing no harm'), were upheld by implementing measures to ensure confidentiality of the data collected from participants, and through the process of informed consent. This research did not deny participants access to

health services. Referral mechanisms were put in place; to ensure participants had access to appropriate support services.

Due to the participants' young age; *informed consent* was ensured in this study through the use of a consent form, and an assent form; to ensure their decision to participate was autonomous.

In upholding principles of *justice*, equality was ensured for participants through promoting fair opportunity, and reciprocity - ensuring equal risks and mutual benefits.

The *autonomy* of participants was upheld by giving participants the choice of whether they wish to participate in the study as well as giving participants the choice to withdraw from the study at any time, without consequences.

*Confidentiality* was upheld in the study; the questionnaires and information provided by participants were anonymous.

The principle of *truth-telling* was upheld by ensuring no information was omitted from participants during the study. The study was explained clearly to the participants, relevant stakeholders and third parties. The participants, community and relevant stakeholders were provided with the results of the study

# CHAPTER 4: Results

## 4.1 Introduction to chapter

In this chapter, the characteristics of the participants will be presented to provide a better understanding of the general population of Ocean View in relation to the sample of participants that were used in the study. The findings of the questionnaire that was used in the study will also be presented and discussed. Lastly, the results around the validity and reliability of the questionnaire will also be discussed, in terms of how accurately and appropriately the questionnaire was answered by the nine participants and thus whether the questionnaire can yield the results required to answer the research question and related objectives.

According to the 2011 Census the demographics of Ocean View are as follows (Frith, 2011): 51.04% of the population is female with 48.96% being male; 93.38% of the population identifies as coloured, 6.80% as Black African, 0.93% as Other, 0.63%, as Indian or Asian and 0.26% as White. Considering the very small sample size of nine participants and the subsequent poor representation of the Ocean View population (as seen by comparing the demographics of the sample to those found in the most recent Census), as well as the poor representation of the full 15-17 year age range, it is not possible to generalise the results found in this study to the Ocean View Population of the 15-17 age group. Thus, the results discussed in this Chapter purely speak to inferences one can make around the prevalence of the nine participants' substance use.

## 4.2 Participant characteristics

As previously mentioned, a convenience sample of nine participants, who had volunteered to be part of the study, was used. All of the nine participants were male, with seven participants being born in 2004 (14/15 years old) and two born in 2003 (15/16 years old). All of the participants resided in Ocean View the majority of the participants having attended Ocean View Secondary School and with only one participant having attended an alternative school, namely Generation Imhoff. Five of the participants were in Grade nine, with the remaining four participants equally divided between Grade eight and ten (two participants in each). Six

participants racially identified as Coloured, while two identified as Black African and one identified as White.

## 4.3 Questionnaire Findings

The results from the study were interpreted in relation to the fact that only nine participants partook in the study. No generalisations were intended to be made from the results, but rather the identification of these results in relation to the research objectives. Therefore, assisting to determine whether the questionnaire (measurement instrument) was able to capture the intended data required to answer the research question. This in turn speaks to the content and construct validity of the questionnaire. All of the participants responses which were deemed inappropriate by the researchers (as the participants answer contradicted a previous answer given by said participant) were excluded from the results discussed below. This was done in order to ensure the results are a more accurate representation of these nine participants substance use as well as person and contextual factors.

### 4.3.1 Frequency of participants reported substance use

The questionnaire asked participants a series of questions around their use of both three specific substances (namely alcohol, cannabis and Tik) as well as on any other substance they identified having used. From Figure 1, it can be seen that out of the three specific substances listed in the questionnaire (alcohol, cannabis and Tik), five (56%) of the participants had tried alcohol and three (33%) had tried cannabis before. Eight (88%) of participants reported never having tried Tik before, while the remaining one participant did not give an answer to said question. Therefore, most of the participants reported having never tried Tik before. Figure 2 shows that one participant listed tobacco as an “other” drug which they reported having used before.

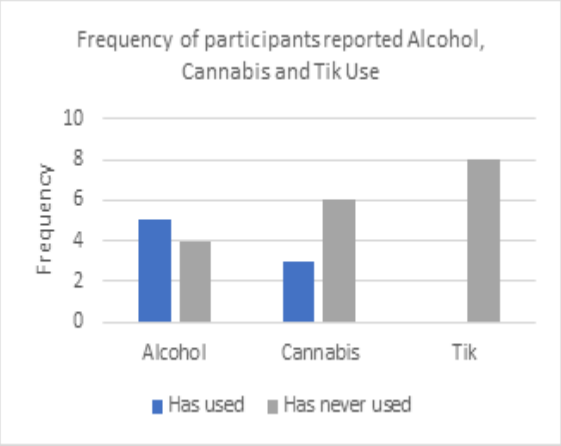


Figure 1: Substance which was most commonly used

Moreover, Figure 3 shows the number of substance's that each participant reported using. Three (33%) participants reported having used no substances, four (44%) reported having used one substance, one (11%) reported having used two substances and one (11%) reported having used three substances. The average number of substance's that each participant reportedly used was one substance. While, the most substances that a participant reportedly used three substances, with the least number of substances a participant reportedly used was no substances. Lastly, the most common number of substances a participant reported using was one substance.

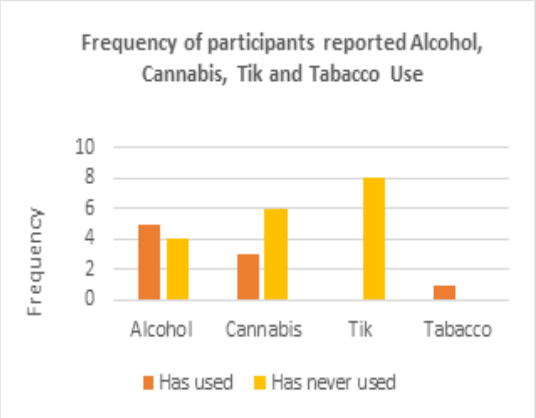


Figure 2: Substance which was most commonly used (including tobacco)

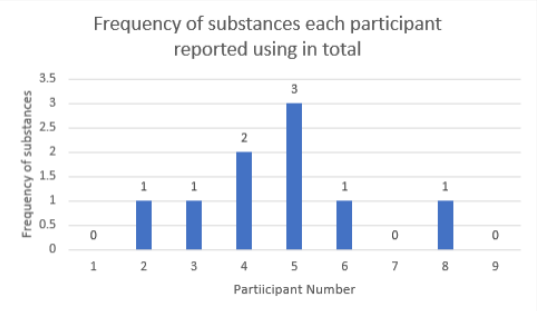


Figure 3: Frequency of substances each participant reported using in total

These results speak to the objective of establishing which substances are most commonly used by school-aged young people in Ocean View, meaning that this objective could be answered by the data collated from the responses to the questions asked in the questionnaire (which speaks to the questionnaire's content and construct validity).

### 4.3.2 Frequency of participants born in 2003 or 2004 reported total substance use

With regards to the objective of establishing at what mean age substance use was the most prevalent amongst school-aged young people in Ocean View, Figure 4 shows that in total seven incidences of substance use were collectively reported by participants born in 2004. Additionally, in total two incidences of substance use were collectively reported by participants born in 2003.

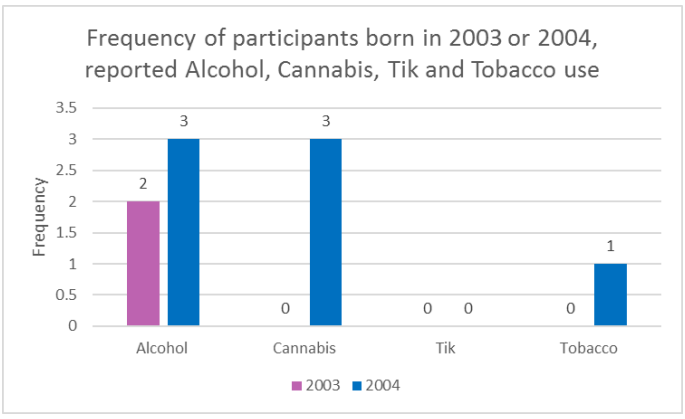


Figure 4: Most prevalent age for total reported substance use

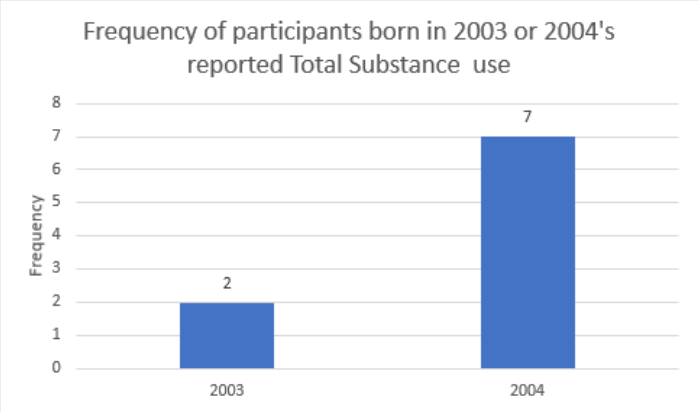


Figure 5: Most prevalent age for specific reported substance use

As seen in Figure 5, both incidences of collectively reported substance use by the two participants born in 2003, were reports of alcohol use. While of the incidences of substance use collectively reported by the participants born in 2004, three incidences were alcohol use, three of cannabis use and one of tobacco use. This makes, alcohol the most frequently substance collectively reported by participants born in 2003 and alcohol and cannabis the most common substances collectively reported by participants born in 2004. Furthermore, of the two participants born in 2003, both reported using one substance each. While of the seven participants born in 2004, three reported having never used any substances, two reported having used one substance and the remaining two participants reported having used two and three substances respectively. However, regardless of the year in which participants were born, on average each participant reported using one substance each. Thus, although more incidences of substance use were collectively reported by participants born in 2004 when considering the skew of the number of participants born in either 2003 or 2004, there appears to be no difference in the prevalence of substance use between those born in 2004 or 2003 in this sample of nine participants. In reference, to the content and construct validity of the questionnaire, the above-mentioned objective could be answered through the responses to the questions posed in the questionnaire.

### 4.3.3 Age of onset of substance use amongst school-aged young people in Ocean View

Speaking to the objective of the 'age of onset of substance use amongst school-aged young people in Ocean View', the results (as represented in figure 6 below) show that of the five (56%) participants that reported having tried alcohol, only one participant did not provide the age at which he started using alcohol. One participant who reported using alcohol (25%) was 13 years old when they first tried it, two (50%) were 14 and one (25%) was 15 years old. Of the three participants who reported having tried cannabis, two (67%) were 13 years old when they first tried it and one (33%) was 15. The single participant who reported having used

tobacco before, reported first trying it at the age of 14. In total, the mean age that any participant started using any of the above-mentioned substances, which participants reported having used, is approximately 14 years old.

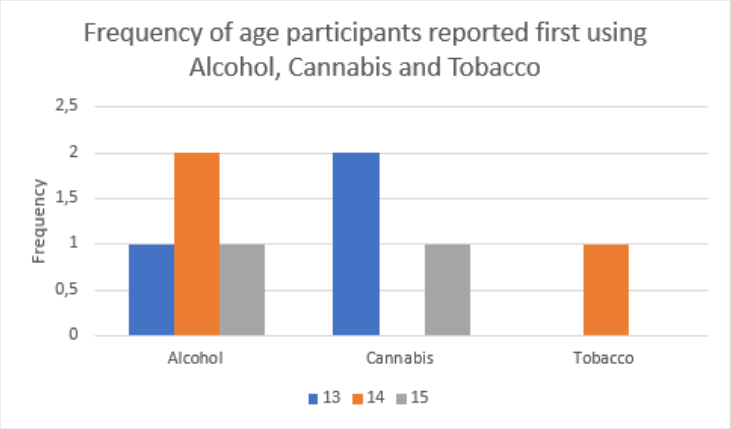


Figure 6: Age of first use of specific substance

## 4.4 Evaluation of how the Questionnaire was answered

### 4.4.1. Proportion of English and Afrikaans Questionnaire's administered

With regards to the proportion of questionnaires administered in different languages, Figure 7 shows that six participants (67%) requested to complete the questionnaire in Afrikaans, while three participants (33%) chose to complete the questionnaire in English.

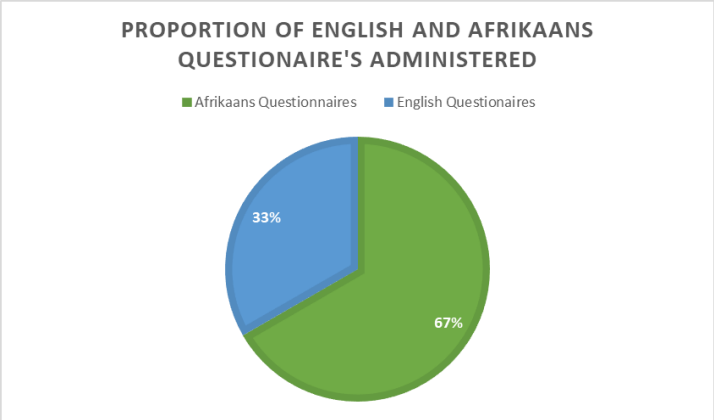


Figure 7: The number of Afrikaans questions compared to English questionnaire requested by participants

### 4.4.2. How well the questionnaire was answered

The questionnaire comprised of 62 questions that each participant could potentially answer, meaning that from the sample of nine participants 594 questions in total were responded to by all nine participants (either through an answer or lack thereof). The Questionnaire was broken down into three sections, namely: Section A which spoke to the participants personal information (birth year, area of residence, gender etc.), Section B which asked questions around the participants schooling (such as whether they have repeated a grade due to failing

exams, whether they like their school and if it is a safe place to learn etc.) and Section C which explored the participants substance use through a set of repeated questions asked for their use of alcohol, cannabis and Tik as well as for any other substance they reported using (the questions included whether they have ever used said substance, how old they were when they first used said substance, if they have used said substance in the last 30 days, month and year as well as how often they used said substance in the last year).

Section A consisted of nine questions, Section B of eight questions and Section C of 49 questions, which each participant responded to through an answer or lack thereof

Considering that each participant was not required to respond to questions pertaining to their use of a substance that they have not reported using, not each participant was required to answer each of the 62 questions present in the questionnaire. Thus, with regards to how the participants answered the questionnaire (speaking to the face validity of the questionnaire), it was considered that a participant answered a question well if they either answered a question when an answer to said question was required or did not answer a question when an answer to said question was not required. Furthermore, a question was considered poorly answered when a respondent either did answer a question when said question did not require an answer from said participant or when the participant did not answer a question when said question required an answer from said participant. It was found that eight of the nine participants answered at least one question in the questionnaire poorly. In total seven of the nine participants answered at least one question when an answer to said question was not required, while five participants did not answer at least one question when an answer to said question was required. Looking closer, Figure 8 shows the number of questions each participant answered poorly (for either reason). The mean number of total questions answered poorly is 18 questions per participant, while the most common number (mode) of questions answered poorly by a participant is four questions. Furthermore, the greatest number of questions answered poorly by a single participant is 37 questions with no questions

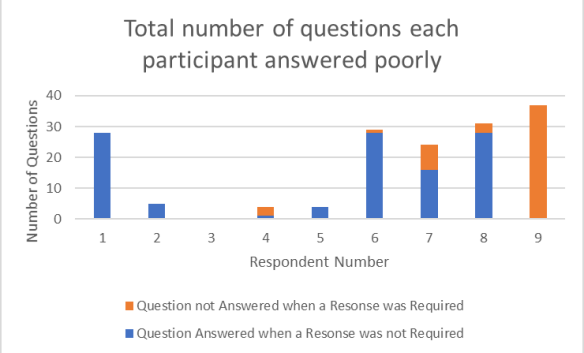


Figure 8: The total number of questions each participant answered poorly in their Questionnaire

being answered poorly by a single participant being the least. With regards to the number of participants that answered questions poorly by providing an answer to a question that did not require an answer from said participant, on average each participant answered 12 questions that did not require an answer from them. Additionally, the most common number of questions a participant answered which did not require an answer was 28 questions with the most number of questions being 28 and none being the least. As for the number of participants that did not answer questions that did require an answer from said participant, on average each participant did not answer six questions which they were required to answer. Moreover, the most common number of questions a single participant didn't answer when an answer was required was none, with 37 being the most and none being the least.

As seen in Figure 9, of the 564 total questions answered collectively by all nine participants, 432 (73%) were answered well (meaning a participant provided an answer when was required or did not provide an answer when one was not –i.e.: they did not answer questions around their use of a substance when they have never used the substance); while 162 (27%) were answered poorly. Of the 27% of questions answered poorly 110 (68%) of these were due to a participant providing an answer to a question when an answer was not required, while the remaining 52 questions (32%) were due to a participant not providing a response to a question that required a response from participants (Figure 10). When exploring which questions in the questionnaire were answered poorly it can be seen that the majority of the poorly answered questions were found in Section C (which pertains to

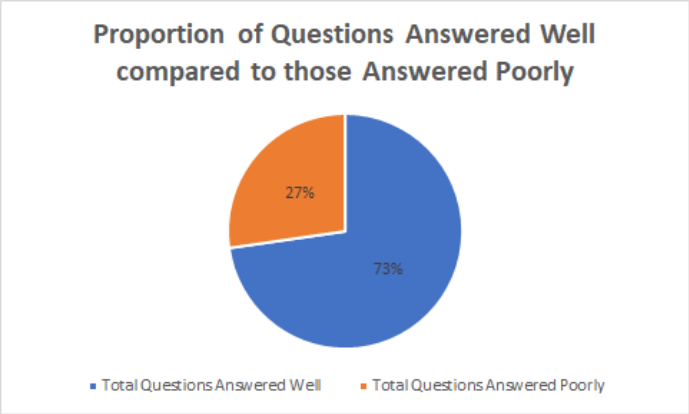


Figure 9: How well questions were answered by the participants

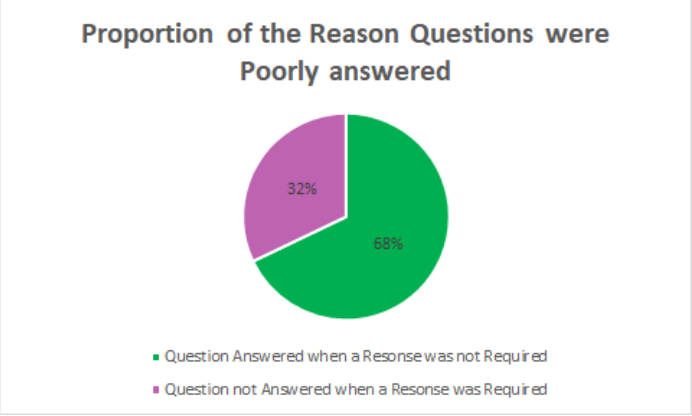


Figure 10: The way that poorly answered questions were answered poorly

questions of the participants' substance use) of the questionnaire, with the remaining poorly answered questions found in Section B (which relates to questions around the participants schooling) under the part of how the participants feel about their school. 7% of the questions in Section B were answered poorly, all of these questions formed part of question 12. With regards to question 12, six questions (17%) of the four sub-questions making up question 12 were answered poorly all due to two participants not answering a total of 6 questions when a response was required. When exploring how well questions were answered in Section C, it can be seen that 156 of the 441 questions (35%) in section C answered by all nine participants) were answered poorly with 110 (71%) of these answered poorly due to participants answering a question when a response was not required while the remaining 46 questions (29%) answered poorly due to participants not responding to a question when a response was required.

Furthermore, patterns around the type of repeated questions within section C that were answered poorly were explored. Section C consisted of 49 total questions which each participant could respond too. These questions took the form of a set of six questions which was asked eight times in relation to different substances as well as one additional question, not repeated, which asked the participant whether they have ever tried any other substance. The repeated question set included the questions: Have you ever tried 'x' substance? (where x is either alcohol, Tik or cannabis), How old were you when you first tried 'x' drug? (where x is either alcohol, Tik, cannabis or an alternative substance the participant reported using), Have you used 'x' drug in the last year? Have you used 'x' drug in the last month?, Have you used 'x' drug in the last week? And in the past year how often have you used 'x' substance? (a participant could choose one of five options ranging from every week to never). The remaining questions which fell under Section C include the question: Have you ever tried any other substance? and five questions that provided space for the participant to list another substance that they have ever tried before (as a follow on from the afore-mentioned question).

It was found that the repeated set of questions pertaining to the specifics of the participant's particular substance use were the most poorly answered, constituting 78% of the total questions answered poorly. The questions pertaining to when a participant last used a certain substance, i.e. in the last 12 months, 30 days and seven days ("Have you used alcohol in the

past 12 months?", "Have you used alcohol in the past 30 days?" and "Have you used 'x' substance in the past 7 days?" respectively), were the most poorly answered with 44%, 43% and 42% of the questions being answered poorly respectively. Moreover, 40% of the questions around how frequently a participant used a substance in the past year ("In the past year how often did you use 'x' substance?"), were answered poorly. Across Section C, the majority of the questions (26%) were answered poorly due participants responding to a question when a response was not required while only 10% were due to participants not providing an answer to a question that required one.

### 4.4.3. How appropriately the questionnaire was answered

Taking a closer look at how appropriately the questions in the questionnaire were answered by the participants (which speaks to the face validity of the questionnaire), a question was considered to be answered appropriately when the participants response did not contradict any previous responses given by said participant, while a question was considered to be answered inappropriately when the participants response contradicted a previous response given by said participant (for example answering that they began using alcohol when they were 14, when they answered that they have never tried alcohol in the previous question).

It was found that all nine participants answered at least one question in a contradictory manner. Taking a closer look, Figure 11 shows the total number of questions each participant answered in a contradictory manner. The mean number of questions each participant responded to in a contradictory manner, was 5 questions each, while the most common (mode) number of questions a single participant responded to in a contradictory manner was one question. The greatest number of questions a single participant responded to in a contradictory manner was 13 questions, with the least being one question.

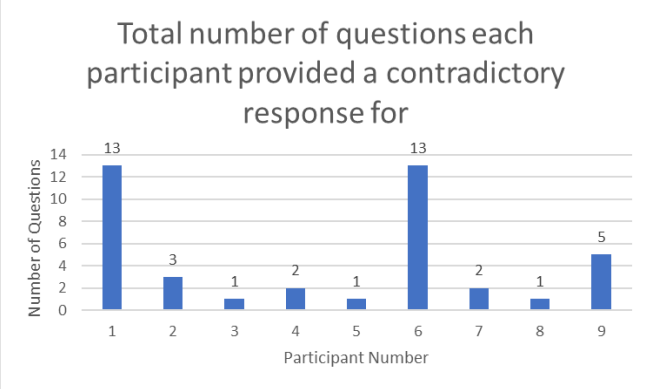


Figure 11: The total number of questions that each participant provided a contradictory response for in their questionnaire

Moreover, Figure 12 shows that of all the questions answered by all nine participants, 94 of the 441 total questions comprising Section C (91%) were answered without contradictions (meaning that the answer to the question did not contradict any previous answers given by the participant). While 41 questions (9%) were answered in a contradictory manner (meaning that the answer to the question contradicted previous answers given by the participant). When exploring which questions presenting with the most questions answered in a contradictory manner, it was found that all contradictory answers are found in section C (pertaining to the participants' substance use) of the questionnaire. Investigating possible patterns of questions answered in a contradictory manner within the repeated question sets comprising section C, it was uncovered that questions pertaining to the participants' frequency use of a particular substance in the past year ("In the past year how often did you use 'x' substance?") held the most contradictory answers, with 15 questions (21%) of the questions answered in a contradictory manner. nine questions (13%) of the question set around the age a participant began using a specific substance ("How old were you when you first tried 'x' substance?") were answered in a contradictory manner, while the question set detailing whether a participant used a particular substance in the last 7 days ("Have you used 'x' substance in the past 7 days?") showed four (6%) of the questions were answered in a contradictory manner. Additionally, two (3%) of the questions in both of the question sets pertaining to whether a participant used a certain substance in the last year and in the last month ("Have you used alcohol in the past 12 months?" and "Have you used alcohol in the past 30 days?" respectively), were answered in a contradictory manner. The remaining questions set comprising section C, namely around whether a participant has ever used a specific substance ("Have you ever tried 'x' substance?"), were all answered without contradictions present.

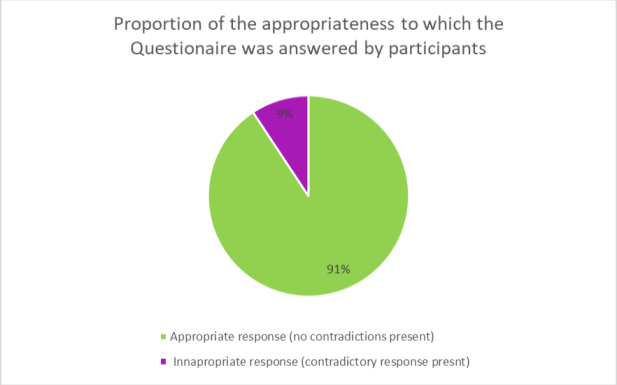


Figure 12: How appropriately all the questions in the questionnaires were answered by the 9 participants

### 4.4.4. The frequency of answers that were crossed out by participants

When further exploring how well the questionnaire was understood by the participants (falling under the face validity of the questionnaire), the number of times that participants crossed out answers was considered. Figure 13, shows the total number of questions each participant crossed out an answer too. In total, four participants crossed out at least one answer due to changing their answer, while two participants crossed out an answer without giving an alternative answer when no answer to the question was required (thus making crossing out the answer appropriate). Additionally, only one participant crossed out an answer without giving an alternative answer when an answer to the question was required (thus making crossing out the answer inappropriate). The mean number of answers crossed out by a single participant (for any reason) in a questionnaire is one answer, with the most common number of answers crossed out (for any reason) by a single participant is one answer. Furthermore, the greatest number of answers crossed out by a single participant (for any reason) is five answers, with the least being none. Moreover, the most common number of answers crossed out without the participant giving an alternative answer (appropriately or inappropriately) or with the participant giving an alternative answer is no answers crossed out by a single participant. The most answers crossed out by a single participant without the participant giving an alternative answer (appropriately) is five, while crossing out without the participant giving an alternative answer (inappropriately) is two and lastly with the participant giving an alternative answer is one.

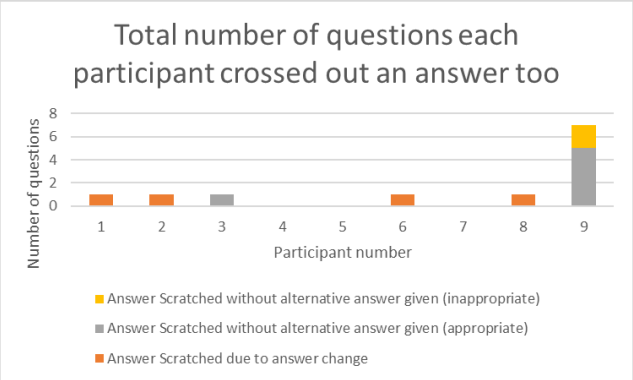


Figure 13: The total number of questions each participant crossed out an answer to within the questionnaire

Additionally, Figure 14 shows the frequency of corrections that were made by the nine participants across the questionnaire. It was found that only 2% (12 answers) of the answers to questions across all nine questionnaires, were crossed out. Of these four answers (0.67%) were crossed out as the participant chose to provide an alternative answer, while six answers (1.01%) were appropriately crossed out with no alternative answer provided when no response for said question was required (Figure 15). Lastly, two answers (0.34%) were inappropriately crossed out with no alternative answer provided, when answers to the question were required (Figure 15). When looking for patterns of crossed out answers amongst specific questions, it was found that all incidences of crossed out answers presented in Section C of the questionnaire. Only 12 of the 441 questions completed in section C by the nine participants (3%) of the answers were crossed out by the participants. Of these, 50% of the answers were crossed out due to the participant changing their answer while 33% were appropriately crossed out with no alternative response given and 17% were inappropriately crossed out with no alternative response offered. Exploring patterns in the sets of repeated questions of answers that were crossed out, results showed that the question sets pertaining to whether the participant has used a specific substance in the last 30 days and whether the participant has used a specific substance, both presented with the highest number of answers crossed out by participants (5.56% of all questions in those question sets). While the questions set's pertaining to whether a participant has used a specific substance in the last year and the set pertaining to the frequency of their specific substance use in a year both displayed 2.78% of the answers being crossed out by participants. Finally, 1.39% of the question set pertaining to the age a

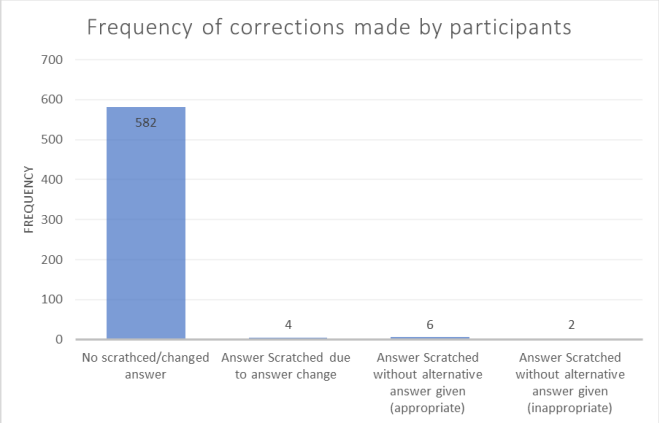


Figure 14: The questions that participants crossed out answers too

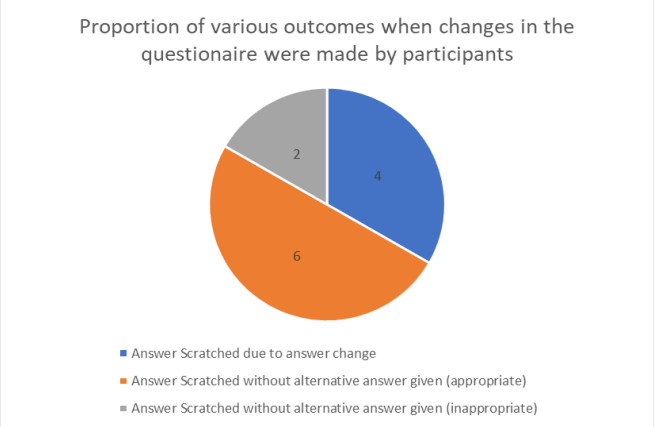


Figure 15: The context of those questions where participants crossed out answers too

participant began using a specific substance as well as the question set around whether a participant has used a specific substance in the last seven days was crossed out.

### 4.4.5. How accurately Question 6 of the questionnaire was answered

When considering the way specific questions within the questionnaire were answered, a pattern emerged around how accurately the question asking participants to name the area in which they live (Question 6; "What is the name of the area that you live in?"), was answered. As seen in Figure 16, five of the nine participants (56%) answered the question by providing the name of the area they reside in (such as "Ocean View"), which was the desired answer type required by the researchers. While four participants (44%) gave the name of a specific place or an address that fell within a larger area.

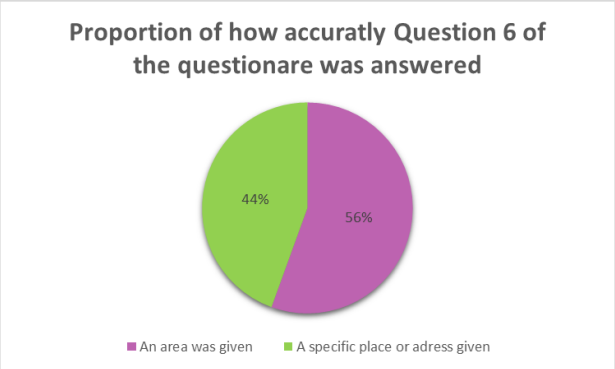


Figure 16: How accurately Question 6 (the name of the area in which the participants reside) was answered

### 4.4.6. The frequency of "other" substances listed by participants

Evaluating the question which allowed participants to list alternative substances, not otherwise mentioned in the questionnaire, which they have ever used showed that four of the nine participants in total listed ten "other" substances when answering this question. Of the substances that were listed six substance names (60% were substance names already present in the questionnaire (namely alcohol, cannabis and Tik) and thus were substances the participants had already answered questions around (Figure 17). While four substance names (40% were new substance names, not previously mentioned in the questionnaire.

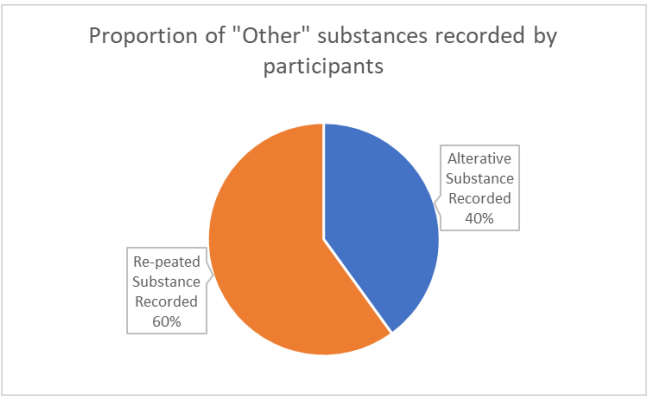


Figure 17: Proportion of substance names listed which are already present in the questionnaire compared to those listed which were not present in the questionnaire

Additionally, as seen in Figure 18, participants listed Cannabis in the “other substances” section three times and Tik, twice.

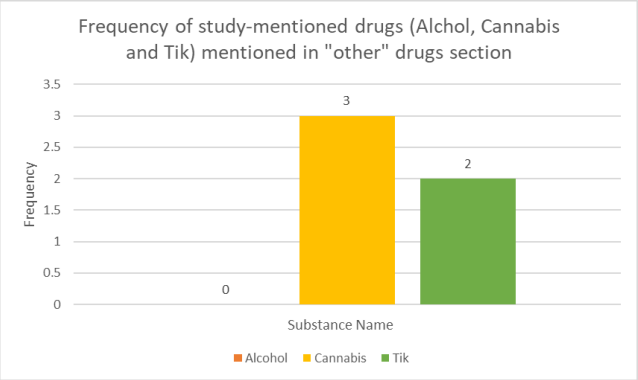


Figure 18: Frequency that drugs already named in the questionnaire were listed by participants in the “other” section

## 4.4 Chapter Summary

First, the majority of participants chose to complete the questionnaire in Afrikaans as opposed to English.

Alcohol was reportedly the most commonly used substance by the nine participants, while Tik was reportedly used the least. On average the participants who had used the respective substances began using Alcohol, Cannabis and Tobacco when they were 14 years old. Furthermore, the participants who were born in 2004 reported more incidences of substance use than those who were born in 2003.

Overall, Section C (involving questions pertaining to the participants’ substance use) showed the most poorly and questions answered in a contradictory manner as well as the most answers crossed out. Additionally, a large proportion of participants answered the question pertaining to what area a participant resided in, in an inadequate way by giving the name of a specific place or address within a larger area.

Additionally, the majority of the “other” substance’s participants reported were substances already mentioned in the questionnaire. The findings of this study piloting this instrument (questionnaire) in order to ensure its’ validity and reliability, speak well to the face validity of the questionnaire as the degree to which the questions make sense to the participants (Ehrlich & Joubert, 2014.

The interpretation of the results discussed above and how these can be used to adapt the questionnaire in order to ensure that the questions are clearer or less confusing for participants (improve its face validity). Thus, ensuring the questionnaire is answered more

accurately and appropriately, thereby yielding valid and reliable results, will be explored and discussed in Chapter 5.

# CHAPTER 5: Discussion

## 5.1 Introduction to chapter

This chapter explores the extensive limitations of this study, resulting from two vast adaptions to the study's protocol. Both of these adaptations were approved by the UCT HREC; the first was necessary in order to adhere to ethical standards requested by the ethics committee. The second major adaptation was made based on the difficulty of recruiting study participants, due to being denied access to the high school in Ocean View and no participants attending the originally planned pilot study.

This chapter also interprets the results discussed in Chapter 4 and evaluates areas for improvement, ensuring valid and reliable results in any future research using this tool. Through the exploration of potential amendments, suggestions will be made on how to address these areas of concern. These amendments will increase the validity of the questionnaire as a research tool, facilitating the next step for future research around this topic within Ocean View (or similar contexts).

## 5.2 Exploration of the key findings in relation to literature

One of the main findings from this study speaks to the objective of establishing which substances are most commonly used by school-aged young people in Ocean View. From the questions relating to this topic that were correctly appropriately, it was found that alcohol, tobacco, and cannabis, were the substances used by the nine participants, with alcohol being the most used (five (56%) of the participants), cannabis being the second most used (three (33%) of the participants), and tobacco the third most used (one participant (11%)). None of the participants reported Tik (methamphetamine) use.

These findings are partially in line with literature found in chapter 2 which states, alcohol, methamphetamine, and cannabis are the most commonly used substances within the South African context (Tshitangano & Tosin, 2016), and that the use of alcohol, methamphetamine, cannabis and tobacco, is a common problem amongst adolescent individuals within the Western Cape and the greater South Africa (W.C. Harker, et al. 2008, Tshitangano and Tosin, 2016). From this present pilot study, it was noted that of the three substances specifically

asked about in the questionnaire (alcohol, cannabis and Tik), alcohol was the most commonly reported substance used. This is agreed upon by many studies, such as the study done by Parry (2004), where alcohol had 31.8% positive results and over 26.9% tested positive for cannabis.

Living Hope has been working within Ocean View, and have observed children and adolescents using substances, as well as the greater community as a whole, so it is likely that many of the young people living in Ocean View would be exposed to substances. Speaking to the objective of determining at what age substance use is most prevalent amongst young people in Ocean View, the results of this pilot study show that of the sample used, there were more total incidences of reported substance use made by participants born in 2004 compared to those born in 2003. Had the sample size been larger, a deduction could have been made that the older a young person is, the greater the likelihood is that they are using substances. What can also be seen from the results was that of the nine participants either born in 2003 or 2004, six of them reported the use of at least one substance, which is in line with older findings from research which found that substance use present in communities and schools is most common amongst adolescents between the ages of 13 and 18 years (Reed & Rountree, 1997). More recent, but still outdated statistics on substance use in South Africa show that substance use is prevalent amongst individuals between the ages of 18 and 29 (Van Heerden, Grimsrud, Seedat, Myer, Williams, & Stein, 2009). While, Ramlagan, Peltzer, & Matseke (2010), found that substances are being used by individuals as young as 10 years old. It is clear that there is a significant gap in recent research on what age substance use is most prevalent. This pilot study shows the need for further investigation.

Speaking to the last objective of this study, the results given by the sample of this pilot study gave a range of 13 to 15 years old for the age of onset of substance use amongst school-aged young people in Ocean View. It was shown that, for these nine participants, it is more likely to try cannabis at a younger age, over alcohol which is more likely to be tried at a later age. As a whole, these results correlate with the findings which emphasize that individuals begin using substances within the adolescent period (Tshitangano & Tosin, 2016, and PlüDdemann et. Al, 2008). It also correlated with (Madu & Matla, 2002), who found that adolescents generally started using substances during adolescence.

The objective of determining the differences between substance use between males and females was removed from this study due to a convenience sample of males only being used. For the nine males who participated, it was found six participants reported having tried at least one substance in their life, with the average number of substances each participant reported having tried being one substance each. Previous studies discovered that the prevalence rates are much higher among males, and there is a greater chance of being exposed and using substances if you are a male (Oshodi, Aina and Onajole, 2010, and Harker et al., 2008). Due to all of the participants in this study were male, deductions related to gender could not be made.

## 5.3 Validity of the Research Tool

### 5.3.1 Deductions made on the validity of the research tool (i.e. questionnaire)

162 of the total 594 (27%) questions answered by all nine participants in the questionnaire were answered poorly. Out of the 594 questions, 110 (18.5%) were answered when a response was not required, and 52 (8.8%) questions were not answered when a response was required. This shows that overall, the questionnaire (as is) is not an adequate tool for future research. If the questionnaire is used for a larger sample size to determine prevalence, errors relating to poorly answered questions may be missed and skew the results. Additionally, it shows that the questionnaire has much room for improvement, in order to produce internally and externally valid results. The areas that need improvement and suggestions for amendment to this questionnaire as a research tool will be explored.

Section A was the most appropriately answered section. The structuring of the questions allowed for no contradictions or potential confusion that would lead to leaving a question out. The only question that could be amended in this section is question 6, which asked: “What is the name of the area that you live in?”. This question intended to inquire if the participant lives in Ocean View, due to the specificities of the research question and thus inclusion criteria. As seen in Figure 16, of the nine participants, five (56%) gave Ocean View as a response. The other four participants (44%) gave a specific place or address in Ocean View. However, when first interpreting the data, the specific place names given were not recognized and the researchers had to inquire whether they were in Ocean View, with a

community stakeholder. Amendments that could be made in the future are to rather provide a list of residential options or simply a yes or no question to inquire if they live in Ocean View (if the research question is specific). This would also make data collation and analysis more efficient.

Upon investigating sections where the questions were poorly answered, the results show that four out of six sub-questions (7%) of question 12, located in section B of the questionnaire, were poorly answered by two of the participants, as they did not answer when an answer was required. Question 12 can be amended by structuring the phrasing of the sub-questions into questions which require a “yes”, “no”, or “not sure” instead of statements, to make it more apparent that each sub-question requires an answer and ensure a wider range of answer options to account for the range of participants potential answers (thereby increasing the chance a participant may answer the question, as a response option they feel is appropriate may be reflected). This is the only amendment to be made to Section B of the questionnaire.

The results show that section C had 156 of the 441 questions in section C (35%) answered poorly. Section C was the most poorly answered section and would, therefore, need to be amended before future research was to take place. Of the questions in section C that were answered poorly, 110 (71%) of these were answered poorly due to participants answering a question when a response was not required while the remaining 46 questions (29%) were left out when a response was required. The effects this had on the measurement of data and its face validity will be discussed throughout the rest of this section.

### 5.3.2. Implications drawn from the deductions:

Section C’s need for amendment in its structure resulted in inadequacy for the objective “to establish which substances are most commonly used by school-aged young people in Ocean View” to be met. Although the questions asked in the questionnaire were sufficient to answer this objective, the structuring of the questions proved as a barrier to allow the questions to be answered accurately and holistically. This resulted in potential confusion and/or misrepresentation in the answers, as seen by the contradicting answers between the questions and the number of poorly answered questions present. The structuring of this section, therefore, reduced the face validity of the study. 41 of the total 441 questions (9%)

in this section were answered in a contradictory manner by a participant contradicting other answers previously given. The contradicting answers related to which substances they have used, therefore deeming their results invalid, and were removed from the overall results of this objective. These answers were then accounted for under the “inappropriately answered” results. While there were “appropriately answered” questions contributing to the results of this study, in analysing the overall results, it was found that the potential for contradicting answers to be given needs to be eliminated, to increase the questionnaire’s face validity. This can be done by eliminating instructions to skip to other questions, or forming a box around each cluster of questions relating to a specific substance, so that it is clear that the questions follow on from each other, as some substances listed contradicted other answers relating to whether or not a participant reported having used said substances.

The results also show that question 34, in particular, would need amendment. The questionnaire only inquired about the participants alcohol, cannabis and methamphetamine (Tik) use, however, question 34 intended to inquire about any other substance’s participants have used, providing space to list the ‘other’ substances. As seen in Figure 18 there was some confusion when answering the question as both cannabis and methamphetamine were repeated.

Furthermore, the results show that there were four (44%) respondents who filled in this question. Six (60%) “other” substance names given were a repeated substance answer, and four (40%) were new substances reported (Figure 17). There was also one respondent who mentioned both Mandraxand “man drugs” (which community stakeholder confirmed to be a name for mandrax). From analysing this question, it is possible that some of the respondents were confused by this question, and may have listed substance’s they knew of.
A possible amendment for this would be to rather draw up a simpler questionnaire format in which a more extensive list of substances is provided and an option to tick which substances they have used, and then more options to tick with regards to how long they have used the substance. An option of an “other” substance can also be provided for alternative answers, thereby reducing the chance of participants re-listing the same substance under the same or a different street name, or giving incomprehensible answers. Listing all possible answers also makes the results more absolute and easier to interpret, aiding the data collation and analysis

process of the study. Frequency of use could also be included in the table in this example, or it could be separate. An example of the above-mentioned possible questionnaire formant amendment is seen in table 1 below.

| Name of drug | Tick if YES I HAVE tried this drug before | I HAVE used this drug in the past 7 days (week) | I HAVE used this drug in the past 30 days (month) | I HAVE used this drug in the past 12 months (year) | At what AGE did you start using this drug? | I CANNOT REMEMBER how old I was when I started using this drug |
|---|---|---|---|---|---|---|
| Alcohol | | | | | | |
| Cannabis | | | | | | |
| Tik | | | | | | |
| Mandrax | | | | | | |
| Tobacco | | | | | | |
| Cocaine | | | | | | |
| Other | | | | | | |

Table 1: An example of a way to amend the format of the questionnaire to reduce possible confusion
***please note that this table is merely an example and would need further explanations such as alternative street names for each substance etc.

This amendment would also assist in meeting the objective "to determine the age of onset of substance use amongst school-aged young people in Ocean View". The pilot study showed that this objective was measured effectively by the questionnaire, as results were recorded for the age of onset for each substance. However, one of the questions relating to this was left blank and had to be left out of the results. Therefore, this could also be prevented by placing each sub-question relating to a particular substance use within a table, as shown above. This would bring clarity by informing participants that it needs to be answered after ticking the box to indicate previous use of that particular substance. An option of "I cannot remember how old I was when I started using this drug" can also be included in the table to account for questions being left out if a participant is unsure.

Lastly, the results show that all of the questions that were answered poorly due to being scratched out inappropriately were in section C. Overall, four out of 441 questions (1%) included scratched out answers due to the participant changing their mind and giving a

different answer. Six (1,4%) were scratched out without an alternate answer given (sufficient for answering appropriately), which could have occurred due to realizing it did not need to be answered, and two (0,5%) were scratched out without an alternate answer given where an answer was in fact necessary.

The above-mentioned table format will also prevent these discrepancies, by having all the sub-questions grouped together in a more comprehensible way and it will also allow for all of the options for a particular question to be provided on the same page. It appears that some of the answers were scratched out due to a change of mind that occurred because the possible answers for that questions were listed on the next page. This table will ensure that all potential answers are clearly seen before the participant starts answering, which will improve their understanding of the question and thereby increase the instrument's face validity.

## 5.4. The language of the questionnaire

A note should be made on language to indicate for future planning on how many of each should be provided. English and Afrikaans questionnaires were provided. Six (67%) of the participants answered in Afrikaans, and Three (33%) participants responded in English (Figure 7).

Future research could explore the effect of language on the accuracy of answers provided. For example, specific words sometimes cannot be directly translated, which could affect the understanding of the questionnaire. However, for the sake of this study, this was not explored, due to time constraints and access to the type of Afrikaans input needed to determine miss-translations and the data differences between those who answered in English, and Afrikaans.

## 5.5 Limitations of the study:

A limitation in meeting the objective "to establish at what age substance use is most prevalent amongst school-aged young people in Ocean View" is that the questionnaire asked for year of birth and not age specifically. This meant that actual age at the time of filling out the questionnaire could not be determined, and the objective was therefore not fully met. In

order to meet it, and to make data collection and analysis more effective and efficient, options for ages should be given instead of the participants filling in their year of birth. This would allow for accuracy in age at the time of completing the questionnaire, as well as decreasing the chance of incomprehensible answers.

This study was not conducted as planned, due to difficulties in the process of recruiting participants. Firstly, the study began with a lack of input from the community stake-holders. The original meeting date was moved by the two research teams, which may have resulted in the stakeholders of Ocean View not prioritizing the new set date. At the meeting on the rescheduled date, none of the community leaders/ stakeholders attended. The school where the study had planned to recruit the sample from also denied access to the researchers. This was due to a negative experience they had in the past, where researchers from another university misrepresented the Ocean View community in their research findings, and their results were shared with the media. This past event resulted in the school wanting to protect their own, as well as their communities' reputation from a similar reoccurrence. It also raises questions around researcher ethical practices and the responsibilities of researchers to the communities they work in. From this limitation, the researchers learned the importance of utilizing the principles of ethical practice from the Declaration of Helsinki (Millum, Wendler & Emanuel, 2013). These include respecting the rights of the Ocean View community, to want to guard their reputation from misrepresentation by the media to the public, and their right to say "no", which also speaks to the principle of informed consent. Lastly, it also called for non-maleficence, as the researchers should not be entering their community to cause harm to their reputation or overall well-being in any way. Another reason why gaining access into the school and overall participant recruitment may not have been possibly relates to the sensitivity of the research topic and substance use as a whole.

The consequences of the community's previous experiences, as well as the sensitive nature of substance use, could also contribute to an explanation around the gaps in literature available around substance use amongst young people in Ocean View and similar contexts. The implication of this was that the researchers were unable to access a sample size large enough to conduct a valid quantitative study. Therefore, the research protocol was amended

to a pilot study in order to test the validity of the research instrument: the questionnaire. The amended protocol was sent to and approved by the ethics board.

The initial pilot study also did not go as planned. It was planned to take place at Living Hope's holiday club, but all of the young people within the 15-17-year-old age group that had signed a consent and assent form did not attend the holiday club that day. From speaking to the holiday club instructor, it appeared that they did not want to do a task with reading and writing, in case they were unsure of something and did not know what to do. She also shared that researchers, who were strangers to the young people, entering into their fun and safe space was intimidating. From this, the researchers learned that it is very important to get to know the potential participants first, participate in their games with them (to build rapport), and explain the study and the piloting process personally, so that they feel more at ease and know that any assistance needed will be discretely provided.

Living Hope then facilitated individuals from a local soccer team they were affiliated to be recruited as participants for the pilot study. The participants were recruited through convenient sampling and were only males. Hence, the objective of determining gender differences in substance use was removed.

## 5.6 Chapter summary

The limitations the study held in sample size and the lack of community buy-in resulted in the inability to meet the aim of the study to establish the extent to which young people living in Ocean View are using substances. Owing to the fact that there were only nine participants, the results of this pilot study cannot be deemed as reliable and valid. The results show where the research tool needs improvement for future research, but the information gathered from the questionnaires' results cannot be used for future research or generalised as an accurate representation for the study population, to answer the research question of the prevalence of substance use amongst young people in Ocean View.

None of the study's objectives were met, due to these limitations. In order to ensure they are met once this study is conducted on a larger scale to determine prevalence, the amendments mentioned in this chapter should be made, to make the research tool easier to understand and to eliminate room for contradiction, leaving out questions when an answer is needed, and answering questions not requiring an answer based on previous answers given.

The pilot study also illustrates that six out of nine (67%) of the questionnaires answered were Afrikaans and that three (33%) were English. This may aid the logistics for future research within Ocean View.

Overall, it is clear that the questions in the questionnaire need to be clearer, and simpler to answer and offering a lot more options to choose answers from. After the analysis of results, obvious amendments were identified that could be made. Perhaps if these amendments are made and another pilot study is completed with a larger sample size, the questionnaire could be a potentially valuable tool for future research. This process highlighted the importance of a pilot study (to identify and amend any problems) and a simple, clear and comprehensive questionnaire.

# CHAPTER 6: Conclusions and recommendations

## 6.1. Introduction to chapter

Substance use is seen as a global problem among school-aged young people. Statistics reveal increasing substance use rates, within South Africa, and Western Cape. Conclusive research findings have proven that substance use is most prevalent among school-aged young people, corresponding with developmental theories that associate the adolescent developmental stage, with increased susceptibility to substance use. From an Occupational Therapy perspective, substance use has far-reaching consequences for school-aged young individuals, negatively impacting their occupational engagement in school, Activities of Daily Living, and leisure or play.

Within developing countries such as South Africa, substance use has damaging consequences; such as increased crime rates, national health cost detriments, stigma, peer pressure and discrimination. Some of these consequences are evident in the community of Ocean View, where substance use in school-aged young people is leading to violence and gang exposure, causing mental health-related illnesses, and an overall decline in occupational well-being. Therefore, this study was conducted with the intent of assisting the NPO Living Hope, in investigating the pressing problem of substance use, in the community of Ocean View.

## 6.2. Conclusion

In this particular study, the researchers were not able to adequately address the research question. The researchers were unable to identify the prevalence of substance use in school-aged young people between 15 and 17 years of age, within the context of Ocean View. The main difficulty lay in being unable to access the only high school in Ocean View and thus, recruit enough participants to yield generalisable results. The community stakeholders in Ocean View have had previous negative experiences with research studies being conducted in their community and were not open to research being conducted at Ocean View Secondary School. The researchers were only able to recruit participants from a local Soccer Team. Therefore, the researchers experienced difficulties with participant recruitment. With the resultant, small and insignificant sample size, the study was amended, and the researchers

were only able to carry out a pilot study, to determine the reliability and validity of the research instrument (the questionnaire)**.**

In piloting the questionnaire, the findings revealed that the questionnaire (as is) was not an appropriate research tool to meet the research objectives. The questionnaire was able to determine substance use prevalence, establish which substances were most commonly used, and identify the age of onset of substance use, amongst school-aged young people in Ocean View. However due to many confusions evident from the respondent's answers to the questionnaire, the answers provided may not be a true representation of what was asked. This affected the face validity of the study, despite language being considered through the provision of questionnaire in the respondent's home language, as the questionnaire appeared to often not make sense as seen through the analysis of the participants responses. The questionnaire should be altered to ensure better face validity and to ensure a smoother data collation and analysis process, in order that the findings are internally valid. This can be done by simplifying the format of the questions posed, and providing answers to choose from rather than having a blank space to fill in as well as simplifying some of the questions, as previously explained.

The pilot study's findings show that the format and layout of the questionnaire were inadequate. Therefore, many of the participants misunderstood or misinterpreted aspects of the questionnaire, and answered the questions poorly, resulting in inconsistent data. The questionnaire needs to be edited and reworded, to ensure the questions are more easily understandable. The layout of the questionnaire needs to be clearer and more concise. The format of the questionnaire must be simplified. The questionnaire needs to include a more extensive list of types of substances. The questions need to be restructured and formatted to eliminate confusion and misinterpretation. For example, the questions must include tick boxes instead of written answers, and sub-questions relating to a particular substance use could be placed within tables.

Additionally, before the questionnaire is used as a research tool, it is recommended for research to be carried out to determine the effect of language on the participants' understanding of the questionnaire, and the accuracy of the answers provided.

## 6.3. Recommendations for further research

### *6.3.1. Recommendations for future researchers*

Further research is recommended in order to uncover the prevalence of substance use in Ocean View, using the findings from this pilot study. These findings include amendments to be made to the questionnaire as the research tool. Further research on substance use in Ocean View needs to be carried out to establish at what age substance use is most prevalent, which substances are most commonly used, and the age of onset of substance use - in school-aged young people, within the context of Ocean View.

As researched literature explains, the community of Ocean View has expressed concern around the extensive substance use among young people. The extent of the problem is not known and thus, there is a need for future research so that statistics can be obtained in order to raise the concern to relevant stakeholders and potential funders.

Having conducted this pilot study, the research team also suggests Initiating, and building good relationships with the community stakeholders and the selected participants, prior to the questionnaire being administered – to ensure the research process is effective. It would be beneficial for future researchers to set up a meeting with the school principal in order to explain the purpose of the study and to offer reassurance, it is critical to build rapport with participants beforehand, to gain their trust and to thoroughly explain the study.

### *6.3.2 Recommendations for Living Hope*

Recommendations for Living Hope include the implementation of aftercare programs in order to expand the learners' occupational possibilities, and offer them alternative ways of engaging, apart from substance use. From this initial pilot, it would be worthwhile for Living Hope to establish an intervention program for young people in Ocean View. Living Hope needs to collaborate with other research organisations, to obtain accurate substance use statistics that can be presented to external agencies - in order to raise the funds necessary to implement aftercare programs (or other types of intervention) and reduce the impact of substance use in the Ocean View community. Other recommendations for Living Hope would be to *continue* organising various fundraising events, health promotion and prevention drives,

to raise awareness around substance use within the community. They could recruit local artists or 'heroes' to come and perform to create awareness against substance use. They could partner with the school to hold events for parents, educating him on the harmful effects of substances on development. The researchers would encourage Living Hope to work with the Schools in Ocean View in order to target young people that partake in substance use, as well as implement programs that can reach young people who are not in the school system.

## 6.4. Conclusion: final summative statement(s) regarding the core/central answer to the research question

Substance use is evidently a concern worldwide and recent statistics on substance use in South Africa and the Western Cape are particularly alarming. There is also a lack of research undertaken in smaller communities, particularly those further from the main urban areas, such as the Cape Town District. The community of Ocean View has been flagged as one of concern with regards to substance use, particularly for the youth. This concern has been raised by community stakeholders, who have observed the negative implications on occupational engagement that substance use presents, for this particular community's young people. The prevalence of substance use in school-aged young people, in Ocean View, urgently needs to be uncovered, to assist NPOs (such as Living Hope) in implementing preventative or remediative interventions, preventing further detriment to the community of Ocean View as a whole. Therefore, this pilot study has been a starting point, highlighting issues in the questionnaire, and suggesting ways forward for the much-needed further research to take place.

# References


Allen, J. P., Chango, J., Szwedo, D., Schad, M., & Marston, E. (2012). Predictors of susceptibility to peer influence regarding substance use in adolescence. *Child Development*, *83*(1), 337-350.

Amoateng, A. Y., Barber, B. K., & Erickson, L. D. (2006). Family predictors of adolescent substance use: The case of high school students in the Cape Metropolitan Area, Cape Town, South Africa. *Journal of Child and Adolescent Mental Health*, *18*(1), 7-15. Alcohol and drug use disorders: Global Health Estimates. (2017). Retrieved from http://www.who.int/substance_abuse/activities/fadab/msb_adab_2017_GHE_23June2017.pdf

Armstrong, T. D., & Costello, E. J. (2002). Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. *Journal of consulting and clinical psychology*, *70*(6), 1224.

Bejerholm, U., & Eklund, M. (2004). Time use and occupational performance among persons with schizophrenia. *Occupational Therapy in Mental Health*, *20*(1), 27-47.

Benninger, E., & Savahl, S. (2016). The use of visual methods to explore how children construct and assign meaning to the "self" within two urban communities in the Western Cape, South Africa. *International journal of qualitative studies on health and well-being*, *11*(1), 31251.

Bennett-Woods, D. (2005). Ethics at a glance. *Regis University*.

Brink, H., Van der Walt, C., & Van Rensburg, G. (2006). *Fundamentals of research methodology for health care professionals*. Juta and Company Ltd.

Bryant, W., Fieldhouse, J. and Bannigan, K. (2014). *Creek's Occupational Therapy and Mental Health*. 5th ed. Churchill Livingstone Elsevier, p.440.

Canadian Association of Occupational Therapists. 1995. *Guidelines for client-centred practice of occupational therapy.* Toronto.Census (2011). *Ocean View*. Retrieved from: https://census2011.adrianfrith.com/place/199054004

Chapparo, C., & Ranka, J. (Eds.). (1997). *Occupational Performance Model (Australia): Monograph 1*. Occupational Performance Network.

Christiansen, C. H., & Baum, C. (1997). Understanding occupation. Definitions and concepts. *Occupational Therapy. Overcoming Human Performance Deficits*, 4.

Columbia Electronic Encyclopedia. (2019). Drug addiction and drug abuse. *MasterFILE Premier (6th ed).*

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Crouch, R., & Wegner, L. (2014). Substance use and abuse: Intervention by a multidisciplinary approach which includes occupational therapy. *Occupational Therapy in Psychiatry and Mental Health*, 446-464.

Degenhardt, L., & Hall, W. (2012). Extent of illicit drug use and dependence, and their contribution to the global burden of disease. *The Lancet*, *379*(9810), 55-70. doi: 10.1016/s0140-6736(11)61138-0

Department of Economic and Social Affairs, U. N. (2014). World urbanization prospects, the 2011 revision. *Population Division, Department of Economic and Social Affairs, United Nations Secretariat*.

Duhaime, L. (2000). *Duhaime's law dictionary*. Victoria, Canada: Lloyd Duhaime.

Ellis, B. J., Del Giudice, M., Dishion, T. J., Figueredo, A. J., Gray, P., Griskevicius, V., . . . Wilson, D. S. (2012). The evolutionary basis of risky adolescent behavior: Implications for science, policy, and practice. Developmental Psychology, 48, 598–623. doi:10.1037/a0026220

Erikson, E. H. (1968). Identity, youth, and crisis. New York: Norton.

Erikson, E. H., & Erikson, J. M. (1998). *The life cycle completed (extended version)*. WW Norton & Company.

Flisher, A. J., Parry, C. D., Evans, J., Muller, M., & Lombard, C. (2003). Substance use by adolescents in Cape Town: Prevalence and correlates. *Journal of adolescent health*, *32*(1), 58-65.

Freeman, M., & Parry, C. (2006). Alcohol use literature review. *Prepared for Soul City. Retrieved May*, *5*, 2013.

Frith, A. (2011). *Ocean View*. Retrieved from: https://census2011.adrianfrith.com/place/199054004

George, Z. (2005). *Community reels as kids use dagga before class*. Daily Dispatch. 5 May 2005.

Goliath, V., & Pretorius, B. (2016). Peer risk and protective factors in adolescence: Implications for drug use prevention. *Social Work*, *52*(1), 113-129.

Goncy, E. A., & Mrug, S. (2013). Where and when adolescents use tobacco, alcohol, and marijuana: Comparisons by age, gender, and race. *Journal of studies on alcohol and drugs*, *74*(2), 288-300.

Griffin, K. W., Lowe, S. R., Acevedo, B. P., & Botvin, G. J. (2015). Affective self-regulation trajectories during secondary school predict substance use among urban minority young adults. *Journal of child & adolescent substance abuse*, *24*(4), 228-234.Harker, N., Kader, R., Myers, B., Fakier, N., Parry, C., Flisher, A. J., & Davids, A. (2008). Substance use trends in the Western Cape: A review of studies conducted since 2000.

Johnson, S. B., Blum, R. W., & Giedd, J. N. (2009). Adolescent maturity and the brain: the promise and pitfalls of neuroscience research in adolescent health policy. *Journal of Adolescent Health*, *45*(3), 216-221.

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harvard review of psychiatry*, *4*(5), 231-244.

Knowledge Co-Op. (2019). Retrieved from http://www.knowledgeco-op.uct.ac.za/

Lasser, J. & Schmidt, E. (2009). Substance Use, Abuse and Dependency in Adolescence. *Principal Leadership, Middle-Level ed.; Reston. 9*(5), 12-16

Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The Person-

Environment-Occupation Model: A transactive approach to occupational performance.

Canadian Journal of Occupational Therapy, 63(1), 9-23

Madu, S. N., & Matla, M. P. (2003) Illicit drug use, cigarette smoking and alcohol drinking

behaviour among a sample of high school adolescents in the Pietersburg area of the

Northern Province, South Africa. *Journal of Adolescence 26* (121-136).

Masitsa, G. M. (2007). Substance use among township secondary school students–an emergent phenomenon. *Africa Education Review*, *4*(1), 70-88.

Mason, M. J., Mennis, J., Linker, J., Bares, C., & Zaharakis, N. (2014). Peer attitudes effects on adolescent substance use: The moderating role of race and gender. *Prevention Science*, *15*(1), 56-64.

Matsumoto, D., & Juang, L. (2016). *Culture and psychology*. Nelson Education.

Matzopoulos, R. G., Truen, S., Bowman, B., & Corrigall, J. (2014). The cost of harmful alcohol use in South Africa. *South African Medical Journal*, *104*(2), 127-132.McLeod, S. A. (2008). Erik Erikson | Psychosocial Stages - Simply Psychology. Retrieved from http://www.simplypsychology.org /Erik-Erikson.html

Meth, P. (2016). Informal Housing, Gender, Crime and Violence: The Role of Design in Urban South Africa. British Journal of Criminology., 57(2). https://doi.org/10.1093/bjc/azv125

Mhlongo, A. (2005). *Pupils' booze breaks. Primary school truants drink, take drugs in shebeens*. Independent. Saturday, 5 March 2005

Millum, J., Wendler, D., & Emanuel, E. J. (2013). The 50th anniversary of the Declaration of Helsinki: progress but many remaining challenges. *Jama*, *310*(20), 2143-2144.

Morojele, N., Myers, B., Townsend, L., Lombard, C., Plüddemann, A., Carney, T., ... & Nkosi, S. (2013). Survey on substance use, risk behaviour and mental health among grade 8–10 learners in Western Cape provincial schools, 2011. *Cape Town: South African Medical Research Council*.

Ocean View – Living Hope. (2018). Retrieved from http://www.livinghope.co.za/about/communities/ocean-view/

Osgood, D. W., Ragan, D. T., Wallace, L., Gest, S. D., Feinberg, M. E., & Moody, J. (2013). Peers and the emergence of alcohol use: Influence and selection processes in adolescent friendship networks. *Journal of Research on Adolescence*, *23*(3), 500-512.

Oshodi, O. Y., Aina, O. F., & Onajole, A. T. (2010). Substance use among secondary school students in an urban setting in Nigeria: prevalence and associated factors. *African journal of psychiatry*, *13*(1).

Parry, C.D.H., Plüddemann, A., Louw, A., & Leggett, T. (2004). The 3-Metros Study of Drugs and Crime in South Africa: Findings and policy implications. *American Journal of Drug & Alcohol Abuse*, 30, 167-185.

Pasche, S. C., & Stein, D. J. (2012). Dealing with substance use disorders in general practice. *South African Family Practice*, *54*(5), 404-407.

Payton, O. 1988. Research: *The validation of clinical practice.* 2nd ed. Philadelphia.

Peltzer, K., Ramlagan, S., Johnson, B. D., & Phaswana-Mafuya, N. (2010). Illicit drug use and treatment in South Africa: a review. *Substance use & misuse*, *45*(13), 2221-2243.

Polit, D.F., & Beck, C.T. (2017). *Essentials of nursing research: Appraising evidence for nursing practice.* Lippincott Williams & Wilkins.

Plüddemann, A., Flisher, A. J., McKetin, R., Parry, C., & Lombard, C. (2010). Methamphetamine use, aggressive behavior and other mental health issues among high-school students in Cape Town, South Africa. *Drug and alcohol dependence*, *109*(1-3), 14-19.

PlüDdemann, A., PlüDdemann, A., Flisher, A. J., PlüDdemann, A., Flisher, A. J., Mathews, C., & PlüDdemann, A. (2008). Adolescent methamphetamine use and sexual risk behaviour in secondary school students in Cape Town, South Africa. *Drug and Alcohol Review*, *27*(6), 687-692.

Ramlagan, S., Peltzer, K., & Matseke, G. (2010). Epidemiology of drug abuse treatment in South Africa. *South African journal of psychiatry*, *16*(2).

Reed, M. D., & Rountree, P. W. (1997). Peer pressure and adolescent substance use. *Journal of Quantitative Criminology*, *13*(2), 143-180.

Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon, Y., & Patra, J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *The Lancet*, *373*(9682), 2223-2233. doi: 10.1016/s0140-6736(09)60746-7

Santor, D. A., Messervey, D., & Kusumakar, V. (2000). Measuring peer pressure, popularity, and conformity in adolescent boys and girls: Predicting school performance, sexual attitudes, and substance abuse. *Journal of youth and adolescence*, *29*(2), 163-182.

Saunders (2003) *Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition*. Retrieved October 23 2018 from https://medical-dictionary.thefreedictionary.com/substance+use

Schronen, J. (2002). *Clampdown soon on offenders*. Cape Argus. 19 September 2002.

Schwartz, S. J., Mason, C. A., Pantin, H., & Szapocznik, J. (2008). Effects of family functioning and identity confusion on substance use and sexual behavior in Hispanic immigrant early adolescents. *Identity: An International Journal of Theory and Research*, *8*(2), 107-124.

Shields, N., Nadasen, K., & Pierce, L. (2008). The effects of community violence on children in Cape Town, South Africa. *Child Abuse & Neglect*, *32*(5), 589-601.

Sokol, J. T. (2009). Identity development throughout the lifetime: An examination of Eriksonian theory. *Graduate Journal of Counseling Psychology*, *1*(2), 14.

Su, J., Supple, A. J., & Kuo, S. I. C. (2018). The role of individual and contextual factors in differentiating substance use profiles among adolescents. *Substance use & misuse, 53*(5), 734-743.

Townsend, E., & Wilcock, A. (2004). Occupational justice. *Introduction to occupation*, 243-273.

Tshitangano, T.G., & Tosin, O.H. (2016). Substance use amongst secondary school students in a rural setting in South Africa: Prevalence and possible contributing factors. *African Journal Of Primary Health Care & Family Medicine*, *8*(2), 1-6. doi: 10.4102/phcfm.v8i2.934

Valkov, P. (2018). School Dropout and Substance Use: Consequence or Predictor?. *Trakia Journal of Sciences*, *16*(2), 95

Van Heerden, M. S., Grimsrud, A. T., Seedat, S., Myer, L., Williams, D. R., & Stein, D. J. (2009). Patterns of substance use in South Africa: results from the South African Stress and Health study. *South African Medical Journal*, *99*(5).

Van Ryzin, M. J., Fosco, G. M., & Dishion, T. J. (2012). Family and peer predictors of substance use from early adolescence to early adulthood: An 11-year prospective analysis. *Addictive behaviors*, *37*(12), 1314-1324.

Watt, M. S., Meredith, A., Watt, P., & Gunn, A. (2013). Use of LiDAR to estimate stand characteristics for thinning operations in young Douglas-fir plantations. *New Zealand Journal of Forestry Science*, *43*(1), 18.

Wechsberg, W.M., Luseno, W.K., Browne, F.A., Sawyer-Kurian, K.M. (2006). Differences in alcohol, methamphetamine, and cannabis use among out-of-school adolescent females in the Western Cape Province of South Africa. College on Problems of Drug Dependence, poster presentation, June 2006.

Wilkinson, P. (2000). City profile: Cape Town. *Cities*, *17*(3), 195-205.

Woolard, I. (2002). An overview of poverty and inequality in South Africa. *Unpublished briefing paper, HSRC, Pretoria*.

World Health Organization. (2001). International classification of functioning, disability and health. Geneva, Switzerland: Author.

World Health Organization. (2015). *World report on ageing and health*. World Health Organization.

[Video] “In Ocean View, we are too far away from mental health facilities” | Live Mag. (2018). Retrieved from http://livemag.co.za/real-life/ocean-view-mental-health-facilities/

Young, S. E., Corley, R. P., Stallings, M. C., Rhee, S. H., Crowley, T. J., & Hewitt, J. K. (2002). Substance use, abuse and dependence in adolescence: prevalence, symptom profiles and correlates. *Drug and alcohol dependence*, *68*(3), 309-322.

# Appendices

## A) Ethics approval letter

**UNIVERSITY OF CAPE TOWN**
**Faculty of Health Sciences**
**Human Research Ethics Committee**

**Room E53-46 Old Main Building**
**Groote Schuur Hospital**
**Observatory 7925**
**Telephone** [021] 406 6626
**Email:** shurette.thomas@uct.ac.za
**Website:** www.health.uct.ac.za/fhs/research/humanethics/forms

23 April 2019

**HREC REF: 2018/0823**

**Ms S Allie**
Occupational Therapy
Health & Rehab
F-floor

Dear Ms Allie

**PROJECT TITLE: SUBSTANCE USE AMONGST SCHOOL-AGED CHILDREN AND ADOLESCENTS IN OCEAN VIEW**

Thank you for submitting your response to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**Approval is granted for one year until 30 April 2020.**

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

**Please quote the HREC REF in all your correspondence.**

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

The HREC acknowledge that the following students will also be involved in this study: Jessica Clark, Jadene Du Preez, Fiona Gie, Jessica Holmes, Micaela Tedder and Melissa Petersen.

***Yours sincerely***

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

HREC 2018/0823

## B) Permission from WCDoE

Western Cape Government
Education

Directorate: Research

Audrey.wyngaard@westerncape.gov.za
tel: +27 021 467 9272
Fax: 0865902282
Private Bag x9114, Cape Town, 8000
wced.wcape.gov.za

**REFERENCE:** 20190529-5264
**ENQUIRIES:** Dr A.T Wyngaard

Ms Jessica Clark, Jadene Du Preez, Fiona Gie, Jessica Holmes, Micaela Tedder, Melissa Peterson
F45 Old Main Building, Groote Schuur Hospital
Observatory
7925

**Dear Ms Jessica Clark, Jadene Du Preez, Fiona Gie, Jessica Holmes, Micaela Tedder, Melissa Peterson**

**RESEARCH PROPOSAL: SUBSTANCE USE AMONGST ADOLESCENTS IN A SECONDARY SCHOOL IN OCEAN VIEW**

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **29 July 2019 till 20 September 2019.**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number?
8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:

    **The Director: Research Services**
    **Western Cape Education Department**
    **Private Bag X9114**
    **CAPE TOWN**
    **8000**

We wish you success in your research.

Kind regards.
Signed: Dr Audrey T Wyngaard
**Directorate: Research**
**DATE: 03 June 2019**

## C) Information sheet and consent forms (English and Afrikaans)

**Detailed explanation of study for parent/ legal guardian**

*A legal guardian is defined as a person who is responsible for the care of the child (person under 18 years). This responsibility is in line with the written law and was legally selected (Duhaime, 2000). In our study, only biological or legally selected guardians of the child may give consent.*

**Dear parent/ guardian**

We are fourth year Occupational Therapy students from the University of Cape Town (UCT). We are doing a research project which aims to find out how many teenagers have used or are using alcohol and/or drugs at this school in Ocean View. We are doing this so that the relevance of our questionnaire can be tested for future research on this topic.

Please read through this page before deciding whether you would like your child to take part.

**Why we invite your child to take part**

The participants of the study are required to be within the age range of 15-17. They also need to be English or Afrikaans speaking. We invite your child to take part because they meet these criteria.

**What does participation in this study involve?**

Participation in this study is completely optional for your child. Your child has the right to say "yes" or "no" to take part in it. They may also withdraw from the study at any given time, without any consequences.

Participating involves your child taking some time to have a questionnaire explained to them by one of the researchers. They will then answer an anonymous questionnaire about substance use. Your child will not be required to put his/her name on it. Your child will have a private workspace in which to complete it. If they have any questions they may ask, and

anonymity will be ensured. Completing the questionnaire will take your child a maximum of 20-30 minutes to complete. Once the questionnaire has been finished it will be put by the participants in a sealed box. This will be collected by the researchers.

**What will happen to the questionnaires?**

The questionnaires will be collected as soon as your child has completed it. Anonymous questionnaires, consent and assent forms will be stored in a locked cabinet in the supervisor's office. The data will then be analysed and research findings will be compiled.

**How will the results of the study be used?**

The results will be shared with the stakeholders of your community. It will also be shared with non-profit organizations, such as Living Hope. These will show if the questionnaire can be used in future research

The results will also be presented at the Undergraduate Occupational Therapy Research Day, at the end of 2019. This will involve presentations from University of Cape Town, Stellenbosch University and University of the Western Cape. Your child will not put their name of the questionnaire, so the results will reflect only numbers.

**Are there any risks involved in participation?**

There are no physical risks involved for your child's participation in this study. This study does, however, have the risk of causing emotional triggers for participants who have been exposed to substance use.

**Is there a cost with participating in the study?**

No, there is no financial cost required for taking part. All that is required is 20 to 30 minutes of your child's time.

**What benefits will my child receive from taking part in the study?**

There are no direct benefits involved for your child. Your child will be offered a R20 airtime voucher as an incentive for participating.

The research findings will benefit the community, as they will show if this questionnaire is suitable to be used in future research projects.

**Has the study received approval from an ethics committee?**

Yes. The study has undergone review by the UCT Faculty of Health Sciences' Human Research Ethics Committee and has received approval.

**Approval number:** 2018/0823

**Informed Consent (For parents/legal guardians)**

1. **I understand that I am giving permission for my child to participate in a research study on the use of substances such as alcohol, and/ or other drugs**

2. **I am aware that in order for my child to participate they need to be between the ages of 15-17**

3. **If I agree for my child to participate in the study, my child will be asked to fill out a questionnaire on my past and current use of alcohol and/ or other substances - for approximately 20 to 30 minutes**

4. **I realise that my child's participation in this study is entirely voluntary, and that I may withdraw my child from the study at any time.**

5. **I understand that all information shared during the study will be kept confidential and anonymous.**

6. **I understand that my child will not sustain any injuries or come to harm if I choose to participate in this research project**

7. **This study has been explained to me. I have read and understood the consent form, all of my questions have been answered, and I agree for my child to participate in this study.**

| | |
|---|---|
| **Signature of participant** | **Date:** |
| **Signature of care guardian:** | **Date:** |
| **Signature of investigator:** | **Date:** |

[Adapted from Polit & Beck (2017)

**Please note:**

If you would like to find out any more information about the study or if you have any queries, do not hesitate to contact either of the following:

**The Researchers**

Fiona Gie, Micaela Tedder, Jessica Holmes, Jessica Clark, Jadene du Preez, Melissa Petersen

4th year Occupational Therapy Students

University of Cape Town

Contact person's Email- dprjad002@myuct.ac.za

**Research Project Supervisor**

Ms Sophia-Lorraine Allie

sophia.allie@uct.ac.za

021 650 5776

Office Hours: 08h30 – 13h00 & 13h30 – 16h00
Monday to Friday

Division of Occupational Therapy

Department of Health and Rehabilitation Sciences

University of Cape Town

F45 Old Main Building, Groote Schuur Hospital

Observatory, 7925

If you have any ethics related queries, please contact the **UCT Faculty of Health Sciences Human Research Ethics Committee.**

Human Research Ethics Committee

Room E52.24 Old Main Building

Groote Schuur Hospital

Observatory 7925

Senior Secretary

Ms. Sumayah Ariefdien

tel: 021 406 6492

fax: 021 406 6411

Website: www.health.uct.ac.za/research/humanethics/forms

**Detailed explanation of study for child participants**

**Dear participant**

We are fourth year Occupational Therapy students from the University of Cape Town (UCT). We are doing a research project to complete our degree. In this project we want to find out if our questionnaire would be suitable to determine how many teenagers have used or are using alcohol and/or drugs in Ocean View.

Please read through this page or listen to someone read it before making the choice to take part in the study or not.

**Why you are invited to take part:**

This study needs teenagers between the ages of 15 and 17 years, and who are Afrikaans or English speaking. . We are asking you to take part because you meet these criteria.

**What does taking part in this study involve?**

Taking part in this study is completely up to you. You and your parent/ guardian may say “yes” or “no” to taking part. You may also tell us at any time if you no longer want to be a part of the study.

If you decide to take part, you will be given a questionnaire to answer. You will not have to put your name on the questionnaire and no one will know what you answer. You will have a private workspace to fill it in. Filling it in will take 20 to 30 minutes at most.

**What will happen to the questionnaires?**

The questionnaires will be collected straight after you have filled it in. It will then be taken to our teacher's office and stored safely in a locked safe. Only the researchers and their teacher will see them. Remember that your name will not be on it, so we will not know which one yours is.

**How will the results of the study be used?**

The overall results will be shared with the leaders of your community (not your names), as well as non-profit organizations, such as Living Hope. The results will tell us if this questionnaire would work in future studies. The results will also be presented at the Undergraduate Occupational Therapy Research Day, at the end of 2019. This will involve presentations from University of Cape Town, Stellenbosch University and University of the Western Cape students and supervisors.

**Are there any risks involved?**

There are no physical risks involved for taking part. Thinking about drugs and alcohol creates the risk of emotional triggers.

**Do you need to pay for anything?**

No, you will not have to pay for anything. If you take part, all you will give is 20-30 minutes of your time.

**What benefits will I get from taking part?**

There are no direct benefits involved for you by taking part, but you will be offered R20 airtime to say thank you for your time.

The research findings will benefit the community, as it will show us if this questionnaire is suitable to use in future research projects.

**Has the study received approval from an ethics committee?**

Yes, the study has been reviewed and approved by the UCT Faculty of Health Sciences' Human Research Ethics Committee.

**Approval number:** 2018/0823

**Informed assent (from child participant)**

**I agree/ I do not agree:**

1. **I understand that I am being asked to take part in a university study about the use of drugs and alcohol.**

2. **I am either 15, 16 or 17 years old.**

3. **If I want to take part, I will be asked some questions about drugs or alcohol, this will take about 20 to 30 minutes**

4. **I know that I do not have to take part, but I can if I want to. If I want to stop at any time, I am allowed to.**

5. **I understand no one will know what answers I give and my name will not be used.**

6. **I understand that I will not be hurt or feel unsafe during this project.**

7. **This project has been explained to me. I have understood this form, all of my questions have been answered, and I agree to take part.**

| | |
|---|---|
| **Signature of participant** | **Date:** |
| **Signature of parent/guardian:** | **Date:** |
| **Signature of investigator:** | **Date:** |

[Adapted from Polit & Beck (2017)]

**Please note:**

If you would like to find out any more information about the study or if you have any queries, do not hesitate to contact either of the following:

**The Researchers**

Fiona Gie, Micaela Tedder, Jessica Holmes, Jessica Clark, Jadene du Preez, Melissa Petersen

4th year Occupational Therapy Students

University of Cape Town

Contact person's Email- dprjad002@myuct.ac.za

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If you have any ethics related queries, please contact the **UCT Faculty of Health Sciences Human Research Ethics Committee.**

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Senior Secretary

Ms. Sumayah Ariefdien

tel: 021 406 6492

fax: 021 406 6411

Website: www.health.uct.ac.za/research/humanethics/forms

**Detailed explanation of study for parent/ legal guardian (In Afrikaans)**

**'n Studieverduidliking vir ouers en/of voogde**

*'n Wettige voog word beskryf as'n persoon wat verantwoordelik is vir die sorg van 'n minder jarige kind (n minder jarige kind is enige persoon onder die ouderdom van 18 jaar). Hierdie verantwoordelikheid is in lyn met die geskrewe wetgewing (Duhaime, 2000). In die studie, het net die biologiese of wettige aangestelde voogde van die minder jarige kind die reg om toestemming te verskaf.*

**Geagte ouer / voog**

Ons is vierdejaar Arbeidsterapiestudente van die Universiteit van Kaapstad.

Ons bestuur 'n navorsing projek wat ondersoek instel oor dwelm misbruik onder tieners in Ocean View. Ons wil hierdie studie doen om uit te vind of die vraestel in die toekoms gebruik kan word. Lees asseblief die onderstaande deur, voordat u besluit of u en u kind wil deelneem.

**Hoekom ons u kind nooi om deel te neem:**

Die deelnemers van hierdie studie moet tussen die ouderdomme van 15 en 17 jaar oud wees, en moet Engels of Afrikaans kan praat. Hiermee nooi ons u kind om deel te neem.

**Wat behels die deelname aan hierdie studie?**

Deelname aan hierdie studie is vrywillig . U kind het die reg om "Ja" of "Nee" te antwoord, deel te neem daaraan en mag op enige tyd tydens die studie onttrek, sonder enige gevolge.

Deelname behels dat u kind som tyd sal vat om n verduideliking oor n vraestel te kry, en som tyd om 'n anonieme vraestel oor middelgebruik te beantwoord (daar sal nie van u kind verwag word om sy/haar naam daarop te skryf nie). U kind sal die vraag stuk in 'n private werk spasie voltooi. Indien u kind/ers enige vrae oor die vraestel sou hê, sal hulle deur die navorsers beantwoord word. Dit sal u kind 'n maksimum van 20-30 minute neem om die vraelys te voltooi. Wanneer die vraelys voltooi is, sal die deelnemers dit in n geseëlde houer plaas. Die geseëlde houers sal dan versamel word deur die navorsers. Dis om konfidensialiteit te verseker.

**Wat sal met die vraestel gebeur**

Die vraestel sal ingeneem word sodra u kind dit voltooi het en sal in 'n geslote kluis in die toesighouer se kantoor gebêre word. Die bevindinge van die vraestel sal geïnterpreteer en ontleed word deur die navorsers van hierdie studie.

**Hoe sal die resultate van die studie gebruik word?**

Die resultate sal gedeel word met die belanghebbendes van u gemeenskap, sowel as nie-winsgewende organisasies bv. Living Hope. Die resultate sal aandui of die vraestel in die toekoms gebruik kan word. Die resultate sal ook gebruik word tydens 'n aanbieding by die voorgraadse arbeidsterapie navorsingsdag in 2019. Dit behels aanbiedings deur die studente en studieleiers van die Universiteit van Kaapstad, die Universiteit van Stellenbosch en die Universiteit van die Wes-Kaap. U kind se naam sal nie op die vraestel geskryf word nie, dus sal die resultate net nommers wys.

**Is daar enige risiko's betrokke by deelname?**

Daar is geen fisiese risiko verbonde aan die deelname van die studie vir u kind nie. Hierdie studie kan wel n emosionele effek op u kind he indien dit moeilik is vir hulle om oor dwelm gebruik te praat en te dink.

**Is daar enige kostes verbonde om aan die studie deel te neem?**

Nee, daar is geen kostes verbonde vir deelname aan die studie nie. Al wat vereis word, is 20 tot 30 minute van u kind se tyd.

**Watter voordele sal my kind ontvang deur deel te neem aan hierdie studie?**

Daar is geen direkte voordele vir u kind nie, maar hulle sal R20 lugtyd kry vir hulle tyd. Die navorsingsbevindinge sal tot voordeel van die gemeenskap wees.

Dit sal ook die gemeenskap bevoordeel om die vraestel in toekomstige studies te kan gebruik.

**Het die studie goedkeuring ontvang van 'n etiese komitee?**

Die studie is deur die UCT Fakulteit van Gesondheids wetenskappe se Menslike Etiese navorsings komitee nagegaan en het goedkeuring ontvang.

**Goedkeuring nommer:** 2018/0823

**Ingeligte toestemming- en bekragtigvorm**

1. **Ek verstaan dat ek gevra word om deel te neem aan 'n navorsingstudie oor die gebruik van middels soos alkohol, dwelms of enige ander skadelike middels.**

2. **Ek verstaan dat my kind tussen die ouderdomme van 15 en 17 jaar oud moet wees, om in hierdie studie deel te kan neem.**

3. **Sou ek instem om aan die studie deel te neem, sal ek gevra word om ’n vraelstel in te vul oor my vorige en huidige alkolhol- en dwelmgebruik. Dit sal 20-30 minute neem.**

4. **Ek verstaan dat my deelname aan hierdie studie vrywillig is en dat ek op enige tydstip van die studie mag onttrek.**

5. **Ek verstaan dat alle inligting wat ek tydens die studie deel, vertroulik en anoniem sal bly .**

6. **Ek verstaan dat ek nie enige beserings sal opdoen of skade sal ly as ek kies om aan hierdie studie deel te neem nie.**

7. **Hierdie studie is aan my verduidelik . Ek het die toestemmings brief gelees en verstaan, en al my vrae is beantwoord. Ek stem in om deel te neem.**

| | |
|---|---|
| **Handtekening van deelnemer** | **Datum:** |
| **Handtekening van ouer / voog :** | **Datum:** |
| **Handtekening van navorser:** | **Datum:** |

[Aangepas uit Polit & Beck (2017)]

**Let wel:**

Indien u enige verdere navrae het moet asseblief nie huiwer om een van die volgende persone te kontak nie:

**Die navorsers**

Fiona Gie, Micaela Tedder, Jessica Holmes, Jessica Clark, Jadene du Preez, Melissa Petersen

4de Jaar Arbeidsterapie studente

Universiteit van Kaapstad

Kontak persoon se e-posaders: dprjad002@myuct.ac.za

**Studieleier**

Me Sophia-Lorraine Allie

sophia.Allie@uct.ac.za

PH: 021 650 5776

Kantoor ure: 08h30 – 13h00 & 13h30 – 16h00 Maandag tot Vrydag

Afdeling vir arbeidsterapie

Departement van gesondheid en rehabilitasie wetenskappe

Universiteit van Kaapstad

F45 Ou Hoofgebou

Groote Schuur hospitaal

Observatory

7925

Indien u enige etiese navrae het, kontak asseblief die **UCT Fakulteit Gesondheidswetenskappe Menslike Etieknavorsingskomitee.**

Menslike Etieknavorsingskomitee

Kamer E52.24

Ou Hoofgebou

Groote Schuur hospitaal

Observatory

7925

Senior Sekretaresse

Me Sumayah Ariefdien

Tel: 021 406 6492

Faks: 021 406 6411

Webwerf: www.Health.uct.ac.za/Research/humanethics/forms

**Detailed explanation of the study for child participants (In Afrikaans)**

**Liewe deelnemer**

Ons is vierdejaar Arbeidsterapiestudente van die Universiteit van Kaapstad. Ons moet 'n navorsingsprojek inhandig om ons graad te voltooi. In hierdie projek wil ons graag bepaal of ons vraestel wys hoeveel tieners in Ocean View in die verlede of tans wel dwelms of alkohol gebruik het.

Lees / luister asseblief goed na die volgende, voordat jy besluit of jy aan die studie sal wil deel neem.

**Hoekom jy genooi word om deel te neem:**

Hierdie studie het die volgende kriteria: kinders en tieners moet tussen die ouderdomme van 15 jaar en 17 jaar oud wees en Afrikaans of Engels kan praat.

Ons nooi jou om deel te neem, omdat jy aan hierdie kriteria voldoen.

**Wat moet ek doen om deel te neem aan hierdie studie ?**

Dit is jou keuse om aan hierdie studie deel te neem. Jy kan "Ja" of “Nee” sê om deel te neem. Jy kan enige tyd vir ons sê dat jy nie meer wil deelneem nie. Daar is geen nagevolge om te ontrek gedurende die studie nie.

As jy besluit om deel te neem, sal jy 'n vraelstel gegee word om te beantwoord. Jy sal nie jou naam op die vraestel skryf nie en niemand sal weet wat jou antwoorde is nie. Jy sal 'n privaat werkruimte kry waar jy dit kan invul. Dit sal 20 tot 30 minute neem om die vraelys te beantwoord.

**Wat sal met die vraestel gebeur?**

Die vraestel sal ingeneem word direk nadat jy dit ingevul het. Dit sal dan na die studieleier se kantoor geneem word en in 'n geslote kluis gebêre word. Slegs die navorsers en hul studieleier sal die vrae- en antwoordstelle sien. Onthou dat jou naam nie daarop sal wees nie, daarom sal ons nie weet watter een joune is nie.

**Hoe sal die resultate van die studie gebruik word?**

Al die resultate sal gedeel word met die leiers van jou gemeenskap, sowel as nie-winsgewende organisasies, soos Living Hope. Die resultate sal wys of die vraestel in die toekoms gebruik kan word. Die resultate sal ook gebruik word in ‘n aanbieding by die voorgraadse arbeidsterapienavorsingdag in 2019. Dit behels aanbiedings deur studente en studieleiers van die Universiteit van Kaapstad, die Universiteit van Stellenbosch en die Universiteit van die Wes-Kaap. Die resultate sal net nommers reflekteer, want ons sal nie vir enige iemand se naam vra.

**Is daar enige risiko's betrokke?**

Daar is geen fisiese risiko's betrokke nie, maar kan wel n emosionele risiko behels indien dit te moeilik is om oor dwelm en/of alkohol gebruik te praat of te dink.

**Moet jy vir enige iets betaal?**

Nee, daar is geen kostes verbonde nie. Indien jy deelneem, is al wat jy gee, 10 tot 20 minute van jou tyd.

**Watter voordele sal jy daaruit kry deur deel te neem?**

Daar is geen direkte voordele nie , maar ons sal vir jou R20 lugtyd gee om vir jou dankie te se vir jou tyd.

**Het die studie goedkeuring van 'n etiese komitee ontvang?**

Ja, die studie is beoordeel en goed gekeur deur die UCT Fakulteit van Gesondheidswetenskappe se Menslike Navorsings -etiese komitee.

**Goedkeuring nommer:** 2018/0823

**Vereenvoudige Ingeligte toestemming- en bekragtigsvorm**

**<u>Ek stem saam / ek stem nie saam nie:</u>**

1. **Ek verstaan dat ek word gevra om deel te neem aan 'n studie oor die gebruik van dwelms en alkohol.**

2. **Ek bevestig ek is 15, 16, of 17 jaar oud.**

3. **Sou ek wil deelneem, sal ek gevra word om vrae oor dwelms of alkohol gebruik te beantwoord. Dit kan 20-30 minute neem.**

4. **Ek weet dat ek nie hoef deel te neem nie, maar ek kan as ek wil. Ek mag enige tyd my deelname staak of ophou om die vrae te beantwoord.**

5. **Ek verstaan dat niemand sal weet wat my antwoorde is nie, want my naam sal nie gebruik word nie.**

6. **Ek verstaan dat ek nie seergemaak sal word of onveilig voel tydens hierdie studie nie.**

7. **Die projek/studie is aan my verduidelik . Ek verstaan hierdie vorm, die inhoud daarvan en al my vrae is beantwoord. Ek stem in om te neem deel.**

| | |
|---|---|
| **Handtekening van deelnemer** | **Datum:** |
| **Handtekening van ouer /voog:** | **Datum:** |
| **Handtekening van navorser:** | **Datum:** |

[Aangepas uit Polit & Beck (2017)]

**Let wel:**

As jy enige verdere navrae oor die studie het, kontak gerus een van die volgende:

**Die navorsers**

Fiona Gie, Micaela Tedder, Jessica Holmes, Jessica Clark, Jadene du Preez, Melissa Petersen

4de Jaar Arbeidsterapie studente

Universiteit van Kaapstad

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## D) Questionnaires

**D.1. Questionnaire (in English)**

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

**INSTRUCTIONS**

Thank you for volunteering to be part of this study. We are researchers working for the University of Cape Town (UCT). We are conducting a study about young individuals' use of alcohol, cannabis and methamphetamine and other drugs.

To answer each question, simply put an X in the box over the answer that applies to you. The questionnaire will take up to 20 to 30 minutes to complete.

Please note that there are no right or wrong answers. We would like you to please be sure to answer the questions as accurately and honestly as you can. Also, please note that you will not have to write your name anywhere on the questionnaire, and once you have handed in your questionnaire, we will not be able to link it back to you. None of the study team members, other learners, teachers or other school staff, or parents will see any of the questionnaires. No-one will know what answers you have given in the questionnaire.

Once you have finished answering all the questions, your questionnaire will be put in a sealed box with all the others.

If you need help with any of the questions, please feel free to ask the study staff members. Please note that they are here to help you, and they will not tell anyone what you ask or tell them.

**SECTION A: PERSONAL INFORMATION**

First, we would like to ask some questions about you.

1. What year were you born?

| | | | |
|---|---|---|---|
| | | | |

2. What is the name of your school?

| |
|---|
| |

3. What grade are you in? (Please mark your answer with an X)

| | |
|---|---|
| Grade 8 | |
| Grade 9 | |
| Grade 10 | |
| Grade 11 | |
| Grade 12 | |

4. Are you male or female?

| | |
|---|---|
| Female | |
| Male | |

5. How would you identify yourself?

| | |
|---|---|
| Black African | |
| Coloured | |
| Indian | |
| White | |
| Other (specify) | |

6. What is the name of the area that you live in?

| |
|---|
| |

7. Which of the following describes your home best?

| | |
|---|---|
| Shack | 1 |
| Wendy house or backyard dwelling | 2 |
| Tent or traditional dwelling | 3 |
| Brick house or flat | 4 |
| Other | 5 |

| | |
|---|---|
| Not applicable | 9 |

8. Which ONE of the following best describes how things are in your home?

| | |
|---|---|
| We don't have enough money for food | |
| We have enough money for food but not for other basic items such as clothes | |
| We have enough money for food and clothes but we are short of many other things | |
| We have the most important things, but few luxury goods | |
| We have money for luxury goods and extra things | |
| Not applicable | |

9. Does anyone from your household, such as your parents, brothers or sisters, cousins, aunt, uncle, grandma, or grandpa (**not** including you) use drugs?

| | |
|---|---|
| Yes | |
| No | |
| I don't know | |

**SECTION B: SCHOOLING**

10. Have you ever repeated a grade at school because you failed the exams?

| | |
|---|---|
| Yes | |
| No | |

11. Give us your best guess of how many days you were absent from school during the last school term.

| | |
|---|---|
| 0 days | |
| 1-2 days | |
| 2-5 days | |

| | |
|---|---|
| 5-10 days | |
| More than 10 days | |

12. Which of the following are true about how you feel about your school?

| | | Yes | No |
|---|---|---|---|
| A | I like my school | | |
| B | My school is a good place to learn | | |
| C | I feel safe in my school | | |
| D | Teachers in my school are fair when dealing with learners | | |

13. Have you ever seriously considered quitting (or dropping out of) school for any reason?

| | |
|---|---|
| Yes | |
| No | |

14. Have you ever been expelled from a school? (told you cannot go back to a school because you did something wrong)?

| | |
|---|---|
| Yes | |
| No | |

**SECTION C: DRUGS**

Below are some questions on drugs.

15. Have you ever tried alcohol/booze?

| | |
|---|---|
| Yes | |
| No | |
| **IF NO, SKIP TO QUESTION 21.** | |

16. If yes, how old were you when you first tried alcohol?

| | |
|---|---|
| | |

Years

17. Have you used alcohol in the past 12 months?

| | |
|---|---|
| Yes | |
| No | |

18. Have you used alcohol in the past 30 days?

| | |
|---|---|
| Yes | |
| No | |

19. Have you used alcohol in the past 7 days?

| | |
|---|---|
| Yes | |
| No | |

20. In the past year how often did you drink alcohol?

| | |
|---|---|
| Every week | |
| About once/twice a month | |
| A few times a year | |
| Hardly ever | |
| Never | |

21. Have you ever tried dagga/weed/cannabis/pot/ganja/Mary Jane?

| | |
|---|---|
| Yes | |
| No | |

**IF NO, SKIP TO QUESTION 27.**

22. If yes, how old were you when you first tried dagga?

| | |
|---|---|
| | |

Years

23. Have you used dagga in the past 12 months?

| | |
|---|---|
| Yes | |
| No | |

24. Have you used dagga in the past 30 days?

| | |
|---|---|
| Yes | |
| No | |

25. Have you used dagga in the past 7 days?

| | |
|---|---|
| Yes | |

| | |
|---|---|
| No | |

26. In the past year how often did you use dagga?

| | |
|---|---|
| Almost everyday | |
| Once a week or more | |
| About once a month | |
| Every few weeks | |
| Only once or twice | |
| Never | |

27. Have you ever tried Tik/speed (methamphetamine)?

| | |
|---|---|
| Yes | |
| No | |

**IF NO, SKIP TO QUESTION 33.**

28. If yes, how old were you when you first tried Tik?

| | |
|---|---|
| | |

Years

29. Have you used Tik in the past 12 months?

| | |
|---|---|
| Yes | |
| No | |

30. Have you used Tik in the past 30 days?

| | |
|---|---|
| Yes | |
| No | |

31. Have you used Tik in the past 7 days?

| | |
|---|---|
| Yes | |
| No | |

32. In the past year how often did you use Tik?

| | |
|---|---|
| Almost everyday | |
| Once a week or more | |
| About once a month | |
| Every few weeks | |
| Only once or twice | |

| | |
|---|---|
| Never | |

33. Have you ever tried any other drug?

| | |
|---|---|
| Yes | |
| No | |

**IF NO, SKIP <u>ALL</u> OF THE FOLLOWING QUESTIONS.**

34. If yes, please provide the name of the drug(s)

| | Name of Drug |
|---|---|
| **Drug 1** | |
| **Drug 2** | |
| **Drug 3** | |
| **Drug 4** | |
| **Drug 5** | |

***Some examples of possible drugs: Heroin, buttons, cocaine/crack, speed, ecstasy, Nyaope/Whoonga, LSD, methadone, glue, shrooms, angel dust, tobacco products.

If necessary, please answer the following questions about the above drug(s) used:

**<u>Drug 1</u> (SKIP THE FOLLOWING QUESTIONS IF YOU DIDN'T ADD ANY OTHER DRUGS)**

**Questions for drug 1:**

35. How old were you when you first tried the drug?

| | |
|---|---|
| | |

Years

36. Have you used this drug in the past 12 months?

| | |
|---|---|
| Yes | |
| No | |

37. Have you used this drug in the past 30 days?

| | |
|---|---|
| Yes | |
| No | |

38. Have you used this drug in the past 7 days?

| | |
|---|---|
| Yes | |
| No | |

39. In the past year how often did you use this drug?

| | |
|---|---|
| Almost everyday | |
| Once a week or more | |
| About once a month | |
| Every few weeks | |
| Only once or twice | |
| Never | |

**Drug 2 (SKIP THE FOLLOWING QUESTIONS IF YOU ENTERED JUST "1" OTHER DRUG)**

**Questions for drug 2:**

40. How old were you when you first tried the drug?

| | |
|---|---|
| | |

Years

41. Have you used this drug in the past 12 months?

| | |
|---|---|
| Yes | |
| No | |

42. Have you used this drug in the past 30 days?

| | |
|---|---|
| Yes | |
| No | |

43. Have you used this drug in the past 7 days?

| | |
|---|---|
| Yes | |
| No | |

44. In the past year how often did you use this drug?

| | |
|---|---|
| Almost everyday | |
| Once a week or more | |
| About once a month | |
| Every few weeks | |

| | |
|---|---|
| Only once or twice | |
| Never | |

**Drug 3 (SKIP THE FOLLOWING QUESTIONS IF YOU ENTERED "2" OTHER DRUGS)**

45. How old were you when you first tried the drug?

| | |
|---|---|
| | |

Years

46. Have you used this drug in the past 12 months?

| | |
|---|---|
| Yes | |
| No | |

47. Have you used this drug in the past 30 days?

| | |
|---|---|
| Yes | |
| No | |

48. Have you used this drug in the past 7 days?

| | |
|---|---|
| Yes | |
| No | |

49. In the past year how often did you use this drug?

| | |
|---|---|
| Almost everyday | |
| Once a week or more | |
| About once a month | |
| Every few weeks | |
| Only once or twice | |
| Never | |

**Drug 4 (SKIP THE FOLLOWING QUESTIONS IF YOU ENTERED "3" OTHER DRUGS)**

50. How old were you when you first tried the drug?

| | |
|---|---|
| | |

Years

51. Have you used this drug in the past 12 months?

| | |
|---|---|
| Yes | |
| No | |

52. Have you used this drug in the past 30 days?

| | |
|---|---|
| Yes | |
| No | |

53. Have you used this drug in the past 7 days?

| | |
|---|---|
| Yes | |
| No | |

54. In the past year how often did you use this drug?

| | |
|---|---|
| Almost everyday | |
| Once a week or more | |
| About once a month | |
| Every few weeks | |
| Only once or twice | |
| Never | |

**Drug 5 (SKIP THE FOLLOWING QUESTIONS IF YOU ENTERED "4" OTHER DRUGS)**

55. How old were you when you first tried the drug?

| | |
|---|---|
| | |

Years

56. Have you used this drug in the past 12 months?

| | |
|---|---|
| Yes | |
| No | |

57. Have you used this drug in the past 30 days?

| | |
|---|---|
| Yes | |
| No | |

58. Have you used this drug in the past 7 days?

| | |
|---|---|
| Yes | |
| No | |

59. In the past year how often did you use this drug?

| | |
|---|---|
| Almost everyday | |
| Once a week or more | |
| About once a month | |
| Every few weeks | |
| Only once or twice | |
| Never | |

**D.2. Questionnaire (in Afrikaans)**

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

**INSTRUKSIES**

Dankie dat jy bereid is om deel te wees van hierdie studie . Ons is navorsers van die Universiteit van Kaapstad (UCT). Ons doen 'n studie oor die gebruik van alkohol, dagga, Tik en ander dwelms vir jong mense. Om elke vraag te beantwoord, plaas 'n X in die blokkie wat van toepassing is tot jou. Die vraelys sal tot 20-30 minute neem om te voltooi.

Let daarop dat daar geen regte of verkeerde antwoorde is nie. Ons wil graag hê dat jy die vrae so akkuraat en eerlik as moontlik moet beantwoord. Moet asseblief nie jou naam op enige plek op die vraelys skryf nie. Dit is sodat wanneer jy die vraelys inhandig, niemand dit weer met jou kan verbind nie.

Geen van die studiespanlede, ander leerders, onderwysers, ander skoolpersoneel of ouers sal enige van die vraelyste sien nie. Niemand sal weet watter antwoorde jy in die vraelys gegee het nie.

Sodra jy al die vrae beantwoord het, sal jou vraelys in 'n verseëlde boks saam met al die ander geplaas word.

As jy hulp nodig het om die vrae te beantwoord of nie die vrae verstaan nie, vra asseblief die personeellede. Hulle is hier om jou te help en sal vir niemand vertel wat jou vraag is nie.

**AFDELING A: PERSOONLIKE INLIGTING**

Eerstens, wil ons graag 'n paar vrae oor jou vra.

1. In watter jaar is jy gebore?

| | | | |
|---|---|---|---|
| | | | |

2. Wat is die naam van jou skool?

| |
|---|
| |

3. In watter graad is jy ? (Merk asseblief jou antwoord met 'n X)

| | |
|---|---|
| Graad 8 | |
| Graad 9 | |
| Graad 10 | |
| Graad 11 | |
| Graad 12 | |

4. Is jy n meisie of ‘n seun?

| | |
|---|---|
| Meisie | |
| Seun | |

5. Hoe sou jy jouself identifiseer?

| | |
|---|---|
| Swart Afrikaanse | |
| Kleurling | |
| Indies | |
| Wit | |
| Ander (Spesifiseer) | |

6. Wat is die naam van die gebied/area waar jy woon?

| |
|---|
| |

7. Watter van die volgende beskryf jou huis die beste?

| | |
|---|---|
| Hut | 1 |
| Wendy huis of agterplaaswoning | 2 |
| Tent of tradisionele woning | 3 |

| | |
|---|---|
| Baksteenhuis of woonstel | 4 |
| Ander | 5 |
| Nie van toepassing | 9 |

8. Watter een van die volgende is die beste beskrywing van hoe dinge in jou huis is/ beskryf jou omstandighede die beste?

| | |
|---|---|
| Ons het nie genoeg geld vir kos nie | |
| Ons het genoeg geld vir kos, maar nie vir ander basiese items soos klere nie | |
| Ons het genoeg geld vir kos en klere, maar ons het ’n te kort aan baie ander dinge | |
| Ons het die al die belangrike dinge, maar net ’n paar luukse goedere | |
| Ons het geld vir luukse goedere en ekstra dinge | |
| Nie van toepassing | |

9. Gebruik enigeiemand in jou huishouding dwelms, soos jou broer, suster, niggie, neef, tannie, oom, ouma, oupa, of ouers?

| | |
|---|---|
| Ja | |
| Nee | |
| Ek weet nie | |

**AFDELING B: Skoolopleiding**

10. Het jy ooit 'n jaar by die skool herhaal omdat jy nie die eksamen kon skryf nie?

| | |
|---|---|
| Ja | |
| Nee | |

11. Gee vir ons ’n skatting van hoeveel dae jy afwesig was by die skool in die laaste kwartaal?

| | |
|---|---|
| 0 dae | |
| 1-2 dae | |
| 2-5 dae | |

| | |
|---|---|
| 5-10 dae | |
| Meer as 10 dae | |

12. Watter van die volgende stellings is die mees waar oor hoe jy voel oor jou skool?

| | | Ja | Nee |
|---|---|---|---|
| A | Ek hou van my skool | | |
| B | My skool is 'n goeie plek om dinge te leer | | |
| C | Ek voel veilig by my skool | | |
| D | Onderwysers in my skool is regverdig teenoor leerders | | |

13. Het jy al ooit dit oorweeg om skool te verlaat?

| | |
|---|---|
| Ja | |
| Nee | |

14. Was jy enige tyd uit die skool geskors?

| | |
|---|---|
| Ja | |
| Nee | |

**AFDELING C: DWELMS**

Hier is 'n paar vrae oor dwelmgebruik/ dwelmmisbruik .

15. Het jy al ooit alkohol/dop probeer drink?

| | |
|---|---|
| Ja | |
| Nee | |
| **INDIEN NEE, GAANNA VRAAG 21.** | |

16. Indien Ja, hoe oud was jy toe jy begin eksperimenteer het met alkohol?

| | | |
|---|---|---|
| | | Jaar |

17. Het jy alkohol in die afgelope 12 maande gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

18. Het jy alkohol in die afgelope 30 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

19. Het jy alkohol in die afgelope 7 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

20. Hoe dikwels het jy alkohol in die afgelope jaar gedrink?

| | |
|---|---|
| Elke week | |
| ongeveer een keer / twee keer per maand | |
| 'nPaar keer per jaar | |
| Amper nooit | |
| Nooit | |

21. Het jy al ooit dagga/ weed/cannabis/pot/ganja/Mary Jane probeer?

| | |
|---|---|
| Ja | |
| Nee | |

**INDIEN NEE, GAANNA VRAAG 27.**

22. Indien Ja, hoe oud was jy toe jy begin het om met dagga te eksperimenteer?

| | | |
|---|---|---|
| | | Jaar |

23. Het jy dagga in die afgelope 12 maande gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

24. Het jy dagga in die afgelope 30 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

25. Het jy dagga in die afgelope 7 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

26. Hoe dikwels het jy dagga gebruik in die afgelope jaar?

| | |
|---|---|
| Byna elke dag | |
| Een keer per week of meer | |
| Meer as een keer per maand | |
| Elke paar weke | |
| Slegs een of twee keer | |
| Nooit | |

27. Het jy al ooit Tik/ speed (methamphetamine) probeer gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

**INDIEN NEE, GAAN NA VRAAG 33.**

28. Indien Ja, hoe oud was jy toe jy begin eksperimenteer het met Tik?

| | | |
|---|---|---|
| | | Jaar |

29. Het jy Tik in die afgelope 12 maande gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

30. Het jy Tik in die afgelope 30 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

31. Het jy Tik in die afgelope 7 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

32. Hoe dikwels het jy Tik in die afgelope jaar gebruik?

| | |
|---|---|
| Byna elke dag | |
| Een keer 'n week of meer | |
| Oor een keer 'n maand | |
| Elke paar weke | |
| Slegs een of twee keer | |
| Nooit | |

33. Het jy ooit enige ander dwelms probeer?

| | |
|---|---|
| Ja | |
| Nee | |

**INDIEN NEE, SLAAN AL DIE VOLGENDE VRAE OOR.**

34. Indien Ja, LYS asseblief die name van die dwelm(s)

| | **Naam van dwelm** |
|---|---|
| **Dwelm 1** | |

| | |
|---|---|
| **Dwelms 2** | |
| **Dwelm 3** | |
| **Dwelm 4** | |
| **Dwelm 5** | |

'N paar voorbeelde van moontlike dwelms: Heroin, buttons, cocaine/crack, speed, ecstasy, Nyaope/Whoonga, LSD, methadone, gom, shrooms, angel dust, tabak produkte

Beantwoord asseblief die volgende vrae oor die gebruik van die bogenoemde dwelm(s).

**<u>Dwelm 1</u> (SLAAN DIE VOLGENDE VRAE OOR AS JY NIE ENIGE ANDER DWELMS BYGEVOEG HET NIE)**

**Vrae vir dwelm 1:**

35. Hoe oud was jy toe jy begin eksperimenteer het met die dwelm ?

| | | |
|---|---|---|
| | | Jaar |

36. Het jy hierdie dwelm in die afgelope 12 maande gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

37. Het jy hierdie dwelm in die afgelope 30 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

38. Het jy hierdie dwelm in die afgelope 7 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

39. Hoe dikwels het jy hierdie dwelm in die afgelope jaar gebruik?

| | |
|---|---|
| Byna elke dag | |
| Een keer 'n week of meer | |
| Oor een keer 'n maand | |
| Elke paar weke | |
| Slegs een of twee keer | |
| Nooit | |

**Dwelm 2 (SLAANDIE VOLGENDE VRAE Oor AS JY NET "1" ANDER DWELM GELYS/ GENOEM HET)**

**Vrae vir dwelm 2:**

40. Hoe oud was jy toe jy die dwelm eerstens probeer?

| | | |
|---|---|---|
| | | Jaar |

41. Het jy hierdie dwelm in die afgelope 12 maande gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

42. Het jy hierdie dwelm in die afgelope 30 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

43. Het jy hierdie dwelm in die afgelope 7 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

44. Hoe dikwels het jy hierdie dwelm in die afgelope jaar gebruik?

| | |
|---|---|
| Byna elke dag | |

| | |
|---|---|
| Een keer 'n week of meer | |
| Oor een keer 'n maand | |
| Elke paar weke | |
| Slegs een of twee keer | |
| Nooit | |

**Dwelm 3 (SLAAN DIE VOLGENDE VRAE OOR AS JY "2" ANDER DWELMS GELYS/GENOEM HET)**

45. Hoe oud was jy toe u die dwelm eerstens probeer het?

| | | |
|---|---|---|
| | | Jaar |

46. Het jy hierdie dwelm in die afgelope 12 maande gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

47. Het jy hierdie dwelm in die afgelope 30 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

48. Het jy hierdie dwelm in die afgelope 7 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

49. Hoe dikwels het jy hierdie dwelm in die afgelope jaar gebruik?

| | |
|---|---|
| Byna elke dag | |
| Een keer 'n week of meer | |
| Oor een keer 'n maand | |
| Elke paar weke | |

| | |
|---|---|
| Slegs een of twee keer | |
| Nooit | |

**Dwelm 4 (SLAAN DIE VOLGENDE VRAE OOR AS JY "3" ANDER DWELM GELYS / GENOEM HET)**

50. Hoe oud was jy toe jy die dwelm eerstens probeer het?

| | | |
|---|---|---|
| | | Jaar |

51. Het jy hierdie dwelm in die afgelope 12 maande gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

52. Het jy hierdie dwelm in die afgelope 30 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

53. Het jy hierdie dwelm in die afgelope 7 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

54. Hoe dikwels het jy hierdie dwelm in die afgelope jaar gebruik?

| | |
|---|---|
| Byna elke dag | |
| Een keer 'n week of meer | |
| Oor een keer 'n maand | |
| Elke paar weke | |
| Slegs een of twee keer | |
| Nooit | |

**Dwelm 5 (SLAAN DIE VOLGENDE VRAE OOR AS JY "4" ANDER DWELMS GELYS/GENOEM HET)**

55. Hoe oud was jy toe u die dwelm eerstens probeer het?

| | | |
|---|---|---|
| | | Jaar |

56. Het jy hierdie dwelm in die afgelope 12 maande gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

57. Het jy hierdie dwelm in die afgelope 30 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

58. Het jy hierdie dwelm in die afgelope 7 dae gebruik?

| | |
|---|---|
| Ja | |
| Nee | |

59. Hoe dikwels het jy hierdie dwelm in die afgelope jaar gebruik?

| | |
|---|---|
| Byna elke dag | |
| Een keer 'n week of meer | |
| Oor een keer 'n maand | |
| Elke paar weke | |
| Slegs een of twee keer | |
| Nooit | |

## E) Letters

**E.1: Letter to Western Cape Department of Education**

**UNIVERSITY OF CAPE TOWN**

**Faculty of Health Sciences**

**Department of Health and Rehabilitation Sciences**
Divisions of Communication Sciences and Disorders; Nursing and Midwifery; Occupational therapy, Physiotherapy; Disability Studies

F45 Old Main Building, Groote Schuur Hospital
Observatory, Cape Town, W Cape, 7925
Tel: +27 (0) 21 406 6401/ 6428/ 6628/ 6534
Fax: +27 (0) 21 406 6323

24/05/2019

Western Cape Department of Education
Private Bag X9114
Cape Town
8000

To whom it may concern:

**Re: Permission to conduct substance use research at Ocean View Secondary School**

We are a group of six fourth year Occupational Therapy students from the University of Cape Town conducting a study on "substance use amongst adolescents at a secondary school in Ocean View" in partial fulfilment of our degree Bachelor of Science in Occupational Therapy.

The aim of the study is to investigate and establish the extent to which adolescents living in Ocean View are using substances.

Its objectives are to establish which substances are most commonly used, whether there are differences in substance use among males and females, at what age substance use is most prevalent, and to determine the most common age of onset of substance use, all amongst adolescents in Ocean View.

**Description of the participants needed for this study**

The sample age range for this study is 15-17 years, therefore Ocean View Secondary School, the high school in Ocean View, is the school that we request permission from the Western Cape Department of Education (WCDOE) to gain access to, in order to conduct this study.
The school will only be contacted regarding this study once permission from the WCDOE has granted permission for accessing it. The participants may be English or Afrikaans speaking.



HREC REF: 2018/0823

**What participating in this study will entail**

Participation in this study is completely voluntary and participants will not take part unless informed consent from their parent or legal guardian and informed assent has been received. Participants and parents/ legal guardians may also decide to withdraw from the study at any given time, without any consequences.
Participating involves participants answering an anonymous questionnaire (in order to ensure confidentiality) about substance use. Completing the questionnaire will take 10- 20 minutes to complete.
A classroom/ a designated area in which participants can privately fill the questionnaires in will also be needed.

The questionnaires will be collected immediately completion and will be stored in a locked safe in the supervisor's office.

**How will the results of the study be used?**
The results will be shared with the stakeholders of the Ocean View community, as well as non-profit organizations, such as Living Hope. The purpose of sharing the results with these parties is to provide the knowledge of the extent of substance use amongst adolescence, so that programs that offer support to the community regrading substance use may be initiated, if it is found to be necessary.
The results will also be presented at the Undergraduate Occupational Therapy Research Day, at the end of 2019. This will involve presentations from University of Cape Town, Stellenbosch University and University of the Western Cape students and supervisors.
The best interest of the community will be protected; therefore, the results will not be shared with the media or any other social platforms.

This study has been approved by the Faculty of Health Sciences' Human Research Ethics Committee. **Approval number:** 2018/0823

If you would like to find out any more information about the study or if you have any queries, do not hesitate to contact either of the following:

**The Researchers**
Fiona Gie, Micaela Tedder, Jessica Holmes, Jessica Clarke, Jadene du Preez
4th year Occupational Therapy Students
University of Cape Town
Contact person's Email- dprjad002@myuct.ac.za

**Research Project Supervisor**
Ms Sophia-Lorraine Allie
sophia.allie@uct.ac.za
021 650 5776
Office Hours: 08h30 – 13h00 & 13h30 – 16h00
Monday to Friday

Thank you for your time.

Regards,
Jessica Clarke, Jessica Holmes, Jadene du Preez, Micaela Tedder and Fiona Gie

***E.2: Letter to principal***

**UNIVERSITY OF CAPE TOWN**

**Faculty of Health Sciences**

**Department of Health and Rehabilitation Sciences**
Divisions of Communication Sciences and Disorders; Nursing and Midwifery; Occupational Therapy;
Physiotherapy; Disability Studies

F45 Old Main Building, Groote Schuur Hospital
Observatory, Cape Town, W Cape, 7925
Tel: +27 (0) 21 406 6401/ 6428/ 6628/ 6534
Fax: +27 (0) 21 406 6323

30 November 2018

Kleinberg Primary School
Aquila Way
Ocean View
Western Cape
7975

To whom it may concern:

**Re: Permission to conduct substance use research at schools in Ocean View**

We are a group of five fourth year Occupational Therapy students from the University of Cape Town conducting a study on "Substance use amongst school-aged children and adolescence in Ocean View" in partial fulfilment of our degree Bachelor of Science in Occupational Therapy.

The aim of the study is to investigate and establish the extent to which the school-aged children and adolescents living in Ocean View are using substances.
Its objectives are to establish which substances are most commonly used, whether there are differences in substance use among males and females, at what age substance use is most

prevalent, and what contextual factors impact substance use, all amongst school-aged children and adolescents in Ocean View.

In order to conduct this study, we request permission and assistance in order to recruit study participants from your school. Permission has been received from the Western Cape Department of Education (please see attached approval letter).

**Description of the participants needed for this study**
The participants of the study are required to be within the age range of 15 - 17 years, English or Afrikaans speaking, and need to be attending your school.

**What participating in this study will entail**

Participation in this study is completely voluntary and participants will not take part unless informed consent from their parent or legal guardian and informed assent has been received. Participants and parents/ legal guardians may also decide to withdraw from the study at any given time, without any consequences.
Participating involves participants answering an anonymous questionnaire (in order to ensure confidentiality) about substance use. Completing the questionnaire will take 10- 20 minutes to complete.
A classroom/ a designated area in which participants can privately fill the questionnaires in will also be needed.
The questionnaires will be collected immediately completion and will be stored in a locked safe in the supervisor's office.

**How will the results of the study be used?**
The results will be shared with the stakeholders of the Ocean View community, as well as non-profit organizations, such as Living Hope. The results will also be presented at the Undergraduate Occupational Therapy Research Day, at the end of 2019. This will involve presentations from University of Cape Town, Stellenbosch University and University of the Western Cape students and supervisors.

This study has been approved by the Faculty of Health Sciences' Human Research Ethics Committee. **Approval number:**

If you would like to find out any more information about the study or if you have any queries, do not hesitate to contact either of the following:
**The Researchers**
Fiona Gie, Micaela Tedder, Jessica Holmes, Jessica Clarke, Jadene du Preez
4th year Occupational Therapy Students
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Contact person's Email- dprjad002@myuct.ac.za

**Research Project Supervisor**
Ms Sophia-Lorraine Allie

sophia.allie@uct.ac.za
021 650 5776
Office Hours: 08h30 – 13h00 & 13h30 – 16h00
Monday to Friday
Division of Occupational Therapy

Regards,
Jessica Clarke, Jessica Holmes, Jadene du Preez, Micaela Tedder and Fiona Gie