#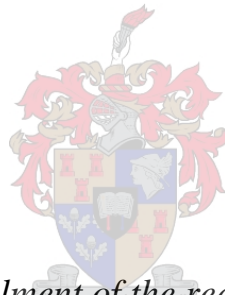 REHABILITATION OF DRUG ADDICTED ADOLESCENT BOYS: THE CONTRIBUTION OF SOCIAL WORKERS WHO ARE EMPLOYED BY THE DEPARTMENT OF SOCIAL DEVELOPMENT

by

Elvira Koleta Appollis

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Supervisor: Dr Ilze Slabbert

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof, that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously submitted it for obtaining any qualification.

March 2016

ACKNOWLEDGEMENTS

This thesis I dedicate to my mum, Irene Hodman who wanted to become a social worker.

At the end of this journey I would like to thank the following people:

- Firstly my Heavenly Father for guiding me through this whole process, thank you for providing me strength and motivation to carry on.

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ABSTRACT

Illicit and legal drugs are a substantial threat to the public good, not only because they adversely affect public health, but also because they generate crime, disorder, family breakdown and community decay. Many people think addiction is the only negative outcome of substance use. A significant number of people, and also adolescents, experience challenges with substance abuse. It is difficult for adolescents to realize the impact of substance and alcohol use on their lives. Many know about the risk of addiction, but cannot see the negative impact their substance use is having on their lives before they reach that point. All they have been taught to look for is the extremes of death, crashed cars, a life on the street, etc. They may still be passing at school for example, but they are not doing as well as they would be if they were not using drugs. There is a loss of potential which they may never regain. Social worker's contribution to render services in the field of substance abuse is valuable, despite some challenges.

The goal of the study was to gain an understanding of the contribution of social workers who are employed by the Department of Social Development to the rehabilitation of adolescent boys who are addicted to substances. A qualitative approach with some quantitative elements was chosen to conduct this study. A combination of an exploratory and descriptive research design was used. The researcher was able to gain an in depth insight into the contribution of social workers regarding addicted adolescent boys. Ethical clearance was obtained to conduct this study.

The literature study explored substance abuse among adolescent boys as well as the intervention and rehabilitation of drug addicted adolescent boys. The empirical study was undertaken and in the last chapter conclusions and recommendations for further social work practice were made. The empirical study was completed with 20 participants by means of semi-structured interviews. An interview schedule based on the findings of the literature study was utilized. Certain criteria for inclusion applied. The results of this study mostly confirmed the findings from the literature study which indicated that the social workers have meaningful contributions to make regarding adolescent boys who are addicted to substances, but that they experience several challenges such as inadequate training in the field of substance abuse.

Recommendations are aimed at the social work profession in South Africa who need to align itself in providing an effective service to the addicted adolescent boy. Programmes were proposed that can serve as a guideline when working with these adolescents. Suggestions for future research are also made in line with how drug addiction in South Africa can be prevented by educating children from a very young age about the danger of substances at home and in schools.

OPSOMMING

Onwettige en wettige dwelms is 'n wesenlike bedreiging vir die publiek, nie net omdat dit nadelig vir die gesondheid is nie, maar ook omdat dit lei tot misdaad, gesinsgeweld en gemeenskapsverval. Baie mense dink verslawing is die enigste negatiewe gevolge van middelgebruik. Die meeste mense, veral adolesente, sal eksperimenteer met dwelms lank voordat hulle op die punt van verslawing is. Dit is moeilik vir adolesente om die impak van dwelms en die gebruik van alkohol op hul lewens te besef. Baie is bewus wat die risiko van verslawing is, maar kan nie die negatiewe impak van hul dwelmgebruik op hul lewens sien, voordat hulle daardie punt bereik het nie. Al wat hulle geleer is, is om te kyk vir die uiterstes soos dood, motorongeluk, 'n lewe op die straat, ens. Hulle kan nog steeds skool gaan, maar hulle doen nie so goed soos hulle sou doen indien hulle nie dwelms gebruik nie. Daar is 'n verlies van potensiaal wat hulle nooit kan herwin nie.

Die doel van die studie was om 'n begrip te kry van die bydrae van maatskaplike werkers wat in diens van die Departement van Maatskaplike Ontwikkeling is, tot die rehabilitasie van adolessente seuns wat verslaaf is aan dwelmmiddels. Die navorser het gebruik gemaak van 'n kombinasie van 'n kwalitatiewe en kwantitatiewe navorsingsbenadering. Deur die gebruik van beide 'n kwantitatiewe en kwalitatiewe benadering in 'n komplimentêre wyse was die navorser in staat om 'n in diepte insig in die lewens van die verslaafde adolessente seun te verkry. Etiese klaring is verkry voordat met die studie begin was.

Die literatuurstudie verken eerstens dwelmmisbruik onder adolessente seuns. Tweedens volg 'n bespreking van die intervensie en rehabilitasie van dwelmverslaafde adolessente seuns. Daarna is 'n empiriese studie onderneem en in die laaste hoofstuk is gevolgtrekkings en aanbevelings vir verdere maatskaplike werkpraktyk gemaak. Die empiriese studie is voltooi met 20 deelnemers by wyse van semi-gestruktureerde onderhoude. 'n Onderhoud-skedule gebaseer op die bevindinge van die literatuurstudie is gebruik. Die kriteria vir insluiting was dat die deelnemers adolessente seuns wat verslaaf is aan dwelmmiddels as deel van hul gevalleladings moes hê en 'n diens aan hierdie adolessente moes lewer. Die resultate van hierdie studie bevestig meestal die bevindinge van die literatuurstudie wat getoon het dat die maatskaplike werkers gekonfronteer word deur adolessente seuns wat verslaaf is aan dwelmmiddels en dat daar uitdagings is in die diensleweringsproses, soos onvoldoende opleiding.

Aanbevelings is daarop gemik om die maatskaplike diens aan te pas ten einde 'n effektiewe diens aan die verslaafde adolessente seun te lewer. Programme is voorgestel wat kan dien as 'n riglyn wanneer met hierdie adolessente gewerk word. Voorstelle vir toekomstige navorsing word ook gemaak oor hoe dwelmverslawing in Suid-Afrika voorkom kan word, deur kinders van 'n baie jong ouderdom oor die gevare van dwelmmiddels by die huis en by die skool bewus te maak.

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CHAPTER 1

INTRODUCTION

1.1   MOTIVATION FOR THE STUDY

In almost every newspaper one reads of the devastating effects of substance abuse. The occurrence of substance abuse is choking high in South Africa. Drug related deaths are the most extreme form of harm that can result from drug use. The United Nations Office on Drugs and Crime estimates that there were 183,000 (range: 95,000-226,000) drug related deaths in 2012, corresponding to a mortality rate of 40.0 (range: 20.8-49.3) deaths per million persons aged 15-64 (World Drug Report, 2014). In almost every school are adolescents who use tobacco or cannabis or alcohol. Drug addiction is a terrible burden to bear. It can totally ruin your life (Van der Westhuizen, 2008:63). Drugs are often used for pleasure and result into pain. Intoxication can bring forth intense feelings of visions of pure beauty for both the body and the mind. In contrast, the "high" may also cause terrifying nightmares or push the senses into paranoia from which no return is possible. There is no escape from the fact that drug consumption can result in death. The opposites of bliss and fear attract attention by their very nature. The author furthermore emphasizes that in the twenty-first century, drugs remain a major acute form in relation to young people (Blackman, 2004:01).

The National Drug Master Plan (NDMP) (2006-2011) compels reasons exist as to why community-based prevention of substance abuse should be a major focus for all practitioners in the field of substance abuse. The combined effects of tobacco, alcohol and other drugs take a greater toll on the health and well-being of South Africans than any other single preventable health problem. Of particular importance is the fact that over the last five years drug use among the youth has been rising and the age of onset has dropped to ten years. The NDMP (2006-2011) also states that the major emphasis of community-based prevention should be on the youth and substances such as tobacco, dagga and alcohol. The researcher will thus focus on these drugs. The researcher will also investigate in which way social workers, who are employed by the Department of Social Development, play an active role in programmes that assist the adolescent who is addicted to drugs. It seems as if social workers concentrate on referring these adolescents to Rehabilitation Centres, which result in a long waiting period. It

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also happens that adolescents who have been admitted to the Rehabilitation Centers do not complete the programme and those who did complete relapse after a period of time. According to Kranzler and Leach (2012:192) low self-esteem, interpersonal conflict and stress are reasons why adolescents relapse. Factors such as environmental factors, family life and peer pressure cannot be left out. According to Hubbard (2012:48) one of the reasons relapse occurs, is because the body is not totally clean from the substance and after a while activates in the blood stream, which can lead to adolescents crave for the drug and start using again. The author advised that a vitamin called niacin can be used to address this issue.

In reviewing the NDMP (2006-2011) several challenges and impediments that need to be addressed and incorporated with the NDMP (2013-2017) were identified. It is generally accepted that a single approach such as criminalizing or decriminalizing substances or abusers will not solve the problem. Instead, a number of strategies should be applied in an integrated way. The commonly recognized strategies applied in the NDMP (2013-2017) are demand reduction, supply reduction and a socialized version of harm reduction. The outcomes include reduction of the bio-psycho-social and economic impact of substance abuse and related illnesses on the South-African population; ability of all people in South Africa to deal with problems related to substance abuse within communities; recreational facilities and diversion programmes that prevent vulnerable populations from becoming substance abusers/dependents; reduced availability of dependence-forming drugs, including alcoholic beverages; development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of drug dependence and co-occurring disorders and for funding such diagnosis and treatment; harmonization and enforcement of laws and policies to facilitate effective governance of the supply chain with regard to alcohol and other drugs and creation of job opportunities in the field of combating substance abuse.

Mrs. Helen Zille, Premier of the Western Cape, said that drug abuse has become one of South Africa's most serious developmental challenges. It is a leading contributor to the national burden of disease and it is at the root of most violent crimes. Drugs have created serious problems for health and police authorities around the world because of the volatile behaviour it triggers. She said that new rehabilitation techniques have had to be developed to address it, as traditional methods often proven to be ineffective (Walker, 2009:xi). Mbuya (2002:50) agrees to Mrs. Zille's statement that alternative treatments need to be considered. He also mentions the limited efficiency and unavailability of treatment approaches. The author also emphasizes the fact that substance use disorder continues to be problematic in society and

remains a serious health problem. Drug disorders cost communities immensely in terms of drug-related crime, physical illness and mortality.

Fisher and Harrison (2013:18) divide the use of drugs into four categories, namely Depressants, Stimulants, Cannabinols and Poly-Drug use. **Depressants** are the most commonly used and abused in society. It includes alcohol, inhalants (such as glue and lacquer thinners), analgesics or painkillers, tranquillizers, hypnotics and sleeping pills and narcotics (such as opium, morphine, heroin, codeine and pethidine); **Stimulants** speed up the way the body and mind work. They include: tobacco, appetite suppressants, ephedrine (found in decongestants and asthma medication), cocaine, crack and amphetamines or amphetamine type substances. **Cannabinolis:** the best known is cannabis (dagga/marijuana), the strongest hallucinogens available is LSD. **Poly-Drug use** refers to the use of different kind of drugs.

According to Walker (2009:47) there is no clear-cut pattern of drug addiction in South-Africa, except that alcohol and dagga are in general the two most greatly abused substances across the entire country. The pattern of illicit drug use seems to be changing. In the late 1980's and early 1990's, the two top drugs were dagga and mandrax. At the beginning of the 2000's methamphetamine and heroin started taking over. Drugs are a huge problem in the country and what is concerning is that drug users appear to be getting younger. The problem with users getting younger is addiction. The younger the user is when they start to use drugs the greater their chance of becoming addicted and there has also been a trend towards hard drugs – heroin and methamphetamine from an early age (Walker, 2009:51). According to a survey of drug and alcohol use among primary school children in the Cape Town metropolitan area in 2002, one-fifth of primary school children have tried drugs. The average age of first using drugs was 12.1 years. In high schools, 45% had tried any drug and 32% were still using drugs (The Cape Town Drug Counselling Centre, 2004).

The World Drug Report (2012) states that there is growing concern about the increased demand for and limited access to substance abuse treatment, also that there is little or no routine monitoring and evaluation of substance abuse services in the country. It is also disquieting, as access to treatment is necessary but not sufficient for positive treatment outcomes. Markus, Schmitz, Moeller, Liehr, Cron and Carrol (2012:175) also state in their research that in the USA substance use among adolescents is common. Prescription and over-the-counter medications were the substances most abused. There is also a disturbing trend in

the intentional abuse of pain killers, tranquilizers, stimulants and sedatives. The rate of adolescents aged 12 to 17 years with illicit drug addiction or abuse was 7.3% in 2010.

Bushwell (2011) indicates that there has been a huge increase in adolescents who are seeking treatment for addiction in South Africa since 2007. According to a study conducted by Bushwell (2011) drug abuse amongst Grade 11 boys are as follows: Cannabis 32%, Mandrax 5.7% and other 3.9%. It is clear that there is an increase in the usage of drugs amongst adolescent boys. According to Van Staden (2012:13) a study on regional level was conducted among high-school pupils in rural KwaZulu-Natal and was found that alcohol is the most commonly used substance, followed by inhalants and cannabis. The lifetime prevalence among township secondary school learners in four education districts in the Free State was found to be above 40% for alcohol use and approximately 5% for cannabis use. A study among grade 6 and 7 learners in four primary schools in a historically disadvantaged area in Tshwane, Gauteng found lifetime prevalence of alcohol and cannabis use of 27% and 7% respectively and past-month prevalence rates of 14% for alcohol and 4% for cannabis. The association between substance use by learners and several demographic, environmental, scholastic, psychological and social factors has been investigated. South African studies have consistently found higher rates of substance use in male learners than female learners. There is evidence that parental drug use increases the likelihood of adolescent drug use. According to Leach and Kranzler (2012:192) in some cases peers were found to have had a greater influence on learners initiating substance use than the family, school and media among learners.

The problem is worldwide and everyone cries for a solution. Part of the problem seems that social workers are not equipped sufficiently for the huge demand of substance abuse among specifically adolescent boys. O'Sullivan (2010:366) states that the social worker's role is primarily related to making decisions concerning other people's safety and well-being. These decisions made by individuals and groups have the potential to significantly impact on the future of vulnerable people and their families. The White Paper for Social Welfare (1997) states that appropriate social service programmes will be provided to promote healthy lifestyle free of drug abuse. Furthermore those strategies will be developed to curb the demand for abusive drugs.

Despite the intension of the Department of Social Development to create a drug free society, the White Paper for Social Welfare (1997) states that substance abuse amongst school children, especially boys are increasing. The Department of Social Development realizes that the different Departments need to work together in order to address this issue. The Department of Health and Social Development need to collaborate in rehabilitating drug-dependent persons. The main task of both these departments is to provide appropriate services to such persons while maintaining a high standard of care. They have to monitor the registration and management of health and social development taking the lead in this regard. The Department of Health must take responsibility for the medical component of the treatment programme, including the provision of detoxification facilities and resources (National Drug Master Plan, 2013-2017).

Adolescents in Rehabilitation Centers have described their experience as restrictive and stressful, an arduous process requiring unique strategies to cope with recovery in this setting, as well as with the demands of a future drug-free lifestyle (Marcus *et al*., 2012:175). The Drug Master Plan (2013-2017) states that the Department of Social Development is the lead department in the campaign against drug abuse and it provides technical and financial support to the Central Drug Authority and its secretariat. It is responsible for developing generic policy on drug abuse and to develop and refine programmes on prevention, early intervention and treatment for drug abuse (The National Drug Master Plan, 2006-2011:32). The Department of Social Development is in the process of implementing these policies, but it seems as if the social workers struggle to render specialized services due to a lack of sufficient manpower, which requires from social workers to reintegrate work.

1.2   PROBLEM STATEMENT

According to Nexus data base some of the research topics during the five past years regarding substance abuse were alcohol misuse and HIV; Fetal alcohol syndrome (FAS); adult addiction; hookah pipe smoking; and aftercare. No study was done on the contribution of social workers regarding the rehabilitation of drug addicted adolescent boys.

The researcher is of opinion that a study about the rehabilitation of drug addicted adolescent boys is a great need, since adolescent boys are in a crisis and every third youngster get at some stage involved in drug use (Van Der Westhuizen, 2008:12). As mentioned earlier

adolescents who experiment with drugs do not always progress to dependence and abuse, but there are those who develop substance use disorders, a major public health problem and an important focus for research (Marcus *et al*., 2012:175). The primary method of rehabilitating is to refer the adolescent to a Rehabilitation Centre. The problem is that the dropout rate of adolescents from Rehabilitation Centers are very high, often as high as 50% with the greatest attrition occurring within the first 30 to 60 days. The dropout rate for adolescents is higher than that of adults (Marcus *et al*., 2012:176). Reasons can be difficulty to adapt in the strange environment and lack of motivation (Marcus *et al*., 2012:175). According to Leach and Kranzler (2012:366) relapse after treatment for drug use disorders is a common problem. Marcus *et al*. (2012:178) indicate that 50% to 70% of adolescent patients are unable to remain abstinent during the first year after addiction treatment in Rehabilitation Centers.

Social work as a profession is dedicated to the understanding and modification of the social factors involved in client problems. Barber (2002:37-38) described the social work perspective in the following terms: "Social work seeks to enhance the social functioning of individuals, singularly and in groups, by activities focused on their social relationships which constitute interaction between individuals and their environments. These activities can be grouped into three functions: restoration of addicted adolescents' impaired capacity, provision of individual and social resources and prevention of social dysfunction." The social work profession thus has a valuable contribution to make regarding service rendering to drug addicted adolescent boys whether it is restoration, provision or prevention, despite some challenges. In this study the researcher attempted to gain an understanding of the contribution of social workers employed by the Department of Social Development to the rehabilitation of adolescent boys who are addicted to drugs.

1.3   THEORETICAL POINTS OF DEPARTURE

Nevid, Jeffrey, Rathus, Spencer and Greene (2006:328) refer to the way in which the major theoretical perspectives view the causes of substance abuse and dependence. According to the author the biological perspective focuses on uncovering the biological pathways that may explain mechanisms of physiological dependence. The biological perspective spawns the disease model, which posits that alcoholism and other forms of substances are disease processes. Learning perspectives view substance abuse disorders as learned patterns of behaviour, with roles for classical and operant conditioning and observational learning.

Cognitive perspectives focus on roles of attitudes, beliefs and expectancies in accounting for substance use and abuse. Sociocultural perspectives emphasize the cultural, group and social factors that underlie drug use patterns, including the role of peer pressure in determining adolescent drug use. Psychodynamic theorists view problems of drug abuse, such as excessive drinking and habitual smoking, as signs of oral fixation.

Fisher and Harrison (2013:36) refer to the different models of drug addiction which include the **moral model** (discourage individuals from treatment), **sociocultural model** (refer to environmental factors), **psychological model** (refer to personality factors), **medical model** (refer to medical factors and focuses on abstinence) and lastly the **bio psychosocial model** which is the most useful model (it focus on different variables). This model also fits well with the matrix model. Rawson and McCann (2005) refer to the matrix model as a multi-element package of therapeutic strategies that complement each other and combine to produce an integrated out-patient treatment experience. The authors furthermore described the model as a set of evidence-based practices delivered in a clinically coordinated manner as a program. For the purpose of this study the researcher will focus on the **matrix model**, which will be discussed in detail in chapter three.

1.4 AIM AND OBJECTIVES

1.4.1 Aim

The aim of the research is to gain an understanding of the contribution of social workers employed by the Department of Social Development to the rehabilitation of adolescent boys addicted to drugs.

1.4.2 Objectives

In order to achieve this goal the following objectives were devised:
- An exploration of substance abuse among adolescent boys.
- Discussion and intervention regarding rehabilitation of drug addicted adolescent boys.
- To investigate how social workers employed by the Department of Social Development contribute to the rehabilitation of adolescent boys addicted to drugs in terms of relevant policies.

- Conclusions and recommendations for further social work practice with regards to the rehabilitation of adolescent boys who are addicted to drugs.

1.5 CLARIFICATION OF CONCEPTS

1.5.1 Drugs

Drugs have been described by Chibaya (2002:09) as a substance, used in medicine or as a stimulant or narcotic. The Prevention of and Treatment for Substance Abuse Act No 70 of 2008 refer to **substances** and defined it as chemical, psychoactive substances that are prone to be used, including tobacco, alcohol, over the counter drugs, prescription drugs and substances defined in the Drugs and drugs trafficking Act No 140 of 1992 or prescribed by the Minister after consultation with the Medicine Control Council established by section 2 of the Medicine and Related Substance Control Act No. 101 of 1965 and drugs in the context of this Act has a similar meaning. A formal definition of **substance abuse** disorder (SUD) is provided by the DSM-IV (APA 1994). Drug abuse is a maladaptive pattern of drug use leading to clinically significant impairment or distress, as manifested by one more of four symptoms or criteria occurring within a 12 month period (Sussman & Ames, 2001:11).

1.5.2 Addiction

According to Volkow (2010:5) **drug addiction** is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use despite harmful consequences. **Addiction** according to Chibaya (2002:09) is a condition that occurs when a person needs to take drugs to survive from day to day also called dependence. **Addiction** is also the compulsion to use alcohol or other drugs regardless of negative or adverse consequences. Addiction is characterized by psychological dependence and often (depending on the use of drugs) physical dependence (Fisher & Harrison, 2013:14). Donovan and Marlatt (2005:04) have proposed that **addiction** is a process whereby a behaviour that can function both to produce pleasure and to provide escape from internal discomfort is employed in a pattern characterized by recurrent failure to control the behaviour and continuation of the behaviour despite significant negative consequences.

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1.5.3 Adolescent

Conceptionalisation of **adolescent** in this study refers to a teenager experiencing the transition from childhood to adulthood. A period in the human life cycle situated between childhood and adulthood (Gouws, Kruger, Burger & Snyman, 2008:201). **Adolescence** is described in the Social Work Dictionary (Barker, 2003:08) as the life cycle period between childhood and adulthood, beginning at puberty and ending with young adulthood. Geldard and Geldard (2010:19) emphasize that **adolescence** is a time of experimentation and of trying out new behaviours in response to new situations. Young people are prone to engage in extreme and unrestricted risk-taking because they often have the egocentric belief that they are almost indestructible.

1.5.4 Social worker

The White Paper for Social Welfare (1997) refers to social work as Professional Services of a **social worker** aimed at the promotion of the social functioning of individuals, families, groups and communities. The Social Service Professions Act states that **social work** means a professional service performed by a social worker, aimed at the improvement of the social functioning of people. Social functioning means the role performance of an individual in its entirety at all levels of his or her existence in interaction with other individuals, families, groups, communities and situations in his or her environment.

1.5.5 Risk factor

Risk factors refer to the issues that adolescents experience in their lives, such as chaotic home environments, particularly where parents abuse substances or suffer from mental illnesses; ineffective parenting, especially of children with difficult temperaments or conduct disorders and lack of parent-child attachments and nurturing; failure in school performance; poor social coping skill; liaising with peers who display deviant behaviour; perceptions of approval of drug-using behaviour in family, work, school, peer and community environments (Fisher & Harrison, 2013; Kilpatrick, Acierno, Resnick, Best & Schnurr, 2000).

1.5.6 Protective factors

Protective factors are those factors associated with reducing the potential for drug use. It include strong, positive family bonds; parental monitoring of children's activities and their peers; clear rules of conduct that are consistently enforced within the family; involvement of parents in the lives of their children; success in school performance and strong bond with institutions such as schools and religious organizations; adoption of conventional norms regarding drug use (The Western Cape Drug Counseling Centre, 2011).

1.6   RESEARCH METHODOLOGY

1.6.1 Literature study

In a general sense a literature review serves to put the researcher's efforts into perspective, situating the topic in a larger knowledge pool (De Vos, Strydom, Fouché & Delport, 2011:134). According to Grinnell and Unrau (2005:46) in De Vos *et al.* (2011:134) a literature review creates a foundation for the study based on exciting related knowledge. Kreuger and Neuman (2006:461) in De Vos *et al.* (2011:134) state that a good literature review places a research project in context – it shows the path of prior research and how the current project is linked to the former articles, books, theses and legislation from the research field to be reviewed. The study will focus on the following aspects: adolescents, drugs, addiction, rehabilitation, risk factors contributing to youths' engagement in drug abuse, statistics about drug abuse as well as the protective factors.

Grinnell and Unrau (2005:47) in De Vos *et al.* (2011:135) also emphasize the fact that literature also assist a researcher after data collection to explain differences between the findings and existing knowledge and allow identification of ways in which the current findings are consistent with and support existing knowledge and how they may advance knowledge.

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1.6.2 Research approach

A qualitative study with elements of a quantitative approach was used for the purpose of this study, as the study focuses on the social workers at the Department of Social Development's contribution to the rehabilitation of adolescent boys, who are addicted to drugs. According to Mouton (2011:142) a qualitative approach has the potential to supplement and revise our current understanding of a situation. The author states furthermore that qualitative research is not a set recipe, but involves learning through doing. Also that it aims to understand the meaning which individuals place on events. It thus calls for personalized responses and includes perceptions of participants. Merriam (2009:152) states that it is the rich, thick descriptions of the words that persuade the reader of the trustworthiness of the findings. This approach was implemented in the form of semi-structured interviews. Bless and Higson (2000:106-107) describe semi-structured interviews as a data collection method, where specific and detailed information is gathered directly from participants. **Qualitative research** serves to identify from the participant's perspectives a deeper understanding of the phenomenon (De Vos *et al.*, 2011:64). **Quantitative research** aims to explain relationships between variables, as well as describe trends. It further undertakes unbiased inquiry by the researcher from theory into a social phenomenon, in order to draw conclusions (De Vos *et al.*, 2011:63-64). The research for the study thus aimed to use flow between inductive and deductive reasoning in the form of using theory and perspectives, in order to determine the contribution of social workers to support adolescent boys in the drug rehabilitation process.

1.6.3 Research design

Descriptive and exploratory research designs were used in this study. According to these designs research have some similarities, but also differ in many respects. Although they might blend in practice, descriptive research presents a picture of the specific detail of a situation, social settings or relationship and focuses on how and why questions (De Vos *et al.*, 2011:96). The researcher therefore begins with a well- defined subject and conducts research to describe it accurately, whereas in exploratory studies the researcher aims to become conversant with basic facts and created a general picture of a condition (De Vos *et al.*, 2011:96). Questions around several themes served as guidelines in this study. As the study was explorative in nature the researcher yields new insights into the contribution that social

workers who are employed by the Department of Social Development had made (Terre, Blanche, Durrheim & Painter, 2006:205).

1.6.4 Population and sampling

The term sample always implies the population or universe of which the sample is a smaller section, or a set of individuals selected from a population. Population is a term that set boundaries on the study unit. It refers to individuals who process specific characteristics. In this study the population was social workers who are employed by the Department of Social Development who rendered services to adolescent boys, who are addicted to drugs (De Vos *et al*., 2011:223).

Non-probability purposive sampling methods were applied to obtain the sample (De Vos *et al*., 2011:392). Purposive sampling is based completely on the judgment of the researcher. The sample composed of elements that contain the most characteristic and representative attributes of the population (De Vos *et al*., 2011:392). The researcher was unaware of the size of the population and a sample of 20 participants was chosen.

The following criteria for inclusion applied:

Participants had to:
- Be social workers employed by the Department of Social Development
- Rendering services to drug addicted adolescent boys
- Has at least 6 months working experience as a social worker
- Speak English or Afrikaans

1.6.5 Data collection

Permission was obtained to do the study by the Department of Social Development (Annexure B). The researcher made use of semi-structured interviews, where the interview was guided by the schedule rather than dictated (De Vos *et al*., 2011:352). Participants shared more closely in the direction the interview took and they could introduce an issue the researcher had not thought of (De Vos *et al*., 2011:352). See Annexure E (English) and Annexure F (Afrikaans).

The researcher used a set of predetermined questions that was used as an appropriate instrument to engage with the participants and designated the narrative terrain (De Vos *et al*., 2011:352). Informed consent was obtained and adequate information regarding the objectives of the study, the procedures to be followed, advantages and possible disadvantages, as well as the credibility of the researcher was provided to the participants. Consent forms were given to the participants to sign after they agreed voluntarily to participate in the study (De Vos *et al*., 2011:117). See Annexure C (English) and Annexure D (Afrikaans).

1.6.6 Pilot study

According to De Vos *et al*. (2011:394) a pilot study is a small study that is conducted before the main research, to determine the adequacy of the methodology, sampling instruments and analysis. A pilot study was conducted using the semi-structured interview. The pilot study allows the researcher to ensure that all appropriate data will be gathered given the research instrument used. Through the use of a pilot study, the researcher was able to confirm whether the questions and terminology used in the structured questionnaire was clear to the interviewees. A pilot study was conducted with three participants who met the same criteria for inclusion.

1.6.7 Method of data analysis

According to Barbie and Rubin cited in De Vos *et al*. (2011:249) quantitative data analysis can be regarded as the techniques by which researchers convert data to a numerical form and subject it to statistical analysis. The purpose of analysis is thus to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied, tested and a conclusion drawn. This is presented in figures and tables. Qualitative data analysis was done by transforming data into findings. This is also the process of bringing order, structure and meaning to the mass of collected data. Patton cited in De Vos *et al*., (2011:397) mentions that the purpose of qualitative analysis is to transform data into findings. Such an analysis would involve reducing large volumes of raw information, sifting significance from trivia, identifying significant patterns and subsequently constructing a framework that would allow for communication of key findings (De Vos *et al*., 2011:397).

De Vos *et al*. (2011:403) give the following guidelines and emphasize the fact that these steps cannot be followed rigidly.

- Preparing and organizing the data by planning for the recording of the data, the collection and preliminary analyses of the data, managing the data and the reading and writing of memos.

- Reducing data through generating categories and coding the data, testing the emergent understanding, searching for alternative explanation, interpreting and developing typologies, as well as visualizing, representing and displaying the data.

In this study the data was audiotaped with informed consent from the participants and then transcribed. Once all the transcription was completed, time was dedicated to read through all transcriptions in their entirety, in an attempt to get immersed in the details and to make sense of the interviews in order to present the data. The data were then ordered into themes, sub-themes and categories (De Vos *et al*., 2011:409).

1.6.8 Method of verification

The researcher verified the qualitative data according to Guba's model for qualitative data analysis, as adapted by Schurink, Fouché and De Vos (2011:419-421). It is based on the following constructs:

1. **Data was verified on the basis of credibility/authenticity.** The researcher demonstrated that the participants' perceptions matched with the description of the data as provided by the participants. It therefore entails that the findings should be a true reflection of the participants' viewpoints.

2. **Data was verified on the basis of transferability.** The researcher took responsibility to ask whether the findings of the research study can be transferred to other applicable studies. Schurink *et al*. (2011:420) explained that this is a "problematic" aspect in qualitative research studies and that the qualitative researcher should take special note of this aspect.

3. **Data was verified based on dependability.** The dependability of a qualitative research study is based on a logical and well-documented research process. This means that the research process that was followed and the methodology utilized were clearly and expansively documented.

4. **Data was verified based on conformability.** This construct refers to the neutrality of the findings. Therefore, the researcher provided evidence that support the findings and interpretation of the study.

1.7   ETHICAL ASPECTS

1.7.1 Ethical clearance

De Vos *et al*. (2011:126) indicate that institutional ethics committees, or institutional review boards, at universities; research institutions and major welfare organizations are responsible for reviewing research proposals according to several strict guidelines and procedures. This process took place and ethical clearance was granted, prior to the research being carried out. The research study was guided under the supervision of the Social Work Department at the University of Stellenbosch. The proposal was submitted to the Departmental Ethics Screening Committee (DESC) of the Department of Social Work for approval, as low risk research in which the only foreseeable risk is one of discomfort or inconvenience (see Annexure A). The researcher remained within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the levels confidentiality of the information gathered (confidentiality is never an absolute and always relative to the research undertaken).

1.7.2 Deception of subjects and/or participants

Misrepresenting the research purpose is an ethical issue and the researcher was cautioned not to do so. The participation of participants was not obtained through intentionally misleading them by withholding information or by offering incorrect information (De Vos *et al*., 2011:117-118).

1.7.3 Confidentiality

Privacy implies the element of personal privacy, while confidentiality refers to dealing with information in a confidential manner (De Vos *et al*., 2011:119). Confidentiality was ensured by keeping all information about the participants in a safe place.

1.7.4 Beneficence

One of the most fundamental ethical rules to take into consideration in social research is that participants should not be harmed in any way (De Vos *et al*., 2011:115). According to Cresswell (2003:64) the researcher has an ethical responsibility to protect their participants from any physical discomfort that may arise from participation in the research project.

This was a low risk study as the research participants were social workers. There was no contact made with the drug addicted adolescent boys. In order to ensure the emotional comfort of the participants, the ethical issue of "voluntary" will be discussed. If an unexpected emergency situation was revealed during the research, whether it was caused by the research or not, it would have been immediately be reported to the supervisor of the study and Departmental Chair for further advice. No emergency situations occurred during this study.

1.8   LIMITATIONS OF THE STUDY

A relatively small sample was used in this study and therefore the findings cannot be generalized. The study also only took place in one district and therefore the findings can also not be generalized. Social workers were interviewed in this study as the goal of the study was to determine their contribution towards the rehabilitation of drug addicted adolescent boys. It could have been meaningful to also determine the experiences of drug addicted adolescent boys. Some of the literature is also dated, but as far as possible in these cases the researcher included more recent literature. Methods to ensure trust worthiness were not done.

1.9   PRESENTATION

The proposed research report will include several chapters that will be organized as follows:
- Chapter 1 – The research proposal
- Chapter 2 – Objective 1 – Exploration of substance abuse among adolescent boys.
- Chapter 3 – Objective 2 – A discussion of intervention and rehabilitation of drug addicted adolescent boys.

- Chapter 4 – Objective 3 – The empirical study which will investigate how social workers employed by the Department of Social Development contribute to the rehabilitation of adolescent boys, addicted to drugs in terms of relevant policies.

- Chapter 5 – Objective 4 – Conclusions and recommendations for further social work practice with regards to the rehabilitation of adolescent boys who are addicted to drugs.

CHAPTER 2

AN EXPLORATION OF DRUG ABUSE AMONG ADOLESCENT BOYS

2.1   INTRODUCTION

In this chapter drug abuse amongst adolescent boys will be explored as well as the nature and the consequences of drug abuse. As discussed in chapter one drug abuse is a reality in South Africa with extremely negative impact on adolescent boys. They are more susceptible to addictive behaviour and thinking less about the consequences of drug abuse. Almost half of all adolescents in South Africa experimenting with drugs today will develop problems with chemical dependency. These young people may destroy their relationships with family, friends, their school education and their self-respect. Some might overdose and die (Van der Westhuizen, 2008:12).

2.2   THEORETICAL PERSPECTIVES OF DRUG ABUSE

In order to understand substance usage *two theories* are presented, namely the reward or reinforcement theory and stress-reduction theory (Anton, 2010:739). *The reward or reinforcement theory* states that experiences of drugs induced euphoria are perceived as a favorable and the individual is as a result motivated to continue usage to sustain this euphoria. *The stress-reduction theory* proposes that daily living creates strain. This stress may be as a result of relationships, economic strain, as well as traumatic life events. Individual resiliency in dealing with stress plays a role in the process, as individuals differ in their capacity for dealing with stressful events. Stressful life events may include exposure to abuse and poverty of fulfillment of needs. Individuals who have experienced severe stress in childhood may be more prone to drug usage as are individuals who experience significant stress in their adult lives, but have had limited experience of dealing with stress when younger. Substances are used to alleviate strain by reducing depression, anxiety and symptoms of exposure to trauma, such as intrusive thoughts (Anton, 2010:739). According to Nevid *et al.* (2006:309) adolescents begin using substances for various reasons. Some adolescents start using drugs because of peer pressure or because they believe drugs make them seem more sophisticated or grown-up. Some use drugs as a way of rebelling against

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their parents or society at large. Most adolescents use drugs for the pleasure they provide. Others use drugs to help them relax when they are tense and paradoxically, to give them a kick or a lift when they are tired. Many would like to quit, but find it difficult to break their addiction. Adolescents also use drugs as a coping mechanism as many of them grew up in very difficult circumstances. Regardless of why people get started with drugs, they continue to use them because drugs produce pleasurable effects and they find it difficult to stop.

2.3   CLASSIFICATION OF DRUGS

Fisher and Harrison (2013:18) divide drugs into four categories as was discussed in chapter one.

2.3.1 Depressants

This class of drugs also known as downers includes all drugs that slow down body functions such as pulse rate and breathing (Fisher & Harrison, 2013). An example of a depressant is alcohol.

Consequences of alcohol use: Adolescents using alcohol resulted in health problems, appetite loss, weight loss, eczema, headaches and episodes of loss of consciousness. Sexually transmitted diseases can also occur due to the fact that alcohol use stimulates their sexual abilities and adolescents can get sexually involved with someone who might be infected by HIV or any other sexually transmitted diseases (The Drug Master Plan, 2013-2017).

2.3.2 Stimulants

This class of drugs contains chemicals that increase the activity of the central nervous system (Nevid *et al*., 2006:305). An example is tobacco. The active chemical in tobacco is nicotine.

The researcher will emphasize on several **consequences** that can be caused by nicotine. According to Louw and Edwards (2005:201) **nicotine** is the most dangerous chemical out of the 4000 chemicals found in tobacco smoke. Stoppard (2000:32) agrees to this fact and according to him it has been scientifically proven that nicotine can lead to physical addiction, which may lead to death from lung cancer and other lung diseases, as well as cardiovascular (heart and artery) disease. Nicotine exerts its effects on the body by altering the operation of

norepinephrine and acetylcholine. A few drops of nicotine in its pure form when swallowed can kill in minutes. The nicotine hit is exceedingly quick. Stoppard (2000:36) also refers to gangrene (that means your blood get so sticky it can block arteries) which can lead to difficult movement and eventually to amputation, emphysema and bronchitis, as well as cancer in the mouth, throat, esophagus, bladder, pancreas, kidney, cervix, breast and stomach. Duodenal ulcers and worsening asthma are also consequences when smoking tobacco.

The researcher will focus on cannabis, alcohol and tobacco and also discuss poly-drugs. Alcohol and tobacco are legal drugs in South Africa, but being legal does not make it less addicted and dangerous. It may be one of the reasons why there are such a huge amount of adolescents who are using tobacco and alcohol. Strang, Babor, Caulkins, Fischer, Foxcroft and Humphreys (2012:71) are of opinion that more effective tobacco and alcohol policies should be put in place. Drug addiction seduces a person into wanting more and different and stronger drugs, against one's will and the natural tolerance of your body. No matter how good one may feel when using drugs, one's body suffers. Drugs are dangerous. If one takes drugs, one is at great risk to becoming addicted (Strang *et al*., 2012:72).

2.3.3 Cannabinols

This includes cannabis/dagga. Most cannabis comes from a plant called Cannabis sativa that is mainly found in Asia and South America, although significant amounts are grown in North America and Europe. The most active chemical in cannabis and the one that makes a person addictive, is called delta 9 − Tetrahydrocannabinol (THC). The amount of THC can vary greatly and dagga that contains high levels can have a greater effect on the user.

The use of **cannabis** can trigger mental problems in the adolescent who may be predisposed to them. It is risky for people with breathing problems, such as bronchitis and asthma. Some long-term users may get panic attacks, exaggerated mood swings and feelings of persecution (Stoppard, 2000:46-47). According to Dodgen and Shea (2000:16) and Fisher and Harrison (2013) the effects can be sick, dizzy and faint and this can hit a user on the first drag or the last one. The adolescent's judgment can be impaired and they can lose co-ordination. They feel too spaced out to speak. Cannabis can dry them out, making their mouth, tongue and lips parched. Time seems to come to a standstill, minutes can seem like hours, which can be unnerving. High doses or even low doses of strong varieties, such as skunk can lead to

unpleasant hallucinations. The result of cannabis use can also be a loss of memory (Dodgen & Shea, 2000:25).

2.3.4 Poly-drug use

Poly-drug use which is generally understood as the use of two or more substances at the same time or sequentially remains a major concern, both from a public health and a drug control perspective (World Drug Report, 2014). There is a distinction amongst three patterns of poly-drug use. One pattern is different substances being taken together to have a cumulative or complementary effect. An example is cannabis and cocaine users, who may use the drug in combination with alcohol. A second pattern is the use of a drug to offset the adverse effects of another drug, e.g., cocaine and heroin use. A third pattern is observed when a drug is gradually replacing or being substituted by another drug due to changes in price or availability or because the drug is in fashion. Common examples are heroin being substituted by oxycodone, desomorphine or other opioids, as observed in various regions. Various studies have documented the extent of poly-drug use. In a study conducted in fourteen European countries 60 % of cocaine users were poly-drug users, of which 42% used alcohol, 28% used cannabis and 16% used heroin (World Drug Report, 2014).

Consequently the prevalence of drug use will be presented.

2.4   PREVALENCE OF DRUG USAGE

As earlier mentioned this study will focus on alcohol, cannabis and tobacco abuse among adolescent boys in the Western Cape, as this province in South-Africa exhibits decidedly elevated levels of substance abuse. In the Western Cape alcohol remains the most frequently abused substance. Harker *et al*. (2008:14) regard cannabis usage as the most frequently used drug within the Western Cape. Although the general public may perceive cannabis to be the least harmful illicit drug, there has been a noticeable increase in the number of persons seeking treatment for cannabis use disorders over the past decade. Treatment for cannabis use is very evident in Africa (World Drug Report, 2014). Although cannabis is used recreationally by people of all backgrounds, the predominant use is among younger people (Dodgen & Shea, 2000:26; Fisher & Harrison, 2013). Large numbers of adolescents in the Western Cape are using alcohol, tobacco and cannabis, for example the 2002 Youth Risk

Behaviour Survey reported that 34% of school-going adolescents binge-drink in the Western Cape, which is significantly greater than the national average of 23% (Reddy, 2003). In contrast, a lower proportion (16%) of persons aged 15 to 19 years of age reported binge-drinking in a 2005 household survey (Harker *et al*., 2000). However in this study, the sample size was small and may have underestimated the prevalence of binge-drinking behaviour among young people in the Western Cape. School-based studies have also reported high levels of substance use among adolescents. Among Grade 8 students Flisher, Mathews, Mukoma, Ahmed and Lombard (2006) reported that in the past 30 days, the proportions of males and females respectively whom had used alcohol were 25.9% and 14.8%; those who had used tobacco were 31.5% and 18.2% and those who had used cannabis were 17.2% and 5.2%. There is some evidence that the rates of use of alcohol, tobacco, and cannabis substances may be increasing (Flisher *et al*., 2006).

It has been suggested that substance preference may be influenced by socio-economic status. In South Africa's case this would imply that ethnicity becomes linked to drug preferences (Parry *et al*., 2004:180). However, it is suggested that the link between race prevalence for certain drugs can be understood by economic reasons as well as social factors. Cannabis is commonly known to be a relatively inexpensive drug, whilst cocaine may be described as more costly. According to Nevid *et al*. (2006:308) cannabis remains the most widely used illegal substance and abuse of cannabis is the most common of all the substances abused disorders involving illicit drugs. That said the prevalence of use and abuse of cannabis does not compare with alcohol. Males are more likely than females to develop a cannabis abuse or dependence disorder.

Nevid *et al*. (2006:310) state that the World Health Organization estimates that 1 billion people worldwide smoke tobacco and more than 3 million die each year from smoking related causes. Rates of adolescent smoking have been on the rise.

The following statistics include adults and adolescents, as well as all the provinces in South Africa in order to give the broader picture of the drug addiction problem.

According to the Drug Master Plan (2013-2017) data on admissions to substance abuse related treatment centers in South Africa suggest that the use and abuse of drugs other than alcohol is (fairly) common. For example, the respective proportions of people who were

admitted to treatment centers in the period 2008-2010 cited the following drugs as their primary substances of abuse.

Cannabis: Between 11.2% (Western Cape) and 50.2% (Mpumalanga/Limpopo) of clients reported this drug as their primary drug of abuse. Cocaine: Between 1.9% (Western Cape) and 20.1% (Eastern Cape) of clients reported this drug as their primary drug of abuse. Heroin: Between 0.3% (Central Region: Free State, Northern Cape, North West) and 29.5% (KwaZulu-Natal) of clients cited heroin as their primary drug of abuse. (The comparatively high proportion of heroin abusers in KwaZulu-Natal could be the result of the use of "sugars" or nyaope (a low-quality heroin and cocaine mixture) by young Indian males in the south of Durban (Dada, Pludderman, Parry, Bhana, Vawda & Fourie, 2011:50, cited in The Drug Master Plan, 2013-2017). It is also important to note that although heroin is mostly smoked, Dada *et al.* (2011:50) cited in The Drug Master Plan (2013-2017) mention that injection of this drug is not uncommon. For example and with regard to the period January to June 2011, respectively 6%, 16% and 11% of those clients who were in treatment centers in the Western Cape, Gauteng and in the Mpumalanga-Limpopo region for primarily heroin use reported that they injected this drug. Between 0.1% (KwaZulu-Natal) and 40.6% (Western Cape) of clients reported methamphetamines as their primary drug of abuse. Methamphetamines were also the most commonly reported primary drug of abuse among clients admitted to treatment centers in the Western Cape.

From the above mentioned discussion it is clear that the prevalence of drug usage is disturbingly high and adolescents are at a great risk. The route of administration will be discussed below.

2.5   THE ROUTE OF ADMINISTRATION

According to Dodgen and Shea (2000:03) and Fisher and Harrison (2013) for a drug to have an effect on an individual, it must enter the body. Routes of administration significantly affect the rate at which a drug enters the bloodstream and reaches the brain. Overall, the quicker a drug reaches the brain, the more intense the response. In general, the faster a drug enters the bloodstream, the shorter it's effect because, once in the bloodstream and circulated to the liver, the drug is broken down and eliminated. Due to the effects on the intensity of response,

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route of administration relates significantly to abuse potential. Regardless the route of intake, addiction is a serious challenge for social workers.

Some drugs are been taken **orally.** The mucous membranes under the tongue, in the nose and in the rectum are richly vascularized, allowing for faster entry into the bloodstream than the oral method. **Inhalation** is another way of intake and is a very effective means of introducing of substances into the bloodstream. The substance moves efficiently from the lungs into the bloodstream and easily passes into the brain. Only the **intravenous injection** of substances results in a more rapid entry into the bloodstream. One special consequence of this method is that, due to entrance into the circulatory system via the lungs, some portion of the drugs is distributed before the liver has a chance to metabolize (it is chemically break the drug down); there is no "first-pass" effect in the liver. The first pass effect refers to "the degradation and loss of a drug on its requisite passage through the liver to the general circulation" (Fisher & Harrison, 2013). Substances entering the circulatory system via all other methods are more quickly metabolized by the liver. Regardless the route of intake, it is clear that social workers face huge challenges regarding substance abuse.

Dodgen and Shea (2000:3-4) also refer to other factors which determine the intensity of the effect on the human body.

Doses of drugs that have been taken will also affect a person. Generally speaking the larger the amount that has been taken the greater the effect. The greater the tolerance the larger the amount needed to produce a given effect. The general personality structure of the user, their emotional state, the time the drug is taken and the social setting at the time the drug is used are also factors that can determine what the effect of the drug on the adolescent user will be. Greater body weight requires relatively more of a drug to produce a given effect. Age also plays a role, because children and older persons are often more sensitive to drug effects. Medical status is also impacted due to drug use. Liver dysfunction, for example, will greatly alter the metabolism of drugs in the body. The effect of a given drug may be altered by the presence of other substances in the body. Gender also plays a role in the effects that drugs have on people. Girls are more sensitive to the effects of drugs than boys.

In the following sections the researcher will specifically concentrate on the adolescent and their substance abuse. It is important that social workers take the developmental stage of the client in consideration when rendering services to the addicted adolescent boy.

2.6   DEVELOPMENTAL STADIA OF THE ADOLESCENT

It is of importance to view the developmental stage of adolescents to gain more insight into why adolescents are prone to use substances. According to Meyer, Moore and Viljoen (2008:202) the adolescent stage starts with the onset of puberty at about twelve and ends with the beginning of early maturity (which could be anywhere between the 18th and 25th year, depending on the culture and the duration of training required for the individual's vocation). It is characterized by the developmental crisis identity versus role confusion. The physical changes of puberty, the onset of sexual maturity and the social expectation that adolescents have to make are all prevalent in this stage. Erikson (1995:105) explained that up until this stage, development depends on what is done to a person. An adolescent must struggle to discover and find his own identity, while negotiating and struggling with social interaction and developing a sense of morality and right from wrong. Some attempt to delay entrance to adulthood and withdraw from responsibilities. Those successful with this stage tend to experience role confusion and upheaval. Adolescents begin to develop strong affiliation and devotion to ideals, causes and friends. The most crucial consequences of continued drug use are the impact the drugs have on the individual's psychological and emotional development. Adolescence is a time when transition from childhood to adulthood takes place. This means that several new things need to be incorporated and learnt by the adolescents in order to take on the role of adult into society. With continued drug use, the individual's development is delayed and sometimes even stopped. This means that while someone is taking drugs, he is not learning how to deal with stress constructively and how to solve problems. Drug addicted adolescents are not having the normal developmental experiences that they should have at that age. Other consequences include a loss of individual potential, tolerance to the substance, developing interpersonal problems, develop the risk of getting caught and regular use can impair decision making ability (The Cape Town Drug Counseling Centre, 2007:08-09).

Anyone can become addicted at any time of their lives, but the adolescent period is perhaps the most critical time in a person's life. However it is adolescents who are the most vulnerable, not only to social pressure to experiment with addictive substances, but also more

vulnerable to the damage these substances can cause. Their minds and bodies are still developing, so adolescent substance use can progress into addiction faster than in adults. Also because of this development period, addiction can wreck more havoc on the adolescent's brain, as well as on the adolescent's body.

In the light of the vulnerability of adolescents using substances, the researcher will look at the adolescent and his drug use, the adolescent and his health problems, the neurobiology of drugs, reasons why adolescents take drugs, risk factors that can lead to drug use/abuse and the stages of drug addiction.

2.7   THE ADOLESCENT'S ALCOHOL AND DRUGS USAGE

According to Meyerson (2009:72) the adolescent drug-taker is generally presented to the public by the mass media as a plague upon our society, never vice versa. The use of drugs to alter psychic states is associated in the public mind with the abuse of hard drugs and conjures up a picture of adolescents who are continually on the fringes of crime, dropping out from society and becoming dependent upon society for their further care and treatment. These inaccurate images tend to prevent any real understanding of the actual reason for drug abuse among a small minority of adolescents today. To understand the adolescent drug-taker, one must be prepared to investigate and identify the underlying problems which lead him to choose to distort or ward off reality with drugs. Today adolescents in Western society live in a drug orientated culture, from aspirins to sleeping pills, from tranquillizers to hard drugs (Meyerson, 2009:72).

Society in general ingests drugs in greater quantity and variety than ever before. All the crises of adolescents, the fluidity, intense personal conflicts, narcissism, preoccupation with body changes, inexperience, the desire to experiment and to identify problems play into the drug-taking culture. The lures of instant cure, instant perception and instant anything through the taking of mind altering drugs are very tempting for the young person of today. The author furthermore explains that there is a caste system developing in groups of young drug-takers. Intellectuals taking drugs, either alone or in groups, are attempting to evaluate some inner meaning to their existence, while the non-intellectual groups simply trip to get some specific bizarre effect (Meyerson, 2009:73).

The user tends to smoke or take small quantities of drugs for psychological reasons and as a means of personal satisfaction. He likes to savor the effects of drugs and to consider the mystical implications of his strange new experience. Adolescents who are addicted to substances are more likely to be a drop-out from school or work, a person who finds it difficult to communicate with people in authority and his life tends around the drug- taking scene. The adolescent boy tends to take drugs to try to escape personal problems. They may also take substances to prove that they are flexible and capable of withstanding stressful situations, demonstrating that they can behave beyond the limits of adults. There is a comparison here with dangerous driving, drinking to excess and all risk taking behaviour, associated with delinquency or even sports (Meyerson, 2009:74).

A further group temptation is offered by those who feel that the taking of drugs promotes a greater emotional maturity and intellectual depth through "having experienced oneself" under the effect of drugs. These rationalizations for drug-taking are presented to the adolescent as a means of proving himself both physically and intellectually. The whole drug-taking scene can have a strong dramatic component, not infrequently ending in tragedy. The feeling of being involved in illicit or taboo practices increases the excitement for the adolescent, and he might lose many of his strong, inner controls. The individual bizarre effects of drug-taking are shown by examples of young people who have jumped to their death from windows during an attempt to flee from an intense internal panic which has overtaken them. Drug escalation and contagion are two of the most difficult problems to understand and to combat. The group behaviour involved in the relatively innocent use of drugs can very often facilitate adolescent associations with others who are involved in more serious drug-taking, leading the adolescent at a very early stage to try anything and everything (Meyerson, 2009:74).

The health problems of adolescents who use drugs will subsequently be presented.

2.8   THE ADOLESCENT AND HEALTH PROBLEMS

Drug abuse may directly provoke health problems or indirectly influence health problems through increased anti-social behaviours or related poor self-care, secondary to adverse psychological impact, or in concert with other co-occurring problems. Direct links between adolescent substance abuse and health outcomes have been reported in several studies. For example, alcohol-abusing adolescents, compared to matched controls, have reported more

physical health symptoms, appetite change, weight loss, eczema, headaches and episodes of loss of consciousness. Adolescent substance use is also associated with sexually transmitted diseases, traumatic injuries, and drug-related human immunodeficiency virus (HIV) infection with consequent immune suppression that can pave the way for opportunistic disorders such as tuberculosis and decreased physical hardiness (The Drug Master Plan, 2013-2017).

Adolescent substance abusers are likely to use multiple substances including tobacco, which raises risks of synergistic adverse health effects for youth and complicates the ability to separate the effects of individual substances from the use of other illicit drugs. Meyerson (2009) found that adolescent smokers followed from 2 to 4 years after substance abuse treatment, regardless of other drug involvement, reported more respiratory problems. Adolescents with more severe substance use disorders are more likely to also engage in other risk taking behaviours, be involved with juvenile justice systems, have problems in school including poor grades and suspensions and expulsions, experience family discord and engage in running away, as well as behaviours (e.g. fighting) that may lead to traumatic injuries.

Such risk-taking and exposure to violence suggest that the risk of traumatic injury can be especially high for alcohol- and drug-involved adolescents. Substance-abusing adolescents are at risk for a variety of co-morbid psychiatric disorders which can affect health-related behaviours. According to Fisher and Harrison (2013) substance abuse is involved with the spread of HIV in two ways: engagement in drugs and high-risk sexual practices. According to Koen, Jonathan and Niehaus (2009:08) the rate of co-morbid cannabis consumption in individuals with schizophrenia is reportedly high. A number of correlates and risk factors predicting substance use in schizophrenia population have emerged with some consistency. These include being unmarried, being male, having lower educational levels, a childhood conduct disorder or a co-morbid antisocial personality disorder. According to the authors, research on the effects of dagga abuse on clinical parameters in individuals with schizophrenia has produced conflicting results. Two prospective studies attempting to examine the longer-term outcome of cannabis use in this illness have both demonstrated poorer outcome and increased intensity of positive symptoms. A number of prospective epidemiological studies also now provide support for the hypothesis that dagga abuse increases the subsequent risk for developing schizophrenia.

The effects of drugs on the brain will be discussed below.

2.9   THE NEUROBIOLOGY OF DRUGS

According to Fisher and Harrison (2013:15) drugs affect the brain by impacting the way nerve cells send, receive and process information. Cannabis activates neurons by mimicking natural neurotransmitters. (Other drugs like methamphetamine and cocaine cause nerve cells to release extremely large amounts of neurotransmitters or prevent the normal reuptake of neurotransmitters into the nerve cells.) Most drugs of abuse directly or indirectly target the brains reward system by releasing or blocking the re-uptake of the neurotransmitter dopamine. Dopamine is present in regions of the brain that regulate movement, emotion, cognition, motivation and feelings of pleasure. When dopamine floods the neuron system in the brain reward center euphoria results. Social workers can explain to the adolescent boys that the body has its own natural way to activate pleasurable feelings in the body by releasing dopamine. They can elaborate by saying that drug use has a negative impact on this function of the body, which means that they at the end will need drugs to activate these feelings (Van der Westhuizen, 2008:70).

Fisher and Harrison (2013:06) state that since our brains are designed for the survival of the species, we want to repeat these natural, pleasurable activities. However, when drugs stimulate the brain's reward center, the brain is in effect "fooled" into believing that drug taking is also a survival behaviour that should be repeated. Many naturally pleasurable activities are not habitually repeated like drug taking can be. The neurobiological explanation is that two to ten times more dopamine is released by drugs than by natural activities. Furthermore, depending on the methods that drugs are administered, this dopamine release is almost immediate and is very intense, therefore the euphoric properties of drug taking can be very powerful and highly reinforcing. Unfortunately the brain adjusts to high levels of dopamine by producing less or reducing the number of dopamine receptors. When this occurs, the drug user has more difficulty experiencing pleasure and must increase the amount of drugs consumed to feel normal. This is referred to as "tolerance". When a drug abuser abstains from drugs for a period of time, the brain usually returns to normal. However, the length of time it takes depends on the type of drugs abused and the number of years that drugs were taken (Fisher & Harrison, 2013:16).

According to Winters (2008) brain development is still in progress during adolescence; immature brain regions may place adolescents at elevated risk to the effects of drugs. New scientific discoveries have put a much different perspective on our understanding of adolescent behaviour. Research now suggests that the human brain is still maturing during the adolescent years, with significant changes continuing into the early 20's. The developing brain of the teenage years may help explain why adolescents sometimes make decisions that seem to be quite risky and may lead to safety or health concerns. It may also add insights into unique vulnerabilities and opportunities associated with youth. According to Giedd (2004) cited in Winters (2008) the brain's maturation tends to occur from the back of the brain to the front. So the front region of the brain, known as the prefrontal cortex, which is responsible for high-level reasoning and decision-making, does not become fully mature until around the early to middle 20's. The author explains furthermore that the prefrontal cortex is the part of the brain that enables a person to think clearly, to make good decisions and to control impulses. It is primarily responsible for how much priority to give incoming messages like "do this now" versus "wait" "what about the consequences?" Because the emotional, "do this now" regions, predominantly located behind the front of the brain, have progressed more with the pruning process, it is difficult for the "wait" part of the brain to exert much influence (Winters, 2008).

2.10   REASONS WHY ADOLESCENTS TAKE DRUGS

As already mentioned, the adolescent years are often considered the most difficult period of a person's life. It's a vulnerable time of life as adolescents attempt to navigate the precarious bridge between childhood and adulthood. And one of the most challenging decisions, for an age group that's ill-prepared to make difficult choices, is whether to start using alcohol or drugs. On the one hand, adolescence is a time of self-exploration (Promises Rehabilitation Centre, 2013). One could argue that it's perfectly natural and normal to want to try new things, such as getting high or drunk for the first time. However, others would argue and wisely so, that adolescents, by virtue of their young age and lack of life experience, aren't prepared for the consequences that often follow. Regardless of which side of the argument one find oneself, most adolescents will experiment with alcohol/ and or drugs at some point, for many different reasons (Promises Rehabilitation Centre, 2013).

Reasons such as peer pressure is a powerful force at any stage of life, but it's especially influential during the adolescence stage. At a time when adolescents are trying to figure out who they are and where they fit in, when insecurities can be fierce, the desire to be accepted and liked makes saying "no" extremely difficult. Saying no can also have painful consequences, ranging from laughed at or mildly teased, to being humiliated, rejected and even bullied. Another reason can be that the adolescent wants to look and feel "grown up" (Promises Rehabilitation Centre, 2013). Adolescents often want to be treated like adults. "I'm not a kid anymore" is a frequent mantra, especially when they want privileges that come with age – like using alcohol. It's no surprise that they're drawn to things that make them feel like an adult – older, more mature, more sophisticated. Drinking, smoking and drug use can all boost those feelings. With the behaviour comes the illusion that one is truly mature – and thus can handle anything. Sadly one bad incident can quickly shatter it and remind them just how young and vulnerable they still are. But until such an event, they naively believe that "bad things" happen only to "other kids". They overestimate their maturity and underestimate their vulnerability (Promises Rehabilitation Centre, 2010).

Another reason can be that adolescents that grow up with parents who abuse alcohol or drugs often follow suit. After all that's what they know and what they've learned. Not to mention, if one or both parents are actively using, they often have easy access as well. Not only does the apple often not fall far from the tree, kids often mimic their parent's behaviours – both good and bad. Curiosity can also be a reason why adolescent boys became involved in drugs. The desire to try new things and explore the world didn't suddenly shut off when puberty commenced, in fact it often becomes even stronger. Most adolescent boys have a lot more autonomy than they did as children. They're less closely supervised and often leave home alone for chunks of time while their parents are still at work or out for the evening. The desire to find out what it feels like to get drunk or high, can be very strong. Unfortunately, far too many kids end up in alcohol or drug rehabilitation treatment centers due to ill-fated need to satisfy their curiosity (Promises Rehabilitation Centre, 2013).

Being bored can quickly get anyone – and especially a restless adolescent – into all sorts of trouble. It's even worse for the adolescent who have bored friends. Passing the time with a few beers or taking drugs with friends (or even alone) is often a slippery slope to addiction. Self-medication can also be a reason as adolescents who struggle with a lot of emotional pain are especially vulnerable to alcohol and drug abuse. They use these drugs as a way to self-

meditate. They know that getting high or getting drunk will, at least temporarily, ease their pain and provide them with a means of escape. These drugs can also appear to ease the problem. For example, a socially awkward or extremely shy adolescent may use alcohol in a desperate attempt to feel more comfortable around others. An adolescent living in a conflicted home environment may resort to drugs to shut out the world for a while – or at least make it feel a little more bearable. Rebellion can also be a reason as adolescent boys like to assert their budding maturity and test the limits with their parents. Those with nagging, overprotective, or strict parents often lash out in a passive-aggressive manner. Rather than talking to their parents about their frustrations, such as what they perceive as overly strict rules, religious hypocrisy, or nagging, they may rebel by using alcohol or drugs – especially if they know that doing so will make their parents angry or embarrassed (Kools, 2010).

Ignorance can also be a reason. Most adolescent boys do not know what is good for them and what not. Not because they are not bright, but because they simply do not have enough information or experience. Experimenting with alcohol or drugs often seems innocent enough – in fact, it's often regarded as a sort of adolescent "rite of passage". Many adolescents feel entitled to experiment at this stage, as if they're expected to do so and therefore should do so. What many do not realize is that it's neither innocent nor harmless. To have fun can also be a reason. Getting drunk or high with friends sounds fun in the moment. What isn't fun about spending time with friends, sharing an intensely pleasurably drug-induced euphoria or the disinhibiting effects of alcohol? The silliness, the slurred words, the stumbling and the bizarre behaviour – all of those things can be very entertaining and make for great stories the next day or down the road. Of course, it's all just good old teenage fun – until someone is seriously injured or has to face a judge or is dead. Adolescents do not use alcohol or drugs with the intent of becoming addicted. In fact, since part of adolescence is the still-intact belief that you're invincible. They do not believe that they can become addicted or that anything bad can happen to them. They see anything as having fun and do not take things seriously (Kools, 2010).

Risk factors that may contribute to drug use will be discussed below.

2.11   RISK FACTORS FOR DRUG ABUSE FOR ADOLESCENCE

According to Kilpatrick *et al*. (2000) risk factors can include adolescents who had been physically and sexually assaulted, who had witnessed violence, or who had family members with alcohol or substance use problems and had increased risk for current substance abuse or dependence. The author state furthermore that posttraumatic stress disorder independently increased by dagga and hard drug abuse. Clinically significant reactions to negative life events, such as those manifested in symptoms of posttraumatic stress disorder (PTSD), might be expected to have strong relationship with substance use behaviours. The authors found support for this hypothesis by demonstrating that the relationship between childhood rape and adult alcohol abuse was mediated by Post Traumatic Stress Disorder. Consistent with theory, individuals high in anxiety sensitivity, particularly those with Post Traumatic Stress Disorder or panic disorder, appear particularly susceptible to the calming effects of alcohol. Whether the potentially causal role of victimization and post victimization, psychopathology in substance abuse is applicable to adolescents remains to be determined.

The following risk factors will be discussed.

2.11.1 Individual characteristics

When exploring cannabis usage the role of personal vulnerability cannot be overlooked. Inherent and established coping mechanisms serve as protective mechanisms against cannabis usage. Individuals who have developed effective coping mechanisms are better equipped to deal with stress and strain. Productive techniques may include distress tolerance (Parry, 2004:01). Social workers can teach the adolescent boys skills, such as the use of distraction techniques and minimizing distress through engaging in relaxing activities. Lack of distress tolerance techniques can be a risk factor for drug usage (Graham, 2004). This view is further supported by Bottorff, Johnson, Moffat and Mulvogue (2009) in a study exploring the relief provided by cannabis usage the respondents reported using cannabis to deal with difficult feelings such as anger, disappointment, fear and anxiety. They appeared to lack effective coping mechanisms to manage uncomfortable feelings and thus relied on cannabis for relief.

2.11.2 Exposure to violence

Kilpatrick *et al*. (2000:02) state that exposure to violence can motivate an individual to seek coping mechanisms in order to avoid distress. These events may cause distress and manifest in the symptoms of posttraumatic stress disorder (PTSD). Substance usage may be utilized as means of dealing with the distress caused by exposure to violence. There appears to be a positive relationship between trauma severity and alcohol abuse, as individuals experiencing symptoms of PTSD are more vulnerable to the sedative effect of alcohol. Fisher and Harrison (2013) however suggest that victims of physical child abuse are more likely to use drugs such as cannabis and hard drugs.

2.11.3 Family

Family substance use has been identified as having a modelling effect on adolescent boys, resulting in an increase in their usage of similar substances (Kilpatrick *et al*., 2000). Familial drug usage is said to increase the prevalence of adolescent use of cannabis and hard drugs, whilst familial alcohol abuse increases prevalence of adolescent alcohol and hard drug usage (Kilpatrick *et al*., 2000:11). The modelling effect of familial drug usage is of a specific nature, as similar substances are adopted by the imitator (Kilpatrick *et al*., 2000:26). In families where substance abuse occurs, elevated conflict and weakened relationships often occur (Moore, Rothwell & Segrott, 2010:03). Increased drug usage by the adolescent boy who is exposed to familial substance and alcohol usage has been explained in part by the resulting associated violence and abuse experienced at the hands of intoxicated family members. De La Rosa, Rice and Rugh (2007:03) however suggest that high drug abuse rates can be understood by accompanying attitudes rather than the actual behaviour. Individuals may internalize their family values and norms with regard to the use of substances. This process is suggested to have more credibility in predicting substance abuse. The reason for this is not clear, but may be due to the ability of attitudes to permeate and pervade family life, as opposed to behaviour, which can be more inconsistent and less chronic in nature in comparison to values and norms (De La Rosa *et al*., 2007:13). In general a significant number of adolescents use tobacco and family usage may be a reason for using.

2.11.4 Peer group

The role of peers in drug usage is well-documented. Moore *et al*. (2010:02) state that individuals who perceive a lack of intimacy with their family are more likely to be influenced by their peers, as peers begin to play a more influential role in their development of norms, values and behaviour. Adolescents who have friends who consume alcohol are more likely to use alcohol because of peer pressure (Andrews *et al*., 2002; Henry *et al*., 2005). Peer pressure may involve encouragement and incitement to use drugs. The peer group may present a permissive perspective of drug usage and further accept drug usage. The adolescent boys' beliefs, systems and behaviour may be influenced as a result of interacting with their peer groups. If drug usage is normalized, the individual may challenge and shift his view about substances. Popularity and inclusion into the peer group can be both a protective and risk factor. Peer groups may reward and reinforce drug usage. Drug usage may be perceived as a means of becoming part of the group, as drug usage may result in cohesion with the peer group. However, isolation from the peer group can be a risk factor as the interaction with drug abuse fosters ego-development, self-esteem, competence and general development. Another risk factor is that of feeling a lack of inclusion as the individual uses drugs to deal with feelings of loneliness and exclusion (Cheung & Tse, 2010:578).

2.11.5 Exclusion from systems

Exclusion may be experienced in other social arenas, such as failure to engage with educational institutions. Individuals may be at a higher risk of using substances if their school functioning is substandard, or if they have experienced victimization. Harker *et al*. (2008:25) state that a correlation exists between drug usage and school dropout. Individuals who lack cohesion and inclusion within their family are even more at risk of using substances. Cohesion thus fulfills a protective function, reducing the individual's likelihood of seeking inclusion in peer groups. Familial attachment may result in feelings of emotional security, whilst disconnected families fail to meet the adolescent boy's needs (Fisher & Harrison, 2013). Disorganized families can lead to unresolved feelings of resentment. These feelings may be as a result of family members being estranged as well as the presence of malfunctioning relationships (Bottorff *et al.,* 2009:04; Fisher & Harrison, 2013). Economic strain and community violence have been identified as playing a role in predicting drug usage (Fisher & Harrison 2013). Families too have the ability to mediate and mitigate stresses

experienced at the hands of neighborhood and broader social contexts (Nevid *et al*., 2006). It would seem that in the case of drug usage, a lack of congruency between the individual and systems increases the risk of drug usage. Should the adolescent boy feel detached from systems, he may be more likely to use substances. The identified risk factors which increase the probability of using drugs sound all familiar. It becomes clear that drug usage and gang membership share common initiating factors.

2.11.6 Gangs and substance usage

The connection between substances and gang membership can be traced back through the history of gangs. It is suggested that post-Revolutionary War America saw gangs involved in the use and trade of illicit drugs (Parry, 2004). Within the South African context similar findings exist. Kinnes (2008:04) states that one cannot separate the South African gangs from drugs and mandrax trade is said to be entrenched within gang activities in the Western Cape (Parry, 2004:180).

Below a description will be given of the protective factors against drug use.

2.12   THE PROTECTIVE FACTORS

According to Jarvis, Mattick, Shand and Tebutt (2005:255) protective factors are those factors that help the adolescent to avoid or reduce drug abuse. According to the authors, protective factors are not simply the opposite of risk factors. Rather they are factors that increase the adolescent's resilience so that they are more able to resist the influence of risk factors. The authors agree that a warm and consistent parental relationship for example, will foster the social skills and self-confidence that the young person needs to cope with stress and resist peer pressure to use drugs or alcohol. Dodgen and Shea (2000:55) and Fisher and Harrison (2013) are of the opinion that the following conditions can help to mitigate risk: an attitude of intolerance of deviance; a positive orientation to school; a positive orientation towards health; positive relations with adults; having friends who model conventional behaviour; a strong perception of regulatory controls (i.e. awareness of rules of conduct); participation in pro-social activities (volunteer activities and school clubs). The authors further state that intervention should include educational, experiential and skill-building activities designed to change attitudes about drugs and alcohol, improve family interaction,

build self-esteem and develop drug-refusal skills. Social workers can hold group sessions with addicted adolescent boys in order to teach them life skills and in some cases it is important to render a family reconstruction service in order to bring the child and his family together. Some children need to be placed back in a school or in alternative care, for them to rebuild their lives and to function in a structural environment with routines.

The following discussion will provide an overview of how social workers can develop protective factors for adolescent boys who use alcohol and/or drugs.

For positive development, adolescent boys must have their physical, emotional and growth needs met by caring adults. When growth needs are met, children can turn risk into resilience. Courage is needed to surmount life's difficulties, but courage only comes from experiencing adversity. Adolescent boys need people in their lives who support them in gaining the courage to face difficulties without becoming overwhelmed and discouraged (Brendtro & Du Toit, 2005:13). The authors explain that children develop courage and resilience in the four directions of the Circle of Courage drawn by Lakota artist George Bluebird. Social workers can use the Circle of Courage when designing an individual development plan for the client.

The Circle of Courage is divided into four components, which are Belonging, Mastery, Independence and Generosity. According to Brendtro and Du Toit (2005:14-15) all children need to belong, to master, to become independent and to contribute to others in a spirit of generosity. Similar practices have existed in other cultures that deeply value people. Long before modern psychology, tribal people on many continents possessed sophisticated child-development knowledge and passed it on through oral traditions and careful modeling. Elders taught important values to each new generation. In close kinship communities, such as tribes of Africa, Australasia and the Americas, children were deeply respected and surrounded by caring relatives who nurtured their needs. Braxelton, a pediatrician, describes a child birth in a South American tribe as a peak event where the crowd that watches has been regarded as "birth parents" who were allowed to share in raising this child. This tradition is unique, but respect for children characterizes tribal cultures in America, Africa and Australasia. The Ladota term for child literally means sacred being. In the Maori tongue, a child is called gift of the gods. Indigenous Australians speak to children with great respect. Traditional African values concerning children are described by Zulu sociologist, Vilakazi: A child draws from within us the inclination and instinct for kindness, gentleness, generosity and love.

Accordingly there is nothing more revolting to our humanity than cruelty to children. These truths we knew at one time and somehow, subsequently forgot. According to Brendtro and Du Toit (2005:14) throughout most recorded history, the treatment of children in Western civilization was a long tale of neglect and abuse.

Children were legally property to be used, misused or discarded at the whims of their "superiors". Many believed children were evil and needed harsh punishment. Abraham Maslow spoke about growth needs: when growth needs are met, youth have positive outcomes, but when growth needs are frustrated, youth show problems. The authors further emphasize that environments that fail to provide belonging, mastery, independence and generosity cause great pain to children and are toxic to positive development. A generic family system approach (that combines components from several approaches) is useful for providing families with help in handling their relationship issues. This approach can be accomplished through problem-solving techniques that provide alternatives for alleviating stress and for communicating more effectively (Brendtro & Du Toit, 2005:15).

2.13   STAGES OF DRUG ADDICTION

According to Dodgen and Shea (2000:37-38) stage or sequential models have been constructed by researchers to describe and analyze the initiation and progression of substance use in adolescent boys. The Macdonald and Newton model is called the Adolescent Chemical Use Experience (ACUE) continuum. The ACUE is a four stage model of adolescent substance use with stages defined in terms of mood swings – that mood swing is defined as" the effect of a drug on the internal subjective state of the person consuming the drug". The four stages of ACUE are described as **Experimental stage** ("learning the mood swing"). This is the normal adolescent curiosity and experimentation with drugs. **Social use** ("seeking the mood swing"). This stage is characterized by drug use with peers, occasional excessive use and intoxication, but no chronic problems. **Operational use** (''preoccupation with the mood swing"). At this stage the criteria for a substance use disorder may be met. **Dependent use** ("using to feel normal"). At this stage the person will meet the criteria for drug abuse if not dependent.

According to Dodgen and Shea (2000:37-38) the majority of adolescents are at Stages 1 or 2 of the proceeding model. They also say that adolescents often start by experimenting with the

gate away drug, such as tobacco and alcohol and most probably progress to the next stage (Dodgen & Shea, 2000:38).

2.14 CONCLUSION

Specialized information regarding the different drugs is necessary in order to give a client specific guidance. It is also necessary to assist drug addicted adolescents in the rehabilitation process. This information can also be utilized to inform adolescent boys about the different aspects of drugs in order to make an informed decision. It is clear that there is a distinction between prevalence in the different geographical areas and between different socio economic groups. It also seems as if peer pressure and dysfunctional families is the risk factors which impacted most amongst adolescent boys. It is clear that as in the toddler stage the adolescent needs love and affection and support in order for him to grow up as a well- behaved citizen. If this important factors lack, the adolescent can become vulnerable and the chance that he will be involved in drugs is huge. The moment when the adolescent lacks a sense of belonging, he can get involved in the negative group, which is the gangs and being part of a gang requires that the adolescent boy must use drugs. It seems as if parents do not always have control over substance use of adolescent boys, considering the different reasons why they get involved in drugs. It is clear that substance abuse cause different sicknesses which can include schizophrenia.

In the next chapter a discussion and intervention regarding the rehabilitation of drug addicted adolescents will be presented.

CHAPTER 3

INTERVENTION REGARDING REHABILITATION OF DRUG ADDICTED ADOLESCENT BOYS

3.1   INTRODUCTION

In the previous chapter substance abuse regarding adolescent boys who are addicted to drugs was explored. In this chapter the intervention and rehabilitation process will be discussed. The researcher will also explore on different processes which can be used in the rehabilitation process, as it is clear that adolescent boys experience a crisis regarding drug addiction. It seems as if social workers are overwhelmed by the demand of substance abuse. Policies will be used as a guideline in order to act in a legal manner whenever support is given to these adolescents. The difference between in-patient and out-patient rehabilitation centers will be discussed briefly. In South-Africa there is a lack of efficient rehabilitation centers it is important that social workers will have to render this service in the community, as will be explored in this chapter.

3.2   POLICY DOCUMENTS AND LEGISLATION

The National Drug Master Plan (2006-2011) was the blueprint for combating substance abuse in South Africa during that period. Its mission was to "strive towards a drug-free society".

The National Drug Master Plan (2006-2011) as well as The Prevention of and Treatment for Substance Abuse Act no 70 of 2008 emphasize on preventative services, which is very valid, but the fact is that there are a huge number of adolescent boys who already experimented and regularly make use of drugs and alcohol, while there are also those who are addicted. According to Van der Westhuizen (2008:12) it seems as if the youth are in a crisis. The author states furthermore that according to statistics one out of every three adolescent boys use or abuse drugs and/or alcohol regularly.

The Prevention of and Treatment for Substance Abuse Act no 70 of 2008 stipulates that the purpose of prevention programmes is to prevent a person from using or continuing to use

substances that may lead to abuse or result in dependence. The Act states that Prevention programmes must focus on:

- preserving the family structure of the persons affected by substance abuse and those who are dependent on substances;
- developing appropriate parenting skills for families at risk;
- creating awareness and educating the public on the dangers and consequences of substance abuse;
- engaging young people in sports, arts and recreational activities and ensuring the productive and constructive use of leisure time;
- peer education programmes for youth;
- enabling parents and families to recognise the early warning signs with regard to substance use and equipping them with information on appropriate responses and available services; and
- empowering communities to understand and to be proactive in dealing with challenges related to substance abuse, and its link to crime, HIV and AIDS and other health conditions.

The Integrated Service Delivery Model (2006) states that institutional development is part of the transformation process and development paradigm. It was required that the Department of Social Welfare changes its name to the Department of Social Development. Social Development is concerned with the development of society in its totality. Its efforts are directed at the development of the total potential of human beings for the maximum improvement of the material, cultural, political and social aspects of their lives. According to the United Nations (UN) Economic Commission for Africa, social development involves the participation of the people in bringing about qualitative and quantitative changes in the social conditions of individuals, groups and communities through planned measures such as social policy, social welfare, social security, social services, social work, community development and institution building. The developmental framework demands that service delivery be inter-sectoral and integrated between the various government departments and sectors. This collaboration and co-ordination is possible only if it is reflected in attitudes, behaviour and values that promote a developmental approach. The Integrated Service Delivery Model (2006) is a guideline for social services within the context of a developmental paradigm and provides a value chain for social development services.

Social work services are rendered in terms of the Prevention of and Treatment for Substance Abuse Act no 70 of 2008 to children, young people and adults who are addicted to substances. The Mental Health Care Act (2002) also applies, as to the aims of the United Nations Decade against Drug Abuse (1991-2000). This Act complies that children who are dependent on substances must be treated in separate facilities and apart from adults, whether within treatment centers or in facilities designated for children. Section 148 of the Children's Act no 38 of 2005 applies in relation to a court order for early intervention programmes for children. The Minister and the ministers responsible for the departments and organs of state listed in section 53(2)*(a)* to *(t)*, that reasonable measures must be taken within the scope of their line functions and available resources to combat substance abuse through the development and co-ordination of interventions that fall into three broad categories, namely: **demand reduction**, which is concerned with services aimed at discouraging the abuse of substances by members of the public; **harm reduction**, which for the purposes of The Prevention of and Treatment for Substance Abuse Act no 70 of 2008 is limited to the holistic treatment of service users and their families and mitigating the social, psychological and health impact of substance abuse; and **supply reduction**, which refers to efforts aimed at stopping the production and distribution of illicit substances and associated crimes through law enforcement strategies as provided for in the applicable laws.

In the following section the role of the social worker regarding early intervention will be presented.

3.3   EARLY INTERVENTION

The Prevention of and Treatment for Substance Abuse Act no 70 of 2008 stipulates that the purpose of programmes for early intervention is to identify and treat potentially harmful substance use prior to the onset of overt symptoms associated with dependency on substances. The Prevention of and Treatment for Substance Abuse Act no 70 of 2008 states that programmes for early intervention must focus on identification of individuals, families and communities at risk. It must also entail screening for problematic substance use to facilitate early detection and appropriate interventions, enabling affected persons to recognize the warning signals of substance abuse and conditions related thereto. The Act further states that families and communities need to be provided with information to enable them to access

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resources and professional help; involving and promoting the participation of children, youth, parents and families, in identifying and seeking solutions to their problems. It also promotes appropriate interpersonal relationships within the family of the affected persons; the well-being of the service user and the realization of his or her full potential; sensitizing users and their families about the link between substance abuse, crime, HIV and AIDS and other health conditions.

Social workers need to carry out the provisions of The Prevention of and Treatment for Substance Abuse Act no 70 of 2008 as stated above. Social workers can utilize different methods, such as group work, case work, community work, as well as statutory work in order to give effect to the principles of The Prevention of and Treatment for Substance Abuse Act no 70 of 2008.

Historically, primary and secondary prevention programmes targeting the individual have combined traditional educational/ information approaches with a range of self-regulation and other skills, such as decision making, goal setting, stress management training, resistance training and life-skills training. Reviews of this literature (Nevid *et al*., 2006) have found that prevention programmes focusing on social influence specifically or integrating a broad spectrum of strategies were able to demonstrate both significant delay in the onset of substance use and reductions in current use. The skills-training components included in many of the school based group prevention programmes, overlap considerably with alcohol-abuse treatment programmes formulated for individual, cognitive-behavioral interventions. Although the effectiveness of these individual interventions has been established for adult alcohol abusers, similar empirical evidence for adolescent boys is only beginning to emerge. For example, after cognitive-behavioral treatment, adolescent alcohol abstainers and adolescents with minor relapses were more likely to use problem-solving coping strategies than adolescents with major relapses. Further coping factors have been identified as significant predictors of treatment outcomes (Barber, 2002:132).

Cognitive-behavioral approaches typically involve multiple components derived from theories of learning and are designed to address individual, intrapersonal factors associated with substance use. Specifically, these models aim to enable adolescents to identify appropriate behavioral goals and develop self-regulation and coping behaviours. Interventions may include techniques to increase self-efficacy for change, contingency

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management to increase activities not associated with substance use, identification of stimulus cues preceding use behaviour, implementation of strategies for avoiding situations in which use is likely to occur and development of coping skills such as drug and alcohol refusal, communication skills and problem solving. Though similar in content domain to the traditional group prevention interventions, individual therapies can be expected to demonstrate more powerful treatment effects than group therapy, in part because of the more focused attention of the social worker and the social worker's ability to tailor the treatment to the specific needs of the individual client. However, because of the potentially greater cost effectiveness of group interventions, it is important to study conditions under which these interventions might be effective. A shortcoming of both the individual and the group-based treatments is that they place considerably less emphasis on addressing the various risk and protective factors associated with the family (Fisher & Harrison, 2013). According to the ISDM (2006) early intervention (non statutory) services delivered at this level make use of developmental and therapeutic programmes to ensure that those who have been identified as being at risk are assisted before they require statutory services, more intensive intervention or placement in alternative care.

In order for the social workers to render an effective service to address the need of the client, proper assessment is important. The assessment process will now be presented.

3.4   ASSESSMENT

According to Fisher and Harrison (2013:105) assessment is a process that should be ongoing during counseling and the social worker should be continually gathering information that will assist the client. The psychosocial history is a structured method of gathering information that may relate to the client's difficulties. Assessment of psycho-active substance use can be conceptualized as a multistage process that is essentially the same for children, adolescents and adults (Sheafor & Horejsi, 2010:201). According to Fisher and Harrison (2013) there are certain goals that need to be accomplished through assessment. These goals include the social worker to obtain information for the development of an individualized treatment plan based on identified strengths and weaknesses. Social workers also need to match clients to appropriate interventions in situations in which a range of treatment options are available and to monitor progress so as to evaluate the effectiveness of treatment. These authors state further that most assessment measures rely on self-report.

According to Donovan and Marlatt (2005:117) one of the most common, face valid and easiest ways to measure smoking rate or amount of smoking is via a self-report assessment that requires smokers to reflect on their smoking behaviour. Typical questions assess the number of cigarettes smoked per day in a given interval (i.e. how many cigarettes per day have you smoked in the last 7 days?). This procedure requires trained interviewers to record in detail, daily smoking rates and/or other variables (e.g. cravings, mood, other substance use), by providing smokers with calendars and specifically prompting them with key dates and events that occurred during the assessment interval (e.g. a holiday or birthday). This retest procedure has demonstrated both test reports of retest reliability and validity with collateral reports of smoking behaviour and biochemical measures (Donovan & Marlatt, 2005:117).

It often happens that adolescent boys who completed the rehabilitation programme can relapse after a few months. It is therefore important that they've been educated in this regard in order to prevent relapsing. Relapse prevention training will now be presented.

3.5   RELAPSE PREVENTION TRAINING

Before assessment can be done it is important to have a working knowledge of relapse prevention, its theoretical underpinnings and its clinical application. This information is a prerequisite for identifying relevant assessment domains. An important component of rehabilitation and treatment planning with individuals attempting to change an addictive behaviour is relapse prevention. Staying clean and sober of refraining from engaging in a particular behaviour is one of the biggest challenges that individuals face after completing a treatment programme or self-change. Although addictive behaviours represent a complex of genetic, physiological, sociocultural and psychological components, there are a number of models of the relapse process that give different weights to biomedical and cognitive-behavioral constructs (Donovan & Marlatt, 2005:05).

According to Donovan and Marlatt (2005:05) the goals of relapse prevention strategies are twofold: (1) *to prevent an initial lapse back to drug use and* (2) *if it does occur, from becoming more serious and prolonged by minimizing the physical, psychological and social consequences of the return to use*. While the relative emphasis will vary depending on the

program, a number of common elements are involved in relapse prevention. Firstly it is important to educate the individual about the relapse process. Despite having relapsed previously many individuals are not familiar with the range of factors that trigger their actions; they feel that their relapse just come "out of the blue" in an unpredictable way. The authors suggested that the adolescent boys should be educated about a number of predictable events that can lead to relapse and the feelings that come after a relapse.

According to Jarvis *et al.* (2005:221-222) the goal of the relapse prevention training is to ensure that clients have a variety of skills and the confidence to avoid lapses to alcohol or drug use, a set of strategies and believes that reduce the fear of failure and prevent such lapses turning into relapse. The authors emphasize on the key concepts, which include high-risk situations. These are situations that the adolescent boy identifies as those in which he is most likely to find it difficult to resist drinking or drug use. The research literature suggests that (re)lapses commonly occur in response to negative emotional states, such as anxiety or depression; interpersonal conflicts and social isolation; social pressure to use or drink and cravings and urges. However, the level of risk involved in these situations is likely to be higher if the adolescent boy has inadequate coping skills, a high level of involvement in drinking or drug use, or low self-efficacy. The authors continue that not all high risk events are negative-celebrations and special occasions might also pose a risk for the adolescent boy. Some may, for example need help with problems such as depression and assertion which pre-date their addictive behaviours and are currently serving to maintain such behaviour.

According to Fisher and Harrison (2013) the key feature of a Relapse Prevention Programme (RPP) is that adolescent boys are engaged in a process of actively learning from mistakes. The social worker simply facilitates the learning – nudging the boys along naturally occurring pathways. The RPP can be like a journey in which the adolescent boy as the driver has decided on the ultimate destination. A "successful" journey involves passage through a number of overlapping phases which broadly correspond to preparing for the journey, getting started, handling slips (meaning when one makes a mistake which can lead to drug use), managing daily hassles, the pursuit of life goals and maintaining vigilance. The length of a RPP will vary considerably from client to client depending on the number and severity of the addiction (Fisher & Harrison, 2013).

Adolescents in their developmental stage have different needs than the adult. They have also different ideas and opinions on life and are always looking for excitement. It will therefore be helpful if the social worker can look at exciting ways to address the needs of the addicted adolescent boys, because if they are not interested in the way the programme is conducted, the programme will not make an impact on their addiction problem. Different manners in which adolescents can be approach will now be presented.

3.6   MANNERS IN WHICH ADOLESCENT BOYS CAN BE APPROACHED

According to Jarvis *et al*. (2005:255) adolescents do not usually seek for help voluntarily, they are highly likely to have entered treatment because they were coerced or persuaded by adults. The adolescent might see the social worker as just another authority figure. The adolescent may also find it hard to adjust to treatment that is designed for adult clients. Therefore it is important that social workers consider how they will engage with the adolescent in the treatment process. The authors furthermore state that the adolescent is more likely to trust the social worker if they take a non-judgmental approach and show a genuine interest in the adolescent's perspective. Social workers should work in a collaborative way by involving the adolescent in all decisions related to their treatment, particularly when setting treatment goals. They should also engage their curiosity with open-ended questions and by fostering a shared interest in discovery. Social workers should be open and responsive to the adolescent's sense of humor or fun. They need to encourage the adolescent's self-efficacy by giving frequent and immediate positive feedback when they notice that they are doing well.

Jarvis *et al*. (2005:256) suggest that social workers use the approach of skating in and out of crucial subjects, rather than rigidly persevering with what they think is important. The social worker's office might not be the best place to work with adolescents. It might be better to go for a walk or choose some other location where the adolescent feels more comfortable. They can also make their treatment approach more youth-friendly by using metaphors, stories, pictures, cartoons, videos, music, therapeutic games, physical activities, role-play and the internet. According to the author it is important to select materials and resources that are in tune with the adolescent's interests, language and sub-culture. The authors also emphasize the importance to stay up-to-date with information about youth and community services and local avenues for recreation so that the adolescent can be effectively linked with protective social

networks. The authors furthermore state that for some adolescents, social workers might need to set up plans for co-ordinated care with juvenile justice, community and welfare services, mental health services or other professionals. Social workers should be aware of their legal and professional obligations regarding duty of care. For example, if the adolescent is at risk of suicide or abuse, social workers need to notify guardians or other authorities. Adolescents need to be informed about their rights to confidentiality and privacy, as well as the social workers right to obligations regarding notification. According to Rawson and McCann (2005) individual sessions are critical to the development of the crucial relationship between the adolescent and the social worker. The content of the individual sessions is primarily concerned with setting and checking on the progress of the patient's individual goals. These sessions can be combined with conjoint sessions, including significant others in the treatment planning. Extra sessions are sometimes necessary.

The individually oriented **Cognitive Behavioral Training** (CBT), skills-training programme was patterned after coping skills-training programmes developed. The underlying model was designed to teach the individual self-control and coping skills useful in avoiding substance use. The Cognitive Behavioral Therapy (CBT) intervention consisted of a two-session motivational-enhancement intervention (MET) and 10 skills modules, including communication training, problem solving, peer refusal, negative mood management, social support, work- and school-related skills, as well as relapse prevention. During the motivational enhancement therapy (MET) sessions, therapists use non-confrontational strategies to maximize motivation for change, prioritize treatment goals, create a treatment plan and enhance the adolescent's sense of self-efficacy. Functional family therapy (FFT) is a systems-oriented, behaviorally based model of relatively structured family therapy in which the overall goal is to alter dysfunctional family patterns that contribute to adolescent substance use. The model has substantial empirical support as an effective treatment for a variety of adolescent problem behaviours (Fisher & Harrison, 2013).

The **Functional Family Therapy** (FFT) intervention is applied in two phases. The first phase focuses on engaging families in the treatment process and enhancing motivation for change. Therapists strive to maximize family's expectations for positive change and to effect changes in attitudes and feelings by reducing blaming behaviour and emphasizing the relationship aspects of identified problems. Family assessment involving the identification of the interactional and functional aspects of specific behaviours, attributions and feelings of family

members is also conducted during this phase. Once the initial phase is completed, the second phase is introduced and the focus of treatment shifts to effecting behavioral changes in the family. Contingency management, communication and problem solving, behavioral contracting and other behavioral interventions are implemented, using the family assessment of relationship functions as a guide, to reduce problems.

3.7   OUT-PATIENT TREATMENT

For the purpose of this study, the researcher will focus on out-patient treatment as in-patient treatment or Rehabilitation Centers are not always the answer to adolescent drug rehabilitation. As a rough estimate, out-patient treatment is the best form of treatment for 80% of those who have substance abuse problems. This is because it is quite easy to get someone to stop using drugs. The adolescent can be locked in, take them to a rural town, etc. What is difficult is keeping a person off drugs while they live, work and socialize to their full potential. In-patient care provides a time out from normal life stresses. The danger is that relapse may occur once the recovery addict returns from in-patient care. In the case of out-patient care the client is receiving guidance, support and learning new skills while still facing the normal challenge of life (Cape Town Drug Counselling Centre, 2007:65).

The Cape Town Drug Counseling Centre (2007:64) shows the difference between in-patient and out-patient treatment as follows:

Table 3.1: Difference between in- and out-patient treatment

IN-PATIENT TREATMENT	OUT-PATIENT TREATMENT
Residential Care	Non-residential care
Less intensive treatment	More intensive treatment
Costly depending on whether it is private or government subsidized	Less costly
More structured programmes	Flexible, appointment based programme
More containment provided	Less containment
Requires a break from home life	Continue with everyday life while in treatment

According to the author it is important to know which client should be suitable for in-patient treatment and which client should be suitable for out-patient treatment. Those who are suitable for out-patient treatment are:

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- Users who have positive social and family support structures.

- Users who are unable to interrupt their life and take the necessary time off for patient treatment.

- Users requiring crisis intervention e.g. when busted by police or family.

- People who face crises that increase the level of motivation to actually attend to the substance abuse problem.

- Users who are able to cope with their environment while receiving treatment.

- People in recovery requiring support in maintaining their sobriety (after care maintenance).

3.8   DIFFERENT MODELS IN THE REHABILITATION PROCESS

The researcher will combine the Matrix Model with some information of other Models and also consider the Integrated Service Delivery Model (2006) (ISDM), The National Drug Master Plan (2006-2011) and the Prevention of and Treatment for Substance Abuse Act no 70 of 2008 in order to provide a clear picture of the contribution Social workers are making regarding the rehabilitation of drug addicted adolescent boys.

The Integrated Service Delivery Model (2006) mentions the developmental approach to social welfare – recognizes the need for integrated and strength-based approaches to service delivery; ensures and promotes the sustainability of intervention efforts; emphasizes appropriate services to all, particularly the poor, vulnerable and those with special needs; recognizes that social work, among other social service professions, plays a major role in addressing the developmental needs of South African society. The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behaviour and social systems, social work intervenes at the point where people interact with their environment.

According to the Prevention of and Treatment for Substance Abuse Act no 70 of 2008, the manager of a treatment center may establish any of the following out-patient services: services consisting of prevention programmes, including programmes on education, skills development, information-sharing and campaigns; services consisting of early intervention programmes; programmes for adults and children who have been diverted from the criminal

justice system; and holistic treatment services, including family programmes, treatment services, therapeutic intervention, aftercare and reintegration services.

The ISDM (2006) states that principles of human rights and social justice are fundamental to social work. Social work services are rendered using three primary methods, namely case work, group work and community work. Case work is a method that utilizes a variety of skills, techniques and other aids to facilitate the client's participation and decision-making in efforts to improve their social functioning. Group work is a method whereby a group achieves group objectives within a group context by the purposeful application of group processes and interventions. Community work is a joint, planned action of a geographical or functional community and a social service practitioner to promote the social functioning of the total community.

According to Hubbard (2012:49) successful rehabilitation of an individual can only be accomplished by cleaning up the body first. The author developed the Purification Programme which is a detox program.

3.8.1 The Purification Programme

According to Hubbard (2012:49) the Purification Programme is a tightly supervised regimen that includes the following elements: Exercise (running), Sauna sweats-out, Nutrition, including vitamins, minerals, etc., as well as oil intake and a proper ordered personal schedule. Adolescents run to get the blood circulating deeper into the tissues where toxic residuals are lodged and thus to loosen and release the accumulated harmful deposits and get them moving. It is very important, that the running be immediately followed by sweating in the sauna to flush out these dislodged accumulations. The author furthermore states that while supplementing one's regular diet with plenty of fresh vegetables, one also takes an exact regimen of vitamins, minerals and extra quantities of oil. The recommended vitamin dosages are gradiently increased over the course of the program. (By gradiently is meant a gradual approach to something, taken step by step: in this case gradual increase of vitamins.) One vitamin in particular, niacin is vital to the effectiveness of the Purification Program. Taken in sufficient quantities, niacin appears to break up and unleash residual drug and toxic residues from the body tissues and cells. This regimen is not only a vital factor in helping the body flush out toxins, it also repairs and rebuild areas affected by drugs. A proper schedule with

enough rest is mandatory, because the body undergoes change and repair throughout the program. These actions carried out on a very stringently monitored basis, apparently accomplish detoxification of the entire system, to the renewed health and vigor of the individual.

Hubbard (2012:47) states that two factors on the programme must be considered. That is the actual drugs and toxic residuals in the body and the other factor is the mental image or pictures of the drugs and the mental image pictures of one's experiences of these drugs.

These two factors are playing against each other in perfect balance. What the person is feeling are the two conditions: the actual presence of the drug residuals and the mental image pictures relating to them. The Purification Programme handles one of these factors, the mental image pictures are no longer restimulative or in constant restimulation. By breaking up the balance between these two factors and handling the toxic residuals on the Purification Program, we remove elements destructive to the individual's physical health and free him for mental and spiritual gain. In other words, the person is now in a state where he can pursue betterment of his own perceptions and abilities (Hubbard, 2012:48).

After the detox process has been completed the therapeutic process can now start. The client can now concentrate better on the context of the program, because cravings and mood swings will be decreased. Social workers are not familiar with this program, but it is a very fundamental part in the rehabilitation process and needs to be used more. The matrix model will now be presented which is a therapeutic program.

3.8.2 The Matrix Model

According to Rawson and McCann (2005:03) the matrix model is a multi-element package of therapeutic strategies that complement each other and combine to produce an integrated out-patient treatment experience. It is a set of evidence-based practices delivered in a clinically coordinated manner as a program. Many of the treatment strategies within the model are derived from clinical research literature, including cognitive behavioural therapy, research on relapse prevention, motivational interviewing strategies, psycho-educational information and 12-Step programme involvement.

The authors of the Matrix approach attempted to integrate existing knowledge and empirically supported techniques into a single, multi-element manual that could serve as an out-patient "protocol" for the treatment of drug addiction (Rawson & McCann, 2005). Each topic is introduced by a simple exercise in which scientific information is explained in patient-friendly terms and questions directed to participants to apply the information specifically to their immediate situation. The groups are focused on discussing the patient's written and oral responses to the questions. Treatment is delivered in a 16-week intensive out-patient programme primarily in structured group sessions targeting the skills needed in early recovery and for relapse prevention. A primary therapist conducts both the individual and group sessions for a particular patient and is responsible for coordinating the whole treatment experience. There is also a 12-week family and patient education group series and induction into an ongoing weekly social support group for continuing care. Weekly urine testing is another programme component and participants are encouraged to attend 12-Step meetings as an important supplement to intensive treatment and a continuing source of positive emotional and social support.

According to Rawson and McCann, (2005) the elements of the treatment approach are a collection of group sessions (early recovery skills, relapse prevention, family education and social support) and 3 to 10 individual sessions delivered over a 16-week intensive treatment period. Patients are scheduled three times per week to attend two Relapse Preventions groups (Monday and Friday) and one Family education group (Wednesdays). During the first four weeks patients also attend two Early Recovery Skills groups per week (these groups occur on the same days as the Relapse Prevention groups just prior to them). After 12 weeks they attend a Social Support group instead of the Family Education group.

3.8.2.1   Programme components

(a) Individual counseling

These sessions are critical to the development of the crucial relationship between the patient and the social worker. The content of the individual sessions is primarily concerned with setting and checking on the progress of the patient's individual goals. These sessions can be combined with conjoint sessions, including significant others in the treatment planning. Extra sessions are sometimes necessary during times of crisis to change the treatment plan. These individual sessions are the glue that ensures the continuity of the primary treatment dyad and thereby, retention of the patient in the treatment process (Rawson & McCann, 2005).

(b) Early Recovery Skills Groups

The eight Early Recovery Skills Groups are designed for patients in the first month of treatment or those who need extra tutoring in how to stop using drugs and alcohol. The purpose of the group is to teach patients how to use cognitive tools to reduce craving, the nature of classically-conditioned cravings, how to schedule their time, about the need to discontinue use of secondary substances and to connect patients with community support services necessary for a successful recovery. The reduced size of the groups allows the therapist to spend more individual time with each patient of these critical early skills and tasks. Patients who destabilize during treatment are often encouraged to return to the Early Recovery group until they re-stabilize (Rawson & McCann, 2005).

(c) Relapse Prevention Groups

The Relapse Prevention groups occur at the beginning and end of each week from the beginning of treatment through Week 16. They are the central component of the Matrix Model treatment package. They are open groups run with a very specific format for a very specific purpose. Most patients who have attempted recovery will agree that stopping using is not that difficult; it is *staying stopped* that makes the difference. These groups are the means by which patients are taught how to stay in sobriety. The purpose of the Relapse Prevention groups is to provide a setting where information about relapse can be learned and shared. The 32 relapse prevention topics are focused on behaviour change, changing the patient's cognitive/affective orientation and connecting patients with 12-Step support systems. Each group is structured with a consistent format during which: patients are introduced if there are new members, patients give an up to the moment report on their progress in recovery,

patients read the topic of the day and relate it to their own experience, patients share their schedules, plans, and commitment to recovery from the end of the group until the group meets again. Input and encouragement from other group members is solicited but the group leader does not relinquish control of the group or promote directionless cross talk about how each member feels about what the others have said. The therapist maintains control and keeps the groups topic centered and positive with a strong educational element. Care is taken not to allow group members to share graphic stories of their drug and alcohol use. Social workers specifically avoid allowing the groups to become confrontational or extremely emotional. Whenever possible the use of a co-leader who has at least 6 months of recovery, is employed. The co-leader serves as a peer support person who can share his or her own recovery experiences (Rawson & McCann, 2005).

(d) <u>Family Education Groups</u>

The 12-week series is presented to patients and their families in a group setting using slide presentations, videotapes, panels and group discussions. The educational component includes such programme topics as the biology of addiction, describing concepts such as neurotransmitters, brain structure and function and drug tolerance; conditioning and addiction, including concepts such as conditioned cues, extinction, and conditioned abstinence; medical effects of drugs and alcohol on the heart, lungs, reproductive system, brain; addiction and the family, describing how relationships are affected during addiction and recovery. Successfully engaging families in this component of treatment can significantly improve the probability of retaining the primary patient in treatment for the entire 16 weeks (Rawson & McCann, 2005).

The importance of family based treatments will be briefly discussed. It shows the effectiveness of family involvement in therapy when it comes to adolescent rehabilitation.

Reviews of formal clinical trials of family-based treatments have consistently found that drug-abusing adolescents who enter rehabilitation centers and are engage in family therapy more than in other treatments significant reductions in substance use from pre- to post-treatment. In seven of eight studies comparing family therapy with a nonfamily-based intervention, adolescents receiving family therapy showed greater reductions in substance use than did those receiving group therapy only (Waldron, Holly, Slesnick, Natasha, Brody, Turner & Peterson, 2001). In a study focusing specifically on adolescent alcohol abusers was

found that both family and individual therapy approaches resulted in reductions in alcohol use, though no changes in use were observed from a drug education condition. One limitation of family-based treatments not often acknowledged, is the lack of attention to intrapersonal risk factors for adolescent substance use disorders, such as substance use expectancies, self-efficacy and specific substance-related coping strategies such as peer refusal and coping with urges and cravings to use (Fisher & Harrison, 2013).

The 12-Step Meetings will now be discussed.

(e) 12-Step Meetings

The optimal arrangement is to have a 12-Step meeting on site at the treatment center one night each week. This meeting does not have to be an official meeting. Rather, the clients presently in treatment and graduated members can conduct an "Introduction to 12-Step Meeting" using the same format as an outside meeting with the purpose of orienting patients unfamiliar to the meetings in a safe setting with people they already know. Attending these meetings often makes going to an outside meeting for the first time much easier and less anxiety provoking. These meetings, along with outside 12-step meetings chosen by patients and the Social Support Group provide strong continuing support for graduated group members (Fisher & Harrison, 2013).

(f) Urine/Breath tests

Urine testing is done randomly on a weekly basis. Positive urine tests revealing previously undisclosed drug use serve as points of discussion rather than incrimination. Patients struggling with secondary drug or alcohol use should also be tested for those substances (Rawson & McCann, 2005).

(g) Relapse analysis

A specific exercise is used when a patient relapses unexpectedly or repeatedly and does not seem to understand the causes of the relapses. The optional exercise and forms are designed to help the therapist and the patient understand the issues and events that occurred preceding the relapse(s) in order to help prevent future relapses. This exercise is typically conducted during an individual session with the patient and possibly, a significant other (Fisher & Harrison, 2013).

(h) <u>Social support</u>

Social support is designed to help patients establish new nondrug-related friends and activities, these groups are less structured and topic-focused than the Relapse Prevention Groups. Patients begin the groups during the last month in treatment at the end of the family education series, in order to ensure that they feel connected before they graduate from the Relapse Prevention Groups. The content of the groups is determined by the needs of those members attending. If patients have relapsed, relapse prevention work may be in order, unstable patients are given direction to help stabilize them and patients moving successfully through the stages of recovery are aided and encouraged to continue with the lifestyle changes that they are making (Rawson & McCann, 2005).

Therapeutic constructs of the Matrix Model will now be presented.

3.8.2.2   *Therapeutic constructs*

(a) <u>Positive and collaborative relationship</u>

According to Rawson and McCann (2005:17) the context of the Matrix Model is characterized by a positive and collaborative relationship between the client and Social worker. Within this model, the Social worker is required to be directive but to maintain a client-centered therapeutic stance. As cited in much psychotherapy research, it is essential to deliver accurate empathy, positive regard, warmth and genuineness. It means treating patients with dignity, respect and listening attentively and reflectively to their unique experience without imposing judgment.

A collaborative relationship will develop when the social worker actively listens to the adolescent boys' concerns and opinions and attempts to see the world from their perspective. This allows the creation of a spirit of cooperation and mutual effort. Conversely, use of a confrontational and therapist imposition of treatment goals and demands will create an adversarial relationship which can frequently contribute to premature treatment termination. Setting mutually agreed upon goals engages the adolescent boy as an active participant. In addition, it validates and acknowledges his expertise and experiences, thereby reinforcing the therapeutic alliance. This collaborative climate increases the client's readiness to learn new skills and practice more adaptive coping strategies and establishes an environment where the

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successes and failures of using these new strategies can be shared (Rawson & McCann, 2005:18).

The Motivational Interviewing techniques developed by Miller and Rollnick (2002) are all extremely valuable in building a successful therapeutic relationship with clients in out-patient treatment. The clinical skills incorporated within this approach are of tremendous value throughout treatment and especially during the early weeks of treatment.

(b) <u>Structure and expectations</u>

According to Rawson and McCann (2005:18) structure is a critical element in any effective out-patient program. In out-patient settings structure is created by defining for clients (in this case adolescent boys) the activities that are required parts of their treatment involvement. These activities include attendance at the individual and group sessions of the program, participation in community self-help groups and the scheduled daily activities that minimize contact with drugs and other high risk situations. The structure provided by treatment helps to define for the client exactly what is expected of him in treatment and provides a "roadmap" for recovery. The authors state further that this information can be useful in reducing the anxiety that is commonly experienced by substance dependent individuals upon treatment initiation. Functioning within a structure can decrease stress and provide consistency and predictability which are all incompatible to an addict's spontaneous, unplanned, chaotic lifestyle.

The patient should keep the schedule and refer to it during day-to-day activities. It is important that the counselor keeps a copy of the schedule and reviews it at the beginning of the next session. During early stages of treatment many patients forget to follow the schedule or decide to ignore the schedule. Frequently lapses will occur and these lapses can reinforce the use of the schedule procedure. Patients should realize that they can change their plan when essential, but they should take the time to actually change the written schedule and write in the new activity. This process allows the patient time to think through the feasibility and advisability of the schedule change (Rawson & McCann, 2005:19). The authors emphasize on some challenges and solutions regarding structure and expectations such as leisure activities, time to rest, or time to relax. As a result the schedule can become a marathon of productive activities. This type of unrealistic scheduling will lead to non-compliance with the schedule and quickly will make the scheduling activity pointless. One

helpful way to make sure that the schedule is realistic is to review the events of typical drug-free days and see what a normal routine is for that person. If the schedule created is too different from normal habits, it will be difficult for the client to incorporate it into his routine (Rawson & McCann, 2005:20).

Many clients have difficulty making an hour-by-hour schedule. If this is the case, it is necessary to simplify the process. One way to do that is to simply use a small, pocket-sized card with the day divided into four sections; morning, midday, afternoon and evening. Beginning scheduling is easier if the client can just plan activities for those four times of day. At first, some have trouble learning this skill. If this is the case, it can be helpful to have them describe what they did for the past 24 hours and then guess what they are likely to do in the next 24 hours. The social worker can write their schedule as they talk about it. Some families want to help "plan" (dictate) a client's schedule. Spouses and parents, especially, have lots of ideas for things that have been neglected or things that the client should do. Since many clients are trying to win back the support of their families, they can be easily convinced that they should do whatever family members want rather than what they need to do, which is sustain a plan for their recovery. If someone else's wishes and desires are the basis for the schedule regularly, sooner or later the recovering person will get resentful and will not find the scheduling useful or helpful. It will be viewed as a "sentence" imposed by the family member and the social worker will be viewed as a colluding compatriot. It is important for the client to be the person who is responsible for constructing the schedule with input from the social worker (Rawson & McCann, 2005).

(c) Psycho-education

A key component of the Matrix Model is information regarding conditioning and neurobiology. Accurate, understandable information helps patients understand what has been happening in the past and also what predictable changes that will occur in their thinking, mood, and relationships over the course of several months. This education process identifies and normalizes symptoms, thereby empowering them to draw upon resources and techniques to help manage the symptoms. The use of client education as a treatment component is not a new treatment concept unique to the Matrix Model. However, teaching clients and their families about how the chronic use of drugs or alcohol produces changes in brain functioning in a manner that has direct application to clients' behaviour is a relatively new strategy. Much of the information about drug-induced changes in the brain is highly technical and requires

extensive scientific knowledge to comprehend the concepts fully. Without scientific training, it is not intuitive to substance abusing individuals or to their families to understand that the behaviour associated with drug use may, in part, be explained by modifications in brain chemistry. Classically conditioned craving occurs independently of rational choice or renewed resolve to stop drug use. This fact provides a reassuring explanation of past behaviour and an uncompromising context for recovery (Rawson & McCann, 2005:21).

According to Rawson and McCann (2005:21) the use of patient education as a treatment component is not a new treatment concept unique to the Matrix Model. However, teaching clients and their families about how the chronic use of drugs or alcohol produces changes in brain functioning in a manner that has direct application to clients' behaviour is a relatively new strategy. Much of the information about drug-induced changes in the brain is highly technical and requires extensive scientific knowledge to comprehend the concepts fully. Without scientific training, it is not intuitive to substance abusing individuals or to their families to understand that the behaviour associated with drug use may, in part, be explained by modifications in brain chemistry. This fact provides a reassuring explanation of past behaviour and an uncompromising context for recovery. From this premise follows many of the treatment handouts and exercises such as time scheduling (to avoid depending on in-the-moment, addiction-compromised thought processes) thought-stopping (to prevent initiation of the craving sequence) and avoidance of triggers (which also trigger release of neurotransmitters and stimulate a desire to use). The authors furthermore explain that the second basic lecture involves continuing changes in brain chemistry as the healing brain attempts to regain normal functioning.

New scientific information continues to provide supportive evidence for the stages of recovery that patients have reported over the last 16 years. Studies are consistently showing that the recovery process often results in some brain functions getting worse before they get better. The brain thus needs a drug free environment for healing to occur and the entire recovery takes a much longer time to return to normal than was ever imagined. Even without a technical understanding of how and why these issues are occurring, social workers can now say that they are occurring with certainty and can provide pictures to support their claims. This knowledge sets the stage for the continued teaching of the relapse prevention activities and supports vigilant treatment participation far beyond the initial withdrawal phase. Patients are comforted by the existence of a roadmap delineating the process of recovery and are more

secure in the knowledge that activities they are asked to do relate directly to their recovery from a very physical disease state (Rawson & McCann, 2005:22).

(d) <u>Challenges and solutions regarding psycho education</u>

The presentation of psycho-educational information based on science can be dull and tedious for clients and families if presented improperly. The material from the research literature has to be "translated" into non-technical language and presented at an 8-10 grade level. Visual aids, including clear and understandable pictures and videos can be very useful to convey this information. It is important that the material be presented in a context of clinical issues so that patients and their family members understand the relevance of the information and how it applies to their addiction recovery. The individual who presents this material as part of the Matrix programme has to be well-versed in the neurobiological concepts and other research information. For the material to be understood and used by clients, the presenter must have credibility, be able to expand on the material, and make the material relevant to clients' clinical challenges (Rawson & McCann, 2005).

(e) <u>Cognitive behavioral skills</u>

Knowledge and skills that have been developed within the field of cognitive behavioral therapy (CBT) plays a large role in the Matrix Model. The work of Marlatt, Gordon, Carroll, colleagues and others have contributed greatly to the content of the group treatment activities at the matrix. This approach teaches clients that drug use and relapse are not random events and that they can learn skills that can be applied in daily life to promote abstinence and prevent relapse. One of these skills is self-monitoring to bring into awareness any dysphoric or uncomfortable symptoms, thoughts, warning signs, high-risk situations, and subtle precipitating events. Clients learn skills to identify triggers, develop coping skills and manage immediate problems. They are encouraged to practice and experiment with new behaviours outside the clinic setting. In the group, patients report back on what worked and what did not work, what obstacles were encountered and what changes need to be made to make the interventions successful in the future (Rawson & McCann, 2005).

In this process clients become the experts on their own individual recovery processes. Each of the matrix groups is anchored with a specific cognitive behavioral therapeutic topic for each session. The topic is introduced by the social worker and a brief explanation is given about how this topic is related to the achievement of a successful recovery. There is a review

of a handout/worksheet that explains the concept and includes questions that are used to personalize the concept and make it relevant to each person. Each client in the group discusses how the topic is a factor in his life and how the skills being introduced could help with specific challenges each one faces in recovery. The discussion is never confrontational and while the primary exchange is typically between the client and the social worker, frequently other clients can make observations about similarities and differences between their experiences and those of other clients. Frequently the social worker will suggest to one or more of the group members to apply the skill in the following days as a homework assignment (Rawson & McCann, 2005).

It is important to know what the challenges are in order to be prepared, and also know what the solutions are in order to apply them at the same time.

A cognitive-behavioral orientation can be very engaging and a non-judgmental stance communicates positive regard for the client. However, if the topic is not accompanied with useful real world examples of how the topic can actually relate to client challenges and benefits, the sessions can feel excessively didactic and academic, in short, boring. An important part of social workers training in the Matrix Model is the art of Cognitive Behavioral Therapy delivery to keep the topic interesting and relevant and find ways to apply it to clients in the group. Another challenge is maintaining a stimulating pace, staying on topic and managing the time of the group. At times, group members may be disruptive and interrupt the group with cross talk or impulsive behaviours. Speaking calmly and redirecting clients is an effective way to keep the group focused and on task (Rawson & McCann, 2005:23).

The authors further state that some patients (particularly those who are mandated) may be at a stage of readiness where they are not receptive to total abstinence, lifestyle change, or even any modification in their current drug or alcohol use. Often the cohesiveness and positive momentum of the group can also move them towards change. A skilled social worker will need to limit negative, counterproductive input from such a client and at the same time be accepting, positive and not be judgmental. On occasion an intoxicated client may not show up for a group session. An auxiliary worker can work with the client to ensure safe transportation home. Any discussion on the matter regarding the drug or alcohol use should be avoided until the next appointment. If possible, an individual session should be scheduled

to address the particular issues surrounding the relapse. The effect of such an event on other group members should not be ignored. They may need to discuss their reactions, and possible triggering, resulting from being in such close proximity to a relapsing colleague.

(f) <u>Positive reinforcement</u>

There is a large amount of research supporting the efficacy of the systematic use of reinforcement for meeting specific behavioral criteria in the treatment of addictions (Rawson & McCann, 2005). Contingency management research with drug abuse problems usually has targeted drug-free urine results, attendance at treatment sessions, or achieving treatment goals as the basis for receiving incentives. Participants in research studies usually receive certificates that are redeemable for items with monetary values ranging from as little as one dollar to as much as one hundred dollars. Coupled with social recognition, relatively inexpensive items can have a strong effect on behaviour. This approach has long been a part of both the educational system and of parenting skills training. Although supported by a large amount of research, contingency management has not made significant inroads into treatment mainly because of cost and complexity. The Matrix Model includes many different uses of contingency management that are simple and inexpensive. The specific behaviour targets and reinforces and may vary from programme to programme depending on the clinical needs and the programme resources, but some general features should be common to all.

These include specific, clear criteria. The requirement for earning an incentive should be described in writing and in detail. For example, if attendance at group meetings earns a voucher, attendance would need to be clearly defined (e.g., attending at least 60 minutes of a 90-minute group; arriving within 5 minutes of the scheduled start time). If urine results are incentivized, it is critical that they are valid and testing procedures should be in place. If achieving treatment planned goals are rewarded, there should be some way of verifying these (e.g., ticket stubs from a museum, job application, or 12-Step meeting attendance cards). Consistency is needed in application of contingencies. If the rules are bent, they quickly become ineffective. Social reinforcement along with other rewards should be used as much as possible. Acknowledging accomplishments in groups magnifies the effects tremendously (Rawson & McCann, 2005:24).

Some examples of contingency management that have been used in the matrix programmes will now be mentioned.

Abstinence: At the beginning of each group session clients are asked to place colored stickers "dots" on a calendar for each drug free day. The session opens with each patient reviewing number of days of abstinence. This public recording of data provides an excellent opportunity to explicitly reinforce the achievement of gaining drug free days. Urine results: Everyone who provides drug-free urine each week participates in a pizza party at the end of the week. Attendance: Participants who attend all treatment sessions over the course of a month earn a gift card which is presented in group. Those who attend 80% of treatment session earn a gift card of lesser value. Promptness: Cookies and chocolates are put out 5 minutes prior to the start of group and are left out until 5 minutes after. Only those who are present within this 10-minute period have access to the treats. Behaviour in group: Social workers give stickers during group sessions to clients who say something reflective of a positive change in attitude or recovery behaviour, something supportive of other group members, or for abiding by group rules for the entire group (Rawson & McCann, 2005:25).

   (g) Family education

The matrix model involves family members in the treatment program. "Family" includes all those people who are part of their everyday existence and are close to them. This includes biological family as well as partners, close friends, associates and people who are part of their extended family. Providing the family with education such as information on classically conditioned craving, helps make the client's behaviour prior to entering treatment understandable and it helps to demystify treatment and recovery. It is also important for significant others to be better prepared for the range of events such as lapses that may happen during the recovery process. In the initial stages of treatment, family members will need to decide whether they are willing to be part of the recovery process. It is often necessary for social workers using the matrix model to schedule a session with family members to explain the manners in which they can be helpful in participating in the treatment process and strongly encouraging them to attend scheduled sessions (Rawson & McCann, 2005:26). Addiction is presented to the family as a chronic condition which they can be helpful in remediating by providing support for the client. By presenting their role as providing supportive and positive assistance, as opposed to entering "therapy" for their family systems

pathology, family members are often more willing to help support the recovery process and attend treatment (Rawson & McCann, 2005:26).

Not all family members will want to be a part of the recovery process, despite the urging by the social worker or client. There are many reasons for this. One may be that the family members feel they have been through tremendous stress and disappointment and that they cannot put themselves through any more of the emotional turmoil. These people usually still care very deeply for their affected family member, but cannot stand to keep watching them destroy their life. Usually they have been involved in previous treatment attempts and are exhausted, emotionally and financially, from multiple unsuccessful attempts at recovery. Another reason for family members being unwilling to participate may be that they are very angry. They may be tired of all the family resources being expended fruitlessly on battling the addiction. Other family members say they are just tired of all the deception and turmoil that is part of the addiction and they are not willing to invest more energy into helping the client recover. These family members might say something like "This is your problem not mine". "Go get fixed and when you are all better we can continue leading our lives together." In these circumstances, if the client initiates treatment and demonstrates some positive progress, family members can then be approached again and invited to participate (Rawson & McCann, 2005:27).

(h) Self-Help groups

Alcoholics Anonymous (AA) meetings are widely available, are free of charge and provide a place where recovering people can meet others who are dealing with many of the same issues. Recently there have been some well-designed studies that have demonstrated empirically the usefulness of participation in 12-Step programmes. It makes sense for patients to use the meetings as an ongoing resource if they find them beneficial, and the Matrix Model includes topics designed to familiarize patients with this resource. According to Rawson and McCann (2005:27) not everyone responds favorably to the concepts of the 12-Steps or to the groups themselves. Many patients are not willing to attend 12-Step meetings, or they sample one or two meetings and find them unhelpful or aversive. Much of the resistance to the 12-Step programme concerns the "spiritual" dimension of AA. This resistance can be reduced by urging clients to focus on other benefits of the programme which they can find useful. For example, one basic principle of the matrix approach is the creation of structure and development of non-drug related activities. The 12-Step groups can be presented as a means

to construct a schedule with drug-free activities during high-risk time periods. Often motivational interviewing strategies can be helpful in addressing resistance to participation in 12-Step programme involvement (Rawson & McCann, 2005:27).

(i) <u>Urine and breath alcohol testing</u>

The matrix approach requires accurate information on the drug use status of clients as they progress through treatment. The most accurate means of monitoring clients for drug and alcohol use during treatment is through the use of urine and breath alcohol testing. The variety of testing options available today makes it much easier for programmes to regularly administer the tests than in the past. Tests can be analyzed on site or sent out to laboratories. Specimens can be monitored with temperature strips; they can be observed or unobserved. Regardless of the specific procedure used, the objective is the same: to monitor drug use and to provide feedback to the client. Some clients may resist the necessity of urine testing. They may view the procedure as coercive or indicative of mistrust by the treatment programme staff. It is possible to mitigate this resistance by describing the purpose of the testing as offering objective evidence of the client's abstinence, if situations occur when family members or others make accusations of drug use. Patients will often say things like, "You don't need to test me. Why would I come in here and lie about using? I will tell you if I use." It's important to let new clients know that the testing procedure is a standard part of the programme and that urine testing is not a way of "catching" misbehavior. One important point to take into consideration is that urine testing should not be presented primarily as a monitoring measure. Instead of being used as a policing device, testing should be seen as a way to help a person not to use drugs. Urine and breath alcohol testing done in a clinical setting for clinical purposes is quite different from urine testing that is done for legal monitoring (Rawson & McCann, 2005:28).

3.9   CONCLUSION

The same principles used in an in-patient rehabilitation programme can be applied in an out-patient program. A cognitive-behavioral approach could be used to correct destructive behaviour and prevent relapse. This behavioral therapy can be done in group therapy and one-on-one counselling sessions with a Social worker. Cognitive behavioral therapy helps the client to examine his inner workings and identify the triggers that set off using behaviour. The clients are helping to find ways to avoid situations that place them at risk. Faulty belief

systems that lead to addiction are challenged and the client is freed from a negative self-image and feelings of worthlessness. This makes it easier for the client to reintegrate back into society after completing the rehabilitation program. An out-patient drug addiction treatment programme is not for everybody. Most clinics will have strict guidelines on who is eligible to join their program. Motivation to stop using is a key requirement for eligibility as well as the ability to stay clean for at least a few days at a time. Because the unit is not residential they are able to save many costs which are passed on to the client. It is no less effective than in-patient therapy for those who are admitted onto the program. This makes out-patient therapy an affordable and attractive option to many.

In the next chapter the researcher will investigate how social workers employed by The Department of Social Development contribute to the rehabilitation of adolescent boys who are addicted to drugs.

CHAPTER 4

RESEARCH FINDINGS FROM THE EMPIRICAL STUDIES REGARDING VIEWS OF SOCIAL WORKERS ON THE NEEDS OF ADOLESCENT BOYS WHO ARE ADDICTED TO DRUGS

4.1   INTRODUCTION

South Africa faces a crisis with drug abuse especially under adolescents and more specific adolescent boys (Van der Westhuizen, 2008). More and more adolescents experiment with drugs and become addicted. Reality is that very few of these adolescents get help and become early school drop outs which result in adults who are not educated and therefore will not be able to lead a meaningful life. They might end up on streets and that can lead to death as was discussed in chapter one. The researcher will indicate in this chapter the scope of the problem of addicted adolescent boys and how social workers render relevant services. The Drug Master Plan (2006-2013) emphasizes the scope of this challenge. Social workers do offer a valuable contribution to address the issue of drug addicted adolescent, but face several challenges as will be presented below. Most of them indicated that they only refer cases to rehabilitation centres and have to wait very long for vacancies, since Rehabilitation Centres in the Western Cape have limited space and there are only a few of them.

In some areas there are limited resources. Private Rehabilitation Centres are very expensive and do not serve any course to the needy clients. The participants mentioned that they are not trained and do not feel capacitated enough to render an effective service to the addicted adolescent boys. Participants mentioned that they need training on a regular basis as will be discussed consequently.

4.2   DELIMITATION OF THE INVESTIGATION

From working in the social worker field the researcher has gained personal experience and became aware of the fact that social workers face certain challenges when rendering services to drug addicted adolescent boys. A literature study was conducted to gain more insight into

different rehabilitation programmes that could be utilized in the field of rendering services to drug addicted adolescent boys, since this is such a challenging situation in South-Africa, as was discussed in previous chapters. The Matrix Model was used for this purpose, as well as the Prevention of and Treatment for Substance Abuse Act 70 of 2008 and the Purification Programme of Hubert and other crucial documents. The majority of the literature used was of South African context, but the researcher also used literature of other countries to show that the problem of drug addiction is worldwide.

Both quantitative and qualitative research was utilized in order to gain a clearer understanding of the contribution of social workers to the rehabilitation of adolescent boys who are addicted to substances. The sample consisted of 20 participants and sufficient data was collected to provide the researcher with the necessary information.

4.3   GATHERING AND ANALYSING DATA

The twenty participants were selected because of the fact that they are employed by the Department of Social Development and are daily confronted with adolescent boys who are addicted to substances. This coincides with the views of De Vos *et al*. (2011:201) who state that a purposive sample is composed of elements that contain the most characteristic and representative attributes of the population. All 20 participants were able to reflect on their experiences in their own words and from their own perspectives. All participants are from the Eden Karoo and more specific, Riversdale, Mosselbay and George. Ethical clearance was obtained from the University of Stellenbosch (Annexure A). Permission was gained from the Department of Social Development (Annexure B), as well as permission from the participants (Annexures C and D) to participate in the study. A pilot study was conducted with three participants who are rendering services to adolescent boys who are addicted to substances. The purpose of this exercise was to ascertain whether the questions were clear and easily understood. By conducting a pilot study, the researcher was made aware of shortcomings and amendments were made to the research instrument (De Vos *et al*., 2011:237). Data were collected by means of semi-structured interviews. The questionnaire consisted of open- and closed ended questions. The open-ended questions allowed interviewees to express themselves freely about their experience in rendering services to these adolescents (De Vos *et al*., 2011). The questionnaire was based on the information gathered from the literature

review in chapters two and three. The descriptive design was applied to provide an in-depth description of the nature of adolescents who are addicted to substances (De Vos *et al*., 2011).

De Vos *et al*. (2011) explain that a combined research study can be described as a study where the researcher can use different methods of data- gathering and analyzing. The study explored the contribution of social workers who are employed by the Department of Social Development regarding adolescent boys who are addicted to substances. The interviews were conducted during June/July 2015 and were 45 minutes to an hour long. The researcher explained that complete confidentiality would be maintained and consent forms were explained and then signed by both parties. Participants were encouraged to ask for better explanation if the questions were unclear. The audio recordings were transcribed shortly after the interviews took place.

The researcher collected the data for analysis. The responses on the interview schedules of all twenty social workers were reviewed and evaluated individually. The confidentiality of the data was maintained to protect the views of the participants (De Vos *et al*., 2011:119). The transcribed data will be presented schematically and identified themes, sub-themes and categories will be presented in tables throughout this chapter. Narratives that best voiced the experience of participants and reflect the captured essence of the themes were chosen and are provided in this chapter as well.

Table 4.1 provides a synopsis of the relevant themes, sub-themes and categories that were identified.

Table 4.1: Schematic representation of Empirical Study

THEMES	SUB-THEMES	CATEGORIES
1. Identifying Details	1.1 Highest qualification in social work 1.2 Years of experience 1.3 Training in drug addiction	
2. Adolescents and drugs	2.1 Reasons why adolescents use drugs	• Individual characteristics • Exposure to violence • Family uses drugs • Peer group • Gangs • Other
	2.2 Drug of choice for adolescent boys	• Tobacco • Alcohol • Cannabis • Other
	2.3 Primary Care Taker	• Mother • Father • Family members • Foster parents
	2.4 Reasons for leaving school	• Crime • Substance abuse • Other
3. Legislation	3.1 The Prevention for and Treatment for Substance Abuse Act 70/2008	• Positive • Negative
4. Intervention	4.1 Programmes	• Type: Prevention • Early Intervention • Rehabilitation: Matrix Model • Aftercare Programme • Detox Programme • Relapse Programme
	4.2 Effectiveness	• Positive • Negative
	4.3 Challenges	• Lack of motivation • Family support • Lack of resources • Community drug use

4.4   RESULTS OF INVESTIGATION

Findings of the study will be discussed under the following themes:

Theme 1: Identifying details

Theme 2: Adolescents and drugs

Theme 3: Legislation

Theme 4: Intervention

4.4.1 Identifying details (Theme 1)

In Table 4.2 below, the profiles of the participants are illustrated, which is followed by an analysis and interpretation of data. A set of questions were asked of each respondent during the interviews to determine these profiles. The biographical profile of the social workers include the years of experience being a social worker, the highest qualification in social work and drug addiction training attended.

Table 4.2: Profile of the participants

YEARS OF EXPERIENCE	Frequency (n=20)	Percentage (%)
0-5 years	10	50
6-10 years	3	15
11-15 years	5	25
16-20 years	2	10
HIGHEST QUALIFICATION		
BA Social Work (3 years)	5	25
BA Diac Social Work	5	25
BA Social Work (4 years)	6	30
Honours BA S.W.	3	15
MA Social Work	1	5
TRAINING IN DRUG ADDICTION		
At University while studying	8	40
In service training	2	10
Workshops	3	15
No training	7	35

N=20

4.4.1.1   Years of experience as a social worker (Sub-theme 1.1)

Ten participants (50%) have between 0-5 years' work experience as registered social workers; three participants (15%) have between 6-10 years' work experience; five participants (25%) have between 11-15 years' experience and two participants (15%) have 16-20 years' experience. From the above mentioned information, it is clear that 50% of the participants have between 0-5 years of experience as a social worker. This can be regarded as very little experience, as drug addiction has overwhelming effects on individuals, families and societies. The social work role is primarily about making decisions concerning other people's safety and well-being. These decisions made by individuals and groups have the potential to significantly impact on the future of vulnerable people and their families for better or worse. The world within which social workers practice is complex and the available information is rarely complete or certain. The social work profession claims expertise in the assessment of need and the planning of services, but it is surprising that there are few texts relating to the theme of decision-making. The concepts of critical thinking and informed or evidence based practice are better served, but it is important that practitioners are equipped with a detailed understanding of the process by which decisions are made. Fisher and Harrison (2013) state that drug misuse is widespread and a growing problem in Southern Africa. This epidemic will have an increasing impact on mental and physical health. The social work profession in South Africa has experienced a critical decrease of social workers. The retention of social workers is challenging not only for South Africa, but also for many different countries, such as the United States of America and the United Kingdom (Vermeulen, 2008:01). South Africa has also experienced a drastic shortage of social workers, which has affected many social welfare organisations. Not only has it contributed to high case loads, but it has also lowered the visible means of support that social workers provide in the community, with regard to families as well as foster care. According to the report by the Department of Social Development (2009:02), the shortage of social workers further contributes to a lack of capacity to implement policies and programmes that deal with social issues such as substance abuse. The participants mentioned that it is expected from them to work integrated and that it is impossible for them to gain enough experience in working with the addicted adolescent boys.

4.4.1.2 Qualifications of social workers (Sub-theme 1.2)

Seven participants (35%) indicated that they have a BA Social work Degree (4 year). Five participants (25%) indicated that they have a BA Diac Social work Degree. Four participants (20%) indicated that they have a BA Social work Degree. One participant (5%) indicated that she has a MA Social work Degree. Three participants (15%) indicated that they have an Honours BA Social work Degree.

4.4.1.3 Social workers who attended training in drug addiction (Sub-theme 1.3)

Eight participants (40%) indicated that they only had substance abuse training at a University or College. Two participants (10%) indicated that they had in-service training. Three participants (15%) said that they attended workshops. Seven participants (35%) indicated that they did not have any training in drug addiction. The social workers who said that they received training as part of the social work course mentioned that the training was not intensive and it is not enough in order for them to be fully equipped to render an effective service to the adolescent boy who is addicted to drugs. The six social workers who said that they did receive training also mentioned that they are not trained enough to render an effective service to these adolescents. The participants, who said that they did not receive any training, mentioned that they refer the clients to rehabilitation centres or organisations who render a specialized service in terms of drug addiction. Participants indicated that they need specific training and on a regular basis. They mentioned that only some social workers get training.

The following narratives indicate how participants viewed training in the substance abuse field.

P1 – "Social workers need more training about substance abuse, specifically for after care, early intervention and relapse prevention."

P2 – I think there must be a lot more training and that must be a specialized area, because it is really a big problem".

P8 – "All social workers are not trained to rendered services to these clients. I think it is important that social workers must be trained, because drug addiction is involved in all aspects of our work".

P13 – "I think more attention should be given to drug addiction, because it is the cause for most problems in our communities. Social workers need to be trained regularly in order to stay aware of new developments".

Goodman (2007) stresses the importance of specialist social workers in treating substance abuse and dependence in the workplace and adds that social workers must have the necessary techniques and skills to engage effectively with clients who have substance abuse problems. Goodman (2007) also mentions that Ray Jones, Chair of the British Association of Social workers, also believes that the core values and competencies of social workers are needed when working with substance abusers.

4.4.2 Adolescents and drugs (Theme 2)

4.4.2.1 *Reasons why adolescents use drugs (Sub-theme 2.1)*

A question was asked as to what participants think are the reasons why adolescents use drugs. A list which consists of reasons, such as individual characteristics, exposure to violence, family involvement in drug use, peer group, exclusion from systems, gang involvement was provided and participants could choose more than one reason. They were also given the opportunity to add any reasons not mentioned by the researcher. The findings are tabled below.

Table 4.3: Reasons why adolescents use substances

REASON	PARTICIPANTS	PERCENTAGE
Individual characteristics	8	40%
Exposure to violence	5	25%
Family involvement in drug use	8	40%
Peer group	19	95%
Exclusion from systems	2	10%
Gang involvement	9	45%
Absent fathers	2	10%
Total	53	

N=20
Participants could give more than one answer.

The areas of reasons will now be discussed.

(a) Individual characteristics:

Eight participants (40%) said that individual characteristics are possible reasons why adolescent boys use substances. They feel very strong that the adolescent should make their own positive decision and cannot allow others to decide for them irrespective home circumstances or irresponsible parents. Individual factors include low self-esteem, poor self-control, inadequate social coping skills, sensation seeking, depression, anxiety and stressful life events. Certain specific risk factors could include being male: Whether one is male or female makes a difference when considering the risk of drug use. It is generally the case that in the majority of countries more men than women use drugs. Being young is another possible reason why substances are used. When one is young, one is often constantly struggling to define and affirm identity. In the course of this process young people often start experimenting as part of their search for an identity. They may use substances in order to define their belonging to a particular group or to relieve feelings of anxiety or stress in this 'search for the self'. However, while the transition, instability and change which characterize adolescence may well make the adolescent vulnerable to some degree, it is dangerous to think of adolescence as being the cause of drug taking (The Cape Town Drug Counseling Centre, 2004).

The views of the participants are as follow:

P1 – *"Some adolescents are more capable to be exposed to drugs and I think it all depends where you stay".*

P8 – *"I believe that adolescents should use their own mind and do what they know is right. They must not allow others to decide or influenced them. One always has the ability to stand up for oneself.*

Watson and Kedge (2004:46) state that everyone has to make choices and decisions in life. As you get older you have to start taking responsibility for yourself. Sometimes decisions are easy and sometimes they are hard. But adolescents have to make up their own minds, the choice are theirs.

(b) <u>Exposure to violence</u>:

Five participants (25%) said that these adolescents were exposed to violence and that it can also be a reason for using drugs. There is risk if the young person is being abused mentally, physically or sexually (The Cape Town Drug Counseling Centre, 2004). Exposure to violence can motivate an individual to seek coping mechanisms in order to avoid distress. Substance usage may be utilized as means of dealing with the distress caused by exposure to violence (Kilpatrick *et al.*, 2000:02).

This correlates with the views of some of the participants:

P 15 – "*Some of my clients were beaten up by their father.*"

P6 –"*I think it is most of the time parents' home where family violence occurred or the example that parents set, or fetal alcohol syndrome where children are born addicts*".

(c) <u>Family involvement in drugs</u>:

Eight participants (40%) mentioned family involvement in substance use as another reason. According to The Cape Town Drug Counselling Centre (2004) a family member may have a substance abuse problem. Aaron (2013) agrees that parents who are involved in substance abuse can also be a reason why adolescents start using drugs. The author is of opinion that not all parents who use alcohol or drugs mistreat their children. Research however suggests that parental substance misuse can adversely affect attachment. Glimpses into the world of children with substance- misusing parents come from two main sources. The first is accounts from adults who have grown up with such parents and are recalling their experiences and emotions at a distance and the second source springs from accounts gained from children themselves in the present or recent past (Aaron, 2003). Such risks would include family disruption, ineffective supervision, criminality and drug use in the family. According to the Cape Town Drug Counselling Centre (2004), risk is involved if a young person is homeless or does not have a secure family environment. It is also present if the family does not take care of the youth emotionally or physically, or does not provide appropriate support and guidance. Aaron (2013) agrees and said that family disruption, inconsistent negative parenting, poor attachment, low parental involvement; poor parental monitoring, psychological trauma, and impulsiveness also lead to adolescents using drugs.

P6 – "The example that parents set are not positive and resulted into adolescents follow them, and because of the fact that mothers are using alcohol when they are pregnant it happened that these adolescent born with the symptoms of fetal alcohol syndrome, which is the reason why they cannot make good progress at school and get involved in substances and alcohol".

P12 –"It is very difficult to change their minds, because most of their parents or family members are using too".

Biddulph (2003:71) agrees that reasons why adolescents also try drugs and alcohol are the absence of values that teach a healthy sense of right and wrong relating to alcohol and substance abuse and misguided values that condone the use of alcohol or other risky behaviour. The author further states that adolescents who have parents who are alcoholics are at risk to also become addicted because of genetic inheritance.

(d) <u>Peer group</u>:

Nineteen participants (95%) feel very strongly that peer group pressure is the greatest reason why adolescents use drugs. Kliewer and Murrelle (2007) mention that one of the most salient risks for youth drug use is associating with drug abusing peers. The most important reference groups for a young person in the community are often his peers. Social interaction with friends and peers may thus provide opportunities for drug use or may encourage or support this type of behaviour. Part of the transition during adolescence involves moving from reliance on the family to individuality. Here peer groups come to replace family as a social support mechanism which can be a turbulent emotional time. Because the peer group is seen as such a vitally important support mechanism for the adolescent, he or she may go to great lengths to maintain acceptance and status in it (The Cape Town Drug Counseling Centre, 2004). According to Leach and Kranzler (2012:192) in some cases peers were found to have had a greater influence on learners initiating substance use than the family, school and media among learners. Anyone can become addicted at any time of their lives, but the adolescent period is perhaps the most critical time in a person's life. However, it is adolescents who are the most vulnerable, not only to social pressure to experiment with addictive substances, but also more vulnerable to the damage those substances can cause. Their minds and bodies are still developing, so adolescent drug use can progress into addiction faster than in adults. Also

because of this development period, addiction can wreak more havoc on the adolescent brain, as well as on the adolescent's body as was discussed in chapter two (Winters, 2008).

P1 – "I believe that adolescents are more attached to their friends then to their family that's why I say peer pressure".

P5 – It is quite difficult to attend to this, because the children influence each other".

P20 – "Peer group pressure leads to drug addiction".

(e) <u>Exclusion from systems</u>:

Two participants (10%) said that one of the reasons can also be the fact that these adolescents are excluded from systems which lead to adolescents not getting the necessary support in their personal development. Having few or no opportunities for education or demonstrating poor school attendance has been shown to contribute to a higher risk of using drugs. Note, however, that some school drop outs may have entirely satisfactory academic records but have still become alienated from the school system. Youth who are homeless or have a tenuous home connection often adopt high-risk lifestyles which can include drug use. Situations where there are few or no job opportunities have been associated with the risk of drug abuse. Related to both these risky school and work settings may be an abundance of free unstructured time in which there are no constructive, imaginative and challenging activities to take part in (The Cape Town Drug Counseling Centre, 2004). Exclusion may be experienced in other social arenas, such as failure to engage with educational institutions. Individuals may be at a higher risk of using substances if their school functioning is substandard, or if they have experienced victimization. Harker *et al*. (2008:25) state that a correlation exists between drug usage and school dropout.

P3 –"In the rural areas are a lack of rehabilitation centres and a lack of programmes".

P8 – "Clients in the rural areas do not have resources and that leads to early school dropout and drug use".

(f) Gang involvement:

Nine participants (45%) mentioned the fact that adolescents are involved in gang activities, which requires from them to use drugs. As was mentioned in chapter two the connection between substances and gang membership can be traced back through the history of gangs. It is suggested that post-Revolutionary War America saw gangs involved in the use and trade of illicit drugs (Bjerregaard, 2010). Within the South African context similar findings exist. Kinnes (2008:04) states that one cannot separate the South African gangs from drugs and mandrax trade. Substance abuse is said to be entrenched within gang activities in the Western Cape (Parry, 2004:180). Aside from dealing in drugs, gang members are the primary consumers of drugs (Legget, 2002:307). As a result of exposure and high consumption rates, drug usage has become normalized and ceases to be viewed as deviant by some South African communities (Standing, 2003:07).

P2 – "Gang involvement in Mosselbay is linked to tik".

P11 – "I believe that the fact that biological fathers are not part of some of these adolescents lives, that can also lead to their involvement in gangs".

P13 – "The adolescents involvement in gangs lead to drug abuse and also to crime. The older men use the children to sell drugs.

(g) Absent fathers:

Two participants (10%) were of opinion that the absent father is also a reason why adolescents use drug.

Participants views follows:
P1 – "The adolescent do not have a father figure to look up to and then they will maybe go to older men to confide in these men who are not always a positive influence".

P11 – "I noticed from my caseload the boys' specific, there are a lack or an absent father. They do not know the biological father or there's no relationship with the biological father so I thought that, that is also a reason why they finding a sense of belonging with the wrong crowd and experimenting with substance abuse to fill that void, because really most of them do not even have a relationship with the father and if you asked them about the father they

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became emotional. Some of them became angry, some of them cry and some do not want to talk about that. So I think the absentee of the father does play a role as to why they get involved with drugs".

According to Perlesz (2005:25) social workers should raise awareness among women regarding the importance of a father-son relationship by promoting the social and emotional reconnection of children with their fathers through collaborative explorations with clients around the particular roles fathers might play in their children's lives and which of the roles could be supported and enhanced. This suggestion is supported by the findings in Makusha *et al*. (2013:154) in which women expressed a wish for the fathers of their children to be emotionally available for their children as opposed to being "distant breadwinners" by providing financial support only.

From the participants views it is clear that there are definitely risk factors which contribute to adolescent drugs and alcohol use which lead to addiction. Kilpatrick *et al*. (2000) agree to the above mentioned and add also that sexual assault and posttraumatic stress disorder might be expected to have strong relationships with substance use behaviours. This was also mentioned in chapter two. According to Hall (2006) peer level risk impacted on adolescents strongly, but risk such as early life family dynamics can either increase the risk for drug use, given poor nurturing or ineffective parenting. Other important community level risk factors for drug initiation are access to and availability of drugs, drug trafficking patterns and normative beliefs that drug use is generally tolerated. Certain family and environmental factors may increase the risk for substance abuse such as disengagement from school, parents or other family members who have problems with alcohol and drugs, have difficulty monitoring their behaviour, or enhance the availability of substances (Kliewer & Murrelle, 2007).

4.4.2.2   *Drug of choice for adolescent boys (Sub-theme 2.2)*

Participants were asked about the drug of choice for these adolescents, according to their experience. The participants could choose from the following: tobacco, alcohol, cannabis and were also given the opportunity to add any other drug. The findings are as follows:
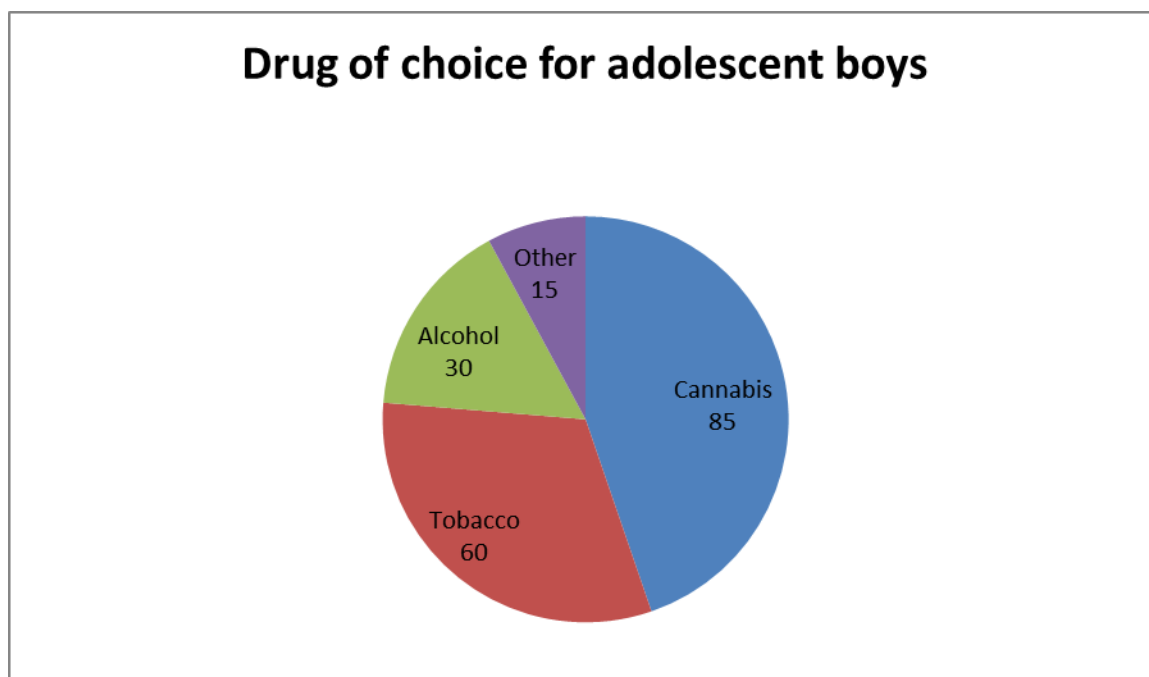
N = 20 – Participants could choose more than one answer.

Figure 4.1: Drug of choice for adolescent boys

(a) <u>Cannabis</u>:

Seventeen participants (85%) said that cannabis is the drug of choice. It is clear from the above mentioned figure that most adolescents make use of cannabis and it can be said that they are addicted to this drug as was mentioned in chapter two. Winters (2008) mentions that adolescents are vulnerable not only for the pressure of using, but also for the damage that these drugs cause. Walker (2009:51) indicated that the younger the user when they start using drugs, the greater the chances of becoming addicted and there has also been a trend towards hard drugs such as heroin and methamphetamine from an early age as was mentioned in chapter two. According to Koen *et al*. (2009) cannabis is currently the world's foremost illicit substance consumed. The authors furthermore state that cannabis is the most common illicit substance used by adolescents. According to Bottorff *et al.* (2009) participants reported using cannabis to deal with difficult feelings such as anger, disappointment, fear and anxiety. Participants appeared to lack effective coping mechanisms to manage uncomfortable feelings and thus relied on cannabis for relief.

The following narratives indicate how participants viewed cannabis as a drug of choice:

P16 – "Most of my clients use dagga and is from opinion that it is legal to use when you is a Rasta, so now they believe they are rastas and do what the rastas do".

P20 – "My clients smoke dagga, but they did not see it as a drug and reason that it is a plant/herb that grows in nature".

(b) <u>Tobacco</u>:

Twelve participants (60%) mentioned tobacco. The participants are from opinion that tobacco is a getaway drug and that adolescents do not regard it as a drug. Jordan (2010) also considers nicotine as a gateway drug and mentions that hard drugs are a significant health concern. Only two participants mentioned that their clients do not smoke tobacco, but the rest of the participants indicated that their clients do smoke tobacco.

P7 – "My clients started with tobacco and then started to use dagga".

P15 – "My clients do not realize that tobacco is a drug and is also no aware of the danger that cigarette smoking can cause".

P18 – "Almost every child on my caseload smoke tobacco, I think it is because the parents also smoke tobacco".

As was mentioned in chapter two the majority of adolescents are at Stages 1 or 2 of the proceeding model. An adolescent also often starts by experimenting of a gate away drug, such as tobacco and alcohol (Dodgen & Shea, 2000:38).

(c) <u>Alcohol</u>:

Six participants (30%) said that alcohol is the drug of choice. According to Aaron (2013) in rural and remote localities, cigarette smoking and excessive alcohol consumption are more prevalent than in cities. The Minister of Social Development, Ms. Dlamini states that "the emotional and psychological impacts on families, the high levels of crime and other social ills have left many communities under siege by the scale of alcohol and drugs (National Drug Master Plan, 2013-2017:2). According to Setlalentoa, Pisa, Thekisho, Ryke and Loots (2005) alcohol abuse has been shown to be a significant risk factor for domestic violence, although the relationship is complex. Drinking has frequently also been associated with intra-family

violence. Alcohol abuse and misuse could lead to stress and anxiety. According to Biddulph (2003:29) adolescents tend to feel that they must drink alcohol, because everybody else does it.

P8 – "My clients are using tobacco, cannabis, alcohol and tik".

P15 – "The adolescents grew up with the thought that it is ok to use alcohol, because community members and even parents use alcohol in front of the children and they abuses it and they do not teach the children about the limits of drinking".

P17 – "I really think that more structure should put in place where it comes to alcohol abuse, because the children has been exposed on a daily basis to alcohol abuse in the house and in the community".

(d) <u>Other</u>:

Three participants (15%) mentioned mandrax and methamphetamine.

P7 – "Some adolescents only use alcohol and cannabis if they do not get hold of methamphetamine."

P8 – "My clients use tik and mandrax. They are also using tobacco and dagga, but do not see it as a big deal".

The prevalence of rate for use of other illicit drugs varied form 2% of a sample reporting that they smoke "white pipe" (mandrax and dagga) to 5.7% of grade 11 males who reported usage of mandrax. Other substances were methaphetamines (Visser & Routledge, 2007).

4.4.2.3   *The primary care taker (Sub-theme 2.3)*

The participants were asked who the primary caretakers of adolescent boys are. Caretakers such as mother, father and family member were listed. The participants were given the opportunity to add any other caregiver which the researcher did not add. The findings are outlined below:
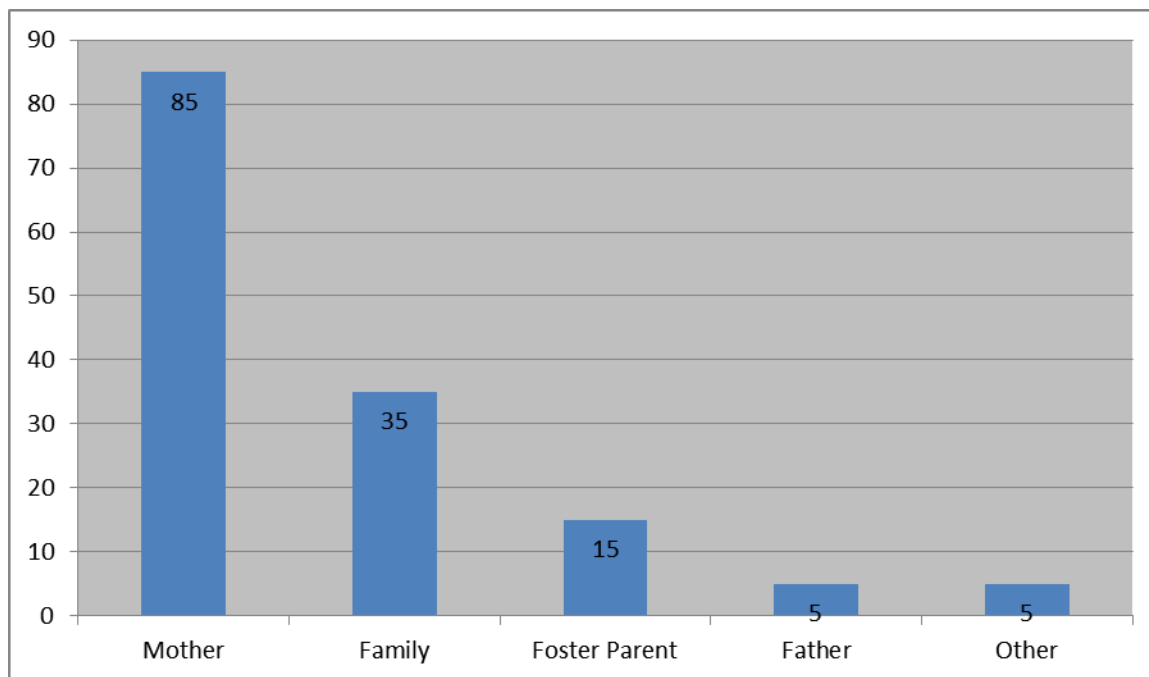
N=20 Participants could choose more than one answer.
Figure 4.2: The primary care taker of the adolescent

(a) Mother:

Seventeen participants (85%) indicated that the single mother is taking care of the adolescent. According to Smith and Estefan (2014:422) women often carry the full responsibility of child rearing and homemaking, which, over time, result in neglect of their own needs and identity. Women often seek to emulate "normal" mothering behaviours to maintain an appearance of a normal family, while men might work long working hours, limiting their involvement with family. These so-called normal mothering behaviours exist in tension with adolescent development and maturation, a process that involves the generation and resolution of conflict, social experimentation, and differentiation from parents. These tensions between mother and adolescent have, historically, created problems for women who seek to parent in ways that are viewed appropriate and acceptable, and for adolescents who are seeking increasing autonomy to express themselves as individuals (Smith & Estefan, 2014:423). The participants are from opinion that the absent father can also be a reason why adolescents get involved in drug use.

The following narratives illustrate where participants viewed the mother as the primary caretaker.

P1 – "Most of the time it is the mother, the father figure is most of the time absent".

P9 – "I believe that single mothers should make the fathers who do not want to take responsibility of the child, responsible by using the law. It is clear that children need their fathers also in their lives".

P20 – "The mother is the primary care taker and act as a single parent".

   (b) <u>Family members</u>:

Three participants (15%) mentioned family members which normally included an aunty as the primary caretaker. Four participants (20%) indicated that it sometimes is the grandparents, perhaps both grandparents or one of the two – grandfather or grandmother.

Compared with peers living in traditional intact families (two married biological parents), adolescents living with family or grandparents engaged on average in higher levels of anti-social behaviour (ranging from running away from home, being suspended from school and substance abuse to committing minor property crime, engaging in violent behaviour and being arrested (Apel & Kaukin, 2008).

The participants indicated as follow:

P4 – "The mother, a family member most of the time grandparents".

P15 – "Most of the time a maternal aunt or grandpa and grandma".

P16 – "Sometimes parents leave the children with the grandparents to look for a job and then it happen that the parent got another partner and build a life together and exclude this child, who then remain in the care of the grandparents. These children most of the time feel rejected by the parents who cause hurt and can lead to drug use".

   (c) <u>Foster parents</u>:

Three participants (15%) mentioned that foster parents can also be the primary caregiver.

According to Kools (2010) foster care placements for children and adolescents include foster care outside the biological home. Foster care placement is most often precipitated by stressful family circumstances that endanger the child and/ or deem the biological parents unable or

unavailable to adequately care for the child. These include child abuse and neglect, parental substance abuse and family homelessness. It has been suggested that growing up in foster care has multiple negative consequences for the child including poor academic achievement, behavioural and emotional problems and health related problems.

Participants viewed the following:

P10 – "It can be the mother and sometimes the foster mother".

P14 – "The foster children is a huge problem when they start using drugs the foster parents are not willing to take the responsibility of the child and it is difficult to find alternative placement".

P16 – "I do appreciate people who are willing to act as foster parents for the children, but it is not always the answer, because children sometimes start with behaviour problems, because they long for their own family".

(d) Father:

One participant (5%) mentioned the biological father as the primary care giver.

P8 – "Some of my clients live with the father."

The concept of father involvement is regarded as a multidimensional construct that includes effective, cognitive and ethical components, inclusive of indirect forms of involvement (Castillo, Welch & Sarver, 2010; Hawkins, Bradford, Palkovitz, Christiansen, Day & Call, 2002; Kelly, 2007). Father involvement specifically refers to the quality of the father-child relationship and is conceptualized to include positive involvement in the child's activities (e.g. homework and school), the strength of the emotional tie between parent and child (e.g. feelings of closeness and positive relationships), authoritative parenting (e.g. effective discipline and parental guidance) and positive effective relationships (Kruk, 2010).

(e) Street children:

One participant (5%) indicated that children prefer to live on the street while they have parents. According to Setlalentoa *et al.* (2005) children live on the streets for a variety of reasons. Some would do so as an escape from reality or as a coping mechanism because of

family disorganisation, divorce, poverty, loneliness, boredom, unemployment and crime. The authors agreed that South Africa is equally plagued by this problem of children leaving home to live on the streets and start sniffing glue, smoking cannabis, using other drugs and using and misusing alcohol.

P6 – "In my experience I saw that children do have families, but they prefer to live on the streets with the friends and also because the families do not have food or money to provide for them".

According to Mans (2000) adolescents live on the streets because of abuse by parents, drinking and drug taking by parents as well as economic difficulties and the inability of parents to raise money to provide for the children.

4.4.2.4   *Reasons why adolescents leave school (Sub-theme 2.4)*

The participants were asked if the reasons for leaving school early are drug related. The findings are outlined below:

Reasons for leaving school

■ Substance   ■ Crimnal   ■ Other
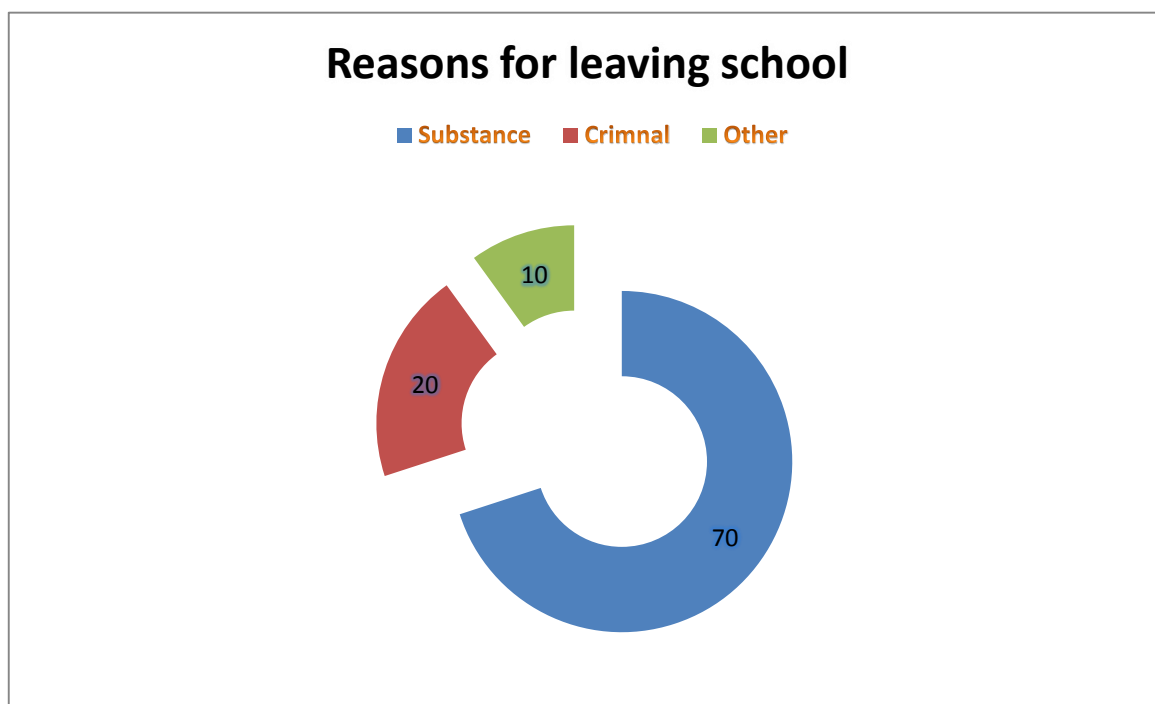
N=20

Figure 4.3: Reason for leaving school

(a) <u>Substance abuse</u>:

Fourteen participants (70%) agreed that the reasons for leaving school are drug related, because some adolescents use drugs and therefore lose interest in school work. They are awake late at night and loose track of time which results in them not to attend school regularly or is not on time for school. They also sell drugs on school premises and get expelled from school. The use of drugs also causes behavioural problems which cannot be controlled by the parents or school staff members. From the findings it is clear that the main reason for adolescents to leave school is drug related.

P13 – "Parents cannot control their children's behaviour, because of drug use".

The adolescent who is becoming dependent on dagga is likely to show a number of other behavioural and attitude changes. There is likely to be deterioration in school marks, employment and academic achievements. They will show extreme mood swings and often exhibit more aggression than usual (Biddulph, 2003:35). According to Hall and Degenhard (2009) research has found that substances negatively effects attention, memory and learning, even after the short-term consequences of the drug recede. Substances are linked with dropping out of school and subsequent unemployment, social welfare dependence and an overall feeling of inferior life satisfaction compared to non-cannabis using. These results remained significant even after controlling for family socio-economic background; family functioning; exposure to child abuse, childhood and adolescent adjustment; early adolescent academic achievement and comorbid mental disorders and substance use (Hall & Degenhard, 2009).

The author's views correlated with these of the participants.

P1 – "They leave school early, because of their addiction they are not willing or motivated to go to school".

P8 – "Clients were expelled from school because they sold drugs at school and could not concentrate on school work, because of drug use".

P14 – "They lost interest in school work and due to the fact that they, after using tik did not sleep at night they are not on time for school and lost track of time and what is important in life".

According to Lennard-Brown (2004:35) cannabis reduces the ability to concentrate and to control movements and make fine adjustments. It also affects the perception of time and space.

   (b) <u>Criminal activities</u>:

Four participants (20%) mentioned that the adolescent get involved in criminal activities which is the cause of leaving school on a young age.

P2 – "The child got involved in criminal activities, because they rob and steal to get money to buy drugs".

P6 – "There is a lot that happen to these clients they come in conflict with their family, they committed crime by stealing and they do not work".

According to Watson and Kedge (2004:32) drug users end up stealing, even from friends and family. One thing leads to another and serious crimes are committed. It might just start with taking their mum's cigarettes but things can quickly get out of control. Nothing will stand in the way of people getting the drugs they need.

   (c) <u>Other</u>:

Two participants (10%) said that poverty and a lack of future vision also are reasons as to why adolescent boys leave school on an early age.

According to Lenard-Brown (2004:32) several studies showed that babies born to women who used cannabis or alcohol during pregnancy tend to weigh slightly less than other babies. The substances can pass to the baby from the mother and the child may have long- term memory and learning problems. This is a result as to why children are not able to progress at school and seem not to have a future vision.

P7 – "They do not think that far of their future all that matters is their lives now, their friends and they are definitely not career wise, so it's difficult to get them motivated and to work with them as they do not trust easily".

P11 – "They do not have a future vision and poverty".

Mans (2000) agrees to the views of the participants saying that economic difficulties are also major reasons why many children drop out of school since they are obliged to seek some kind of work to contribute to the family income.

4.4.3 Legislation (Theme 3)

4.4.3.1 The Prevention of and Treatment for Substance Abuse Act 70 of 2008 (Sub-theme 3.1)

The purpose of the above mentioned act is to provide for a comprehensive national response for the combating of substance abuse; to provide for mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and re-integration programmes; to provide for the registration and establishment of treatment centres and for their treatment, rehabilitation and skills development in such treatment centres; to provide for the establishment of the Central Drug Authority; and to provide for matters connected therewith.

(a) Negative:

The question was asked if the Prevention of and Treatment for Substance Abuse Act 70 of 2008 is helpful as a guide. The findings are outlined below:
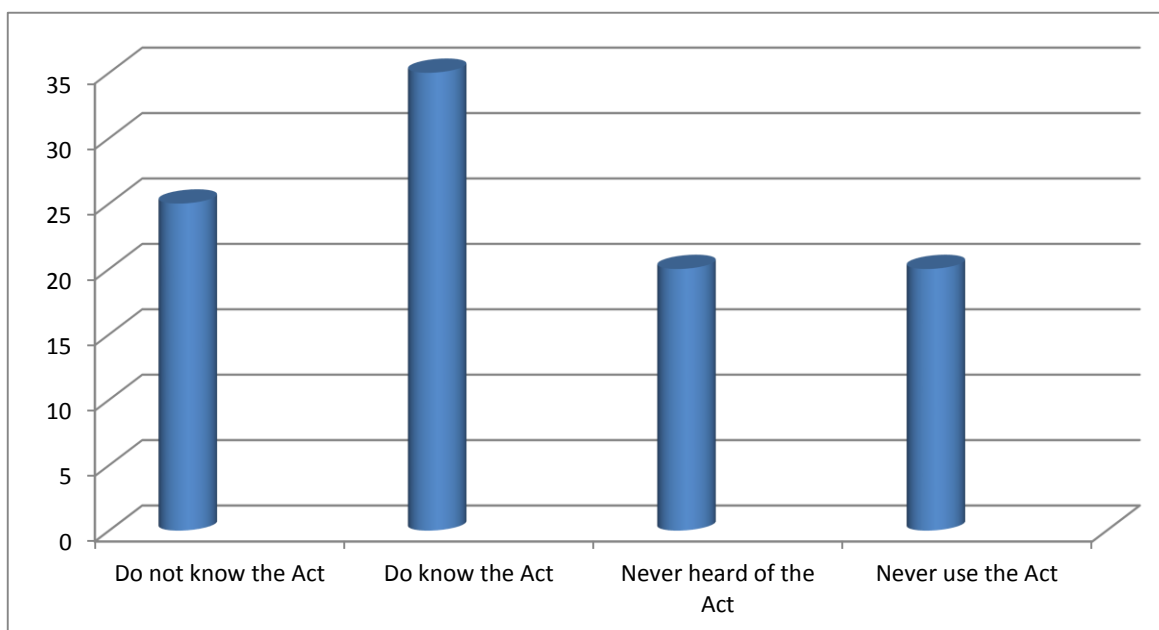
N=20

Figure 4.4: Are the Prevention of and Treatment for Substance Abuse Act helpful as a guide

Five participants (25%) said that they do not know the Prevention of and Treatment for Substance Abuse Act 70 and 2008. Seven participants (35%) said this Act is helpful and give guidance on how to deal with substances. Four participants (20%) said that they never heard of the Prevention of and Treatment for Substance Abuse Act 70 and 2008 and four participants (20%) said that they never used the Prevention of and Treatment for Substance Abuse Act 70 and 2008. The participants indicated that the stakeholders, who are supposed to work with the social worker to render a service to the client, do not know what their role is. According to the above mentioned it is clear that some of the participants do not know the Prevention of and Treatment for Substance Abuse Act 70 of 2008. They indicated that training is needed.

P9 – "*The Act is not implemented by all relevant stakeholders, so it does not have an impact on the program*". *If you refer a client to other resources like the hospital staff does not know what to do*".

P3 – "*I do not know the Act and never use it, I think they must train us in this Act*".

According to Strang *et al*. (2012) drug policy should aim to promote the public good by improving individual and public health, neighbourhood safety and community and family cohesion and by reducing crime. The effectiveness of most drug supply control policies is unknown because little assessment has been done and very little evidence exists for the effectiveness of alternative development programmes in source countries.

The respondents were asked how the Prevention of and Treatment for Substance Abuse Act 70 of 2008 impacted on the substance abuse programme that they are using. The findings are outlined below:
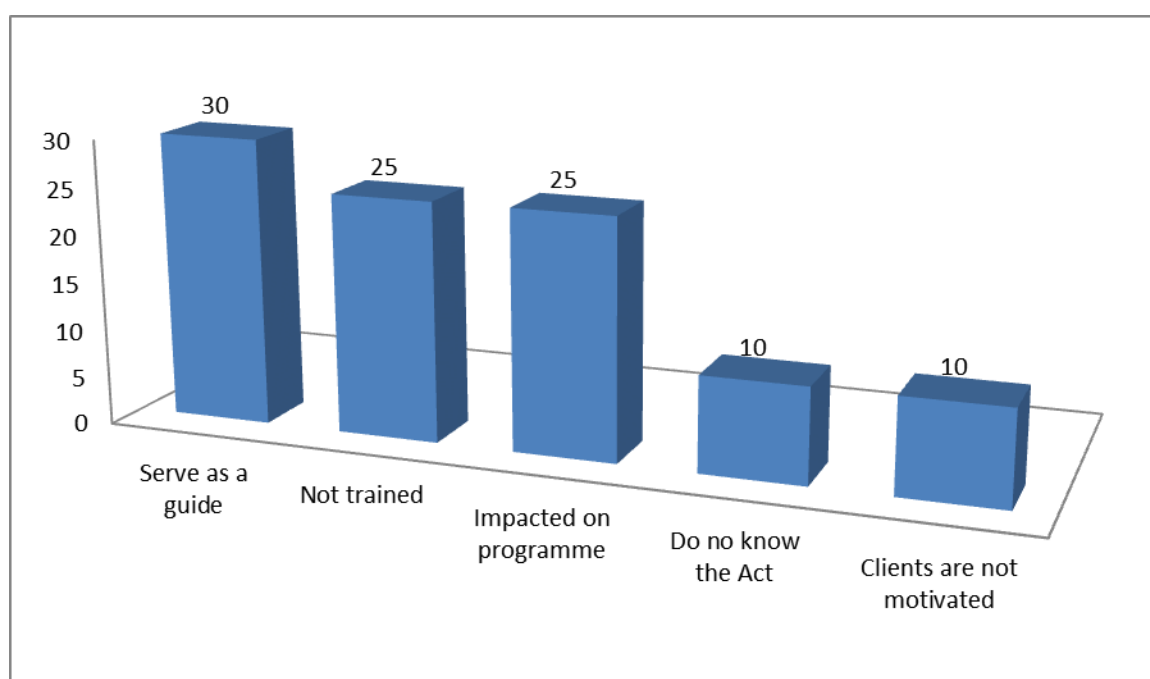
N=20
Figure 4.5: Prevention of and Treatment for Substance Abuse Act's impact on rehabilitation programme

(b) Positive:

Six participants (30%) mentioned that the Act serves as a guideline in the management of drug addiction. Five participants (25%) indicated that they were never trained about the Act and thus cannot use it. Five participants (25%) said the Act does impact on their programmes. Two participants (10%) said that they do not know the Act and never use it. Two participants (10%) said that if clients are motivated they will adhere to a positive lifestyle. The Prevention of and Treatment for Substance Abuse Act 70 of 2008 serves as a guideline in the type of

programmes and also regarding statutory work where a person needs to be committed to a rehabilitation centre.

P7 –" Yes the Act gives us guidance, it's a legal process that governs us and it did guide us".

P8 – "Yes it gives guidelines how to act so that you can know what your boundaries are, but it can also limit you as you look at the rehabilitation process as to who can go to rehab centres".

P11 – "I think it helps with the referral of clients, especially involuntary clients through court to rehabilitation centres".

P19 – "The Prevention of and Treatment for Substance Abuse Act 70 of 2008 serves as a guide and is helpful in the rendering of service to clients. The client was removed on a temporary placement to a Rehab centre according to this Act".

According to Strang *et al*. (2012) evidence of good scientific quality that can inform decision-making about drug policies that can be introduced, modified, expanded, reduced or stopped is examined. This includes scientific evidence for the likely benefits to randomized trials and quasi-experimental designs with similar control conditions.

4.4.4 Intervention (Theme 4)

4.4.4.1 Programmes (Sub-theme 4.1)

The participants were asked what programmes they use in intervention with these adolescents. The findings will be tabled below. The respondents could choose more than one answer and the findings will thus not add up to 100%.

Table 4.4: Programmes that's been used when working with these adolescents

Programmes	Participants	%
Prevention	10	50%
Early Intervention	12	60%
Rehabilitation	3	15%
After care	4	20%
Detox	1	5%
Relapse programme	3	15%

N=20 Participants could give more than one answer

(a) Prevention programmes:

The respondents also indicated that they do prevention programmes. Cannabis prevention efforts are critical because cannabis is often the first illegal drug used by youth. Preventing substance use before it begins not only makes common sense it is also cost-effective. Prevention programmes should enhance protective factors and reduce risk factors. Prevention programmes should be localized and community specific, addressing the actual problems and drugs threatening the community specific, the risk factors unique to the community and strengthening the community's identified protective factors (National Institutes of Health, National Institute on Drug Abuse, 2003). Historically primary and secondary prevention programmes targeting the individual have combined traditional educational/information approaches with a range of self-regulation and other skills, such as decision making, goal setting, stress management training, resistance training and life-skills training as was discussed in chapter three (Nevid *et al*., 2006).

The views of the participants are stipulated below:

P1 – "What I do I refer clients to rehabilitation centres and I also do prevention programmes".

P8 – "*I facilitate a Prevention programme at a school, but the children could tell me how the drugs been made and use. They know more than me about the drugs".*

(b) Early intervention programmes:

The findings show that most of the participants are doing early intervention programmes. The purpose of early intervention programmes according to the Intervention of and Treatment for

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Substance Abuse Act 70 of 2008 was discussed in chapter three. The respondents are from opinion that adolescents are exposed to drugs from a very young age and that early intervention and rehabilitation programmes are very necessary.

P17 – "I rendered an early intervention programmes, because most of the adolescents already use drugs".

P11 – "I refer the clients to the early intervention programme at the office I do not facilitate the programme myself".

    (c)   Rehabilitation programme – The Matrix Model:

Participants indicated that rehabilitation programmes is such a challenge as adolescents are not motivated to attend the programmes and to give up their drug negative life style. Six participants (30%) said that they heard of the Matrix Model. Fourteen participants (70%) said that they never heard of the Matrix Model. According to Rawson and McCann (2005:03) the matrix model is a multi-element package of therapeutic strategies that complement each other and combine to produce an integrated out-patient treatment experience. It is a set of evidence-based practices delivered in a clinically coordinated manner as a program. Many of the treatment strategies within the model are derived from clinical research literature, including cognitive behavioural therapy, research on relapse prevention, motivational interviewing strategies, psycho-educational information and 12-Step programme involvement. The Matrix Model is in detail discussed in chapter three and can serve as an ideal guideline for out-patient treatment.

P1 – "I heard of the Matrix Model, but don't use it".

P6 – "I never heard of the Matrix Model".

P9 – "I find the individual counselling and early recovery skills group most helpful when using the Matrix Model".

    (d)   Aftercare programme:

Four participants (20%) indicated that they render a aftercare service.

P1 – "I do not stop at sending them to the Rehab, but if they return I monitor them, I do home visits to see how they are doing. I sometimes supported them in getting a job and that's basically all that I'm doing".

P5 – "I think after care programmes are very important when clients come back from the Rehabilitation Centres. I think it is important that they participated in after care programmes. I refer them to AA groups".

A structured aftercare programme is regarded as an important component in the treatment plan for substance dependence and contributes significantly to abstinence (Doweiko, 2006:368; Eberlein, 2010:211; Hitzeroth & Kramer, 2010:114-115). The Prevention of and treatment for Substance Abuse Act 70 of 2008 describes aftercare as an on-going professional support to a client after formal treatment has been completed and is aimed at enabling the client to maintain sobriety and personal growth and enhance his self-reliance and proper social functioning. Aftercare is designed and carried out with the assumption that treatment does not end with the completion of the formal treatment programme.

(e)   Detox programme:

Most of the participants mentioned that they did not render a detox programme themselves. Only one participant (5%) indicated that she did a detox programme. The findings are tabled below:

Table 4.5: Detox programme

Out-patient		Percentage (%)
In-patient	14	70%
Community base service	3	15%
Other	1	5%
None	4	20%

N=20 Participants could give more than one answer

Fourteen participants (70%) said that they refer the clients to in-patient facilities which include the hospital or the rehabilitation centres. Three participants (15%) said that they refer the clients to organisations who render a community base service. One participant (5%)

indicated that she renders a detox service. From the above mentioned information it is clear that most of the participants do not render a detox service. Hubbard (2012) emphasizes the importance of detox and therefore developed a purification programme, which was discussed in chapter three. According to Hubbard (2012) clients need to get rid of the toxin in their bodies in order for them to totally rehabilitate from substance use.

One participant said the following:

P11 – "I refer clients to the hospital for three days and from there they went straight to the Rehabilitation Centre".

The National Drug Master Plan (2013-2017) states that The Department of Health and Social Development need to collaborate in rehabilitating drug-dependent persons. The main task of both these departments is to provide appropriate services to such persons while maintaining a high standard of care.

Another participant indicated the following:

P5 – "I refer the clients to CEF (Creating Effective Families) who renders a community based detox programme".

   (f)   <u>Relapse programme</u>:

The participants were asked if they provide relapse prevention training. Three participants (15%) said that they do provide the training, while seventeen participants (85%) indicated that they do not render the service. The findings are tabled below:

Table 4.6: Relapse programme

		Percentage (%)
Yes	3	15%
No	17	85%

N=20

From the above mentioned information it is clear that seventeen participants (85%) do not provide relapse prevention training. Only three participants (15%) indicated that they do

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provide relapse prevention training. Rawson and McCann (2005) regard the relapse prevention groups as the central component of the matrix model treatment package. They state that the purpose of the relapse prevention groups is to provide a setting where information about relapse can be learned and shared. The programme was discussed in chapter three.

P5 – "I do not render relapse prevention programmes".

P8 – "The clients relapse short after they come from the rehab centre."

P20 – "I facilitate relapse prevention programmes to prepare the client what to do and what not to do after rehabilitation".

According to Leach and Kranzler (2012:366) relapse after treatment for drug use disorders is a common problem. Marcus *et al*. (2012:178) indicate that 50% to 70% of adolescent patients are unable to remain abstinent during the first year after addiction treatment in Rehabilitation Centers. As was mentioned in chapter two, an important component of rehabilitation and treatment planning with individuals attempting to change an addictive behaviour is relapse prevention. Staying clean and sober and refraining from engaging in a particular behaviour is one of the biggest challenges that individuals face after completing a treatment programme or self-change. Although addictive behaviours represent a complex of genetic, physiological, sociocultural and psychological components, there are a number of models of the relapse process that give different weights to bio-medical and cognitive-behavioural constructs (Donovan & Marlatt, 2005:05).

An important component of rehabilitation and treatment planning with individuals attempting to change an addictive behaviour is relapse prevention. Staying clean and sober and refraining from engaging in a particular behaviour is one of the biggest challenges that individuals face after completing a treatment programme or self-change. Although addictive behaviours represent a complex of genetic, physiological, sociocultural and psychological components, there are a number of models of the relapse process that give different weights to bio-medical and cognitive-behavioural constructs (Donovan & Marlatt, 2005:05). This was also discussed in chapter three.

4.4.4.2   Effectiveness of programmes (Sub-theme 4.2)

The participants were asked if their programmes are effective. The findings are tabled below:

Table 4.7: Effectiveness of programmes

		Percentage (%)
Yes	7	35
No	8	40
Yes and No	3	15
Other	2	10

N=20

Seven participants (35%) said that the programmes are effective. Eight participants (40%) said that the programmes are not effective, because the clients use drugs again after the programmes. Two participants (10%) mentioned that they only refer the clients. Three participants (15%) said yes and no, because the clients remain sober for a while, but start using again. Some of the respondents are from opinion that the problem lies not with the program, but with the adolescents themselves. The ineffectiveness of didactic educational tactics is a serious challenge for mass media approaches and also many traditional community and classroom programmes. In many studies it has been shown to neither prevent nor delay drug use. Likewise a large-scale assessment of a mass media campaign to prevent cannabis use also showed that it had, at best, no effect and possibly increased use (Strang *et al.*, 2012).

P2 – "It is not effective, because we only focus on the individual, but should focus on the family too".

P4 – "The programmes must include the family of the adolescent, for them to gain insight and knowledge to handle or support the adolescent effective.

P6 – "We need more Rehabilitation Centres as well as programmes for the families too. I don't think families are aware of what drugs do to the adolescents so they do not support the child, but instead put them down and always remind them of their addiction. They do not realize that these children sometimes want to stop."

P10 – "The ideal should be that each boy should see by a disciplinary panel, with people who can address the emotional, physical, psychosocial and medical that result from drug use. The multi-disciplinary team should have a contingence plan and work with it. You cannot work in isolation with them you should go back to the family and address the issue that originally is the result of the drug use".

P16 – "The programme is not effective, because adolescents became easily demotivated and parents only support to a certain extend and when the parents became demotivated then it is very difficult to keep the child interested, because sometimes you need the parents' consent and their participation and I think that adolescents feel that if their parents don't care why should I".

P20 – "I do not think the programmes are effective, because although adolescents attend the programme they still using drugs".

4.4.4.3   Challenges when working with adolescents who are addicted to drugs

The participants were asked what the challenges are when working with these adolescents. Challenges included lack of motivation, family support, lack of resources and community drug use. The findings are outlined below:
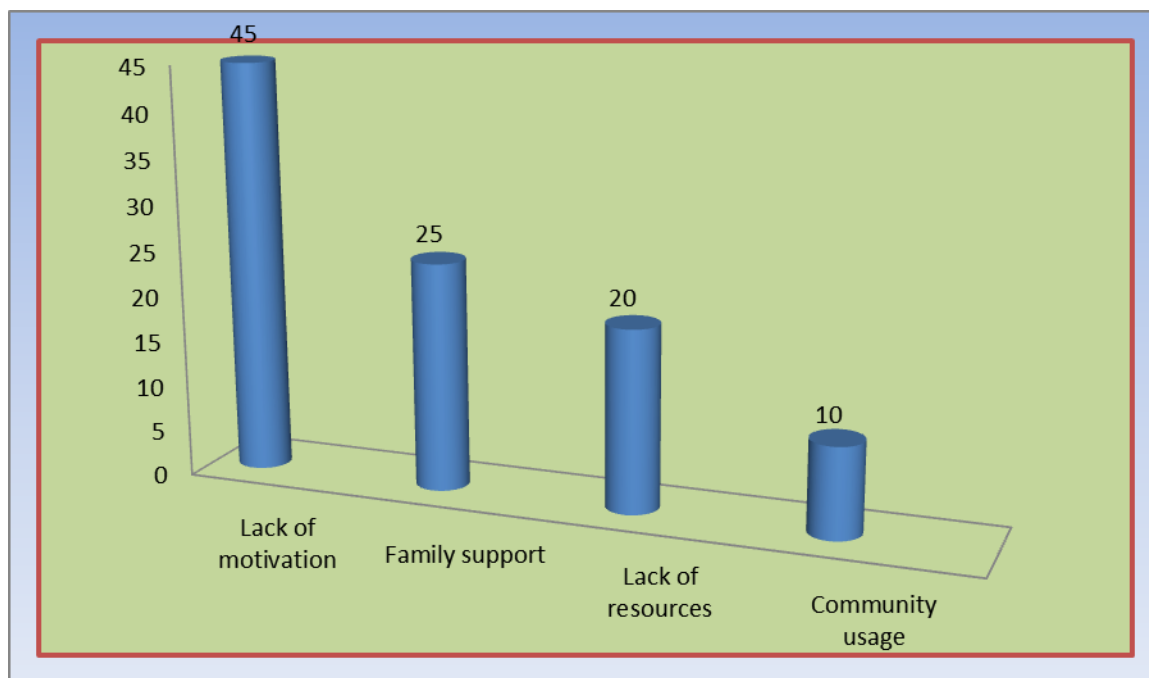
N=20

Figure 4.6: Challenges when working with adolescent boys who are addicted to drugs

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(a) <u>Lack of motivation</u>:

Nine participants (45%) are from opinion that the adolescents are not motivated to work on their drug addiction problem. According to the participants adolescents do not trust easily. Participants said that adolescents have been told about the dangers of drugs, but after they left they use again, they are not motivated enough to make sacrifices.

P7 – "The adolescents do not understand or grasp how substance abuse impacted on their lives and they are not career wise. They are not at a point where they want to change. They do not return to the program, which make progress difficult. The development stage of the adolescents is also a challenge, because they are moody".

P11 – "It is quite difficult to attend to this, because the children influence each other. So I think the main challenge is peer pressure and I think you must have a lot of time when working with these children. It is difficult to keep them motivated and it feels you do not make an impact and they are not honest".

According to Biddulph (2003:115) alcohol and drug addiction often disrupts important family relationships and adolescents' failure to fulfill their expected role can cause conflict, worry and pain to everyone. Addicted adolescents may fail or refuse to perform domestic chores. Their lifestyle changes can be annoying and disconcerting to family members. They may violate and even defy parental rules and treat parents with belligerence and disrespect when confronted. They may even run away from home and for extended periods cause parents to worry about their whereabouts and health.

P1 – "Clients are not all motivated to go for Rehabilitation; some only go because they do not want to go to prison. I think social workers who lack training are also a challenge".

According to Jarvis *et al.* (2005:255) adolescents do not usually seek for help voluntarily, they are highly likely to have entered treatment because they were coerced or persuaded by adults. The adolescent might see the social worker as just another authoritative figure. The adolescent may also find it hard to adjust to treatment that is designed for adult clients.

P7 – "The motivation levels amongst adolescents are relatively low. I don't think they fully understand or grasp how substance abuse impacted on their lives".

As was mentioned in chapter two, many adolescents feel entitled to experiment at this stage, as if they're expected to do so and therefore should do so. What many do not realize is that it's neither innocent nor harmless. To have fun can also be a reason. Getting drunk or high with friends sounds fun in the moment. What isn't fun about spending time with friends, sharing an intensely pleasurably drug-induced euphoria or the disinhibiting effects of alcohol? The silliness, the slurred words, the stumbling and the bizarre behaviour – all of those things can be very entertaining and make for great stories the next day (Promises Rehabilitation Centre, 2013).

P3 – "They have mood swings so you must always take their developmental stage in mind".

As was mentioned in chapter two, the adolescent years are often considered the most difficult period of a person's life. It's a vulnerable time of life as adolescents attempt to navigate the precarious bridge between childhood and adulthood. And one of the most challenging decisions for an age group that's ill-prepared to make difficult choices, is whether to start using alcohol or drugs. On the one hand, adolescence is a time of self-exploration (Promises Rehabilitation Centre, 2013). According to Biddulph (2003) adolescence can be a very difficult stage of development with extreme mood swings which are unrelated to drugs. Mood swings which are on-going and do not appear to be reactive to any event in their lives are more likely to be drug related.

(b) <u>Family support</u>:

Five participants (25%) said that the parents of the adolescents are not involved in the programmes and their lives. Parents do not have insight and knowledge about drug addiction. Adolescents do not have support.

Adolescents have been found to run away from their homes because of parental practices. Parents' guidance is therefore of the utmost importance – the nature of interaction, discipline and dealing with the child's behaviour and emotions have an impact on the success with which the developing child will negotiate challenges (Choudhury & Jabeen, 2008).

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P4 – "And the parents, I think they show this kind of behaviour, because of the parents that lack and these parents really need to come to the party".

P6 – *"Service delivery to these clients are very challenging as they are confronted with the pressure from their peers, socio-economic factors and the lack of support from family members".*

P4 – *"The parents do not have insight and knowledge regarding the challenges experienced by the adolescent".*

  (c) <u>Lack of resources</u>:

Four participants (20%) said a lack of resources is also a challenge. Adolescents have to go back to the same community after a program. Distance is also a challenge.

South African children are increasingly regarded as being in need of care. As indicated by Louw and Louw (2007) South African families are increasingly challenged by financial problems and poverty. Socio-economic factors, such as family income and living conditions, have an influence on children's development. Many South African children come from deprived homes and communities and consequently their parents do not have the means to provide them with educational toys, stimulate their language development or send them to preschool. Poverty can therefore be viewed as a factor generating children in need of care. Thus economic disadvantage may decrease their opportunities for peer companionship and hamper their opportunities for learning many of the social skills necessary to maintain positive peer relations.

P8 – "There are not Rehabilitation Centres in the Eden Karoo and Rehabilitation Centres in Cape Town are full and are situated far distances".

P3 – "In Eden Karoo is only Private rehab centres and our clients do not have R20 000.00 to R30 000.00 to pay for rehabilitation centres".

(d) <u>Community drug use</u>:

Two participants (10%) mentioned that the community is not rehabilitated and the adolescents need to go back to the communities where they come from after rehabilitation programmes.

P3 – "After rehabilitation clients need to go back to the same community where they use to use drugs".

P12 – "There is a lot of pressure of the community members regarding the abuse of substances. Children even use drugs in the school yard and it also effect children who do not use substances. So it also affected the safety of school children".

As was mentioned in chapter two, economic strain and community violence have been identified as playing a role in predicting drug usage (Fisher & Harrison, 2013).

P5 – "The individual is rehabilitated, but the community is not rehabilitated so the influence in the community is still big. So the community also needs to rehabilitate in order to reduce positive influence on the adolescent".

Families too have the ability to mediate and mitigate stresses experienced at the hands of neighbourhood and broader social contexts (Nevid *et al*., 2006). It would seem that in the case of drug usage, a lack of congruency between the individual and systems increases the risk of drug usage, as was stated in chapter two.

4.5   CONCLUSION

Within this chapter the experiences of twenty social workers who rendered services to adolescent boys were investigated and it was determined that they experience difficulties and huge challenges in working with these adolescents. Social workers indicated that they are not well- trained and are not capacitated enough to work with these adolescents. The different challenges and risk factors were emphasized. One could sense the hopeless feeling amongst the participants. It was evident that there is a lack of support in communities, as well as resources. It seems also as if parents and communities are not educated enough regarding the negative impact of substance abuse on adolescents. From the above findings it is clear that there is a huge need for social workers to be trained in the field of substance abuse.

CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

5.1   INTRODUCTION

The aim of this chapter is to present the findings from the empirical study that was conducted about the contributions of social workers who are employed by the Department of Social Development to drug addicted adolescent boys. Recommendations that could potentially improve service rendering to adolescent boys who are addicted to drugs and guidelines to social workers will be presented. A final recommendation for further research will also be made that stemmed out of the findings of the previous chapter and as far as possible is related to the findings and conclusions of this research study.

5.2   CONCLUSIONS AND RECOMMENDATIONS

The following section will constitute the conclusions and recommendations made as a result of the findings yielded by the empirical study (see chapter four). The format that will be followed will be in accordance with the layout of chapter four. The identifying details, adolescents and drugs, legislation and interventions will be concluded and followed by corresponding recommendations.

5.2.1 Identifying details

This section will discuss the years of experience as a social worker, highest qualification in social work and training in drug addiction entails the identifying details of the participants.

Conclusions

- In terms of _years of experience as a social worker_ it was found that half of the participants had between two and five years of experience. The participants who had more experience indicated that they needed more training in the field of substance abuse.

- In terms of _the highest qualification_ most of the participants have a BA degree in Social Work. One participant has a Master's Degree in Social Work.

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- In terms of *training in drug addiction* most participants indicated that they had limited training in drug addiction. Some participants mentioned that training at university or college regarding drug addiction was very introductory.

Recommendations

- Inexperienced social workers need to be supported by supervisors and more intensive training regarding the rehabilitation of drug addicted adolescent boys are needed.
- It is important for social workers to enhance their field of knowledge, especially in the field of substance abuse as this is regarded as a specialized field.
- More training in drug addiction should be provided to social workers. All social workers should receive some training in the field of substance abuse.
- Substance abuse training at Universities should be broader and more intensive and should start from the first year till the last year.

5.2.2 Adolescents and drugs

The theme "Adolescents and drugs" included: reasons why adolescents use drugs, drug of choice for adolescent boys, reasons why adolescents leave school and the primary caretaker of the adolescent.

5.2.2.1 Reasons why adolescents use drugs

Conclusions

- In terms of the *reasons why adolescents use drugs*, it seems as if the peer group and family play a huge role in the reasons why drugs are abused.
- Participants also referred to reasons such as *individual characteristics* and it was clear that participants feel that, although the adolescent stage is been regarded as the experimental stage, that adolescents also need to make positive decisions as they do have the ability to do so.
- Regarding the e*xposure to violence* participants also indicated that adolescents that are exposed to violence are vulnerable and this could lead to the adolescents' involvement in drug use.
- Some participants also mentioned *family involvement in drug use* as a reason for adolescents using drugs.

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- *Peer group pressure* often leads to *gang involvement* as indicated by some participants.

- Two participants raised the point that adolescents are sometimes *excluded from systems* meaning that these adolescents live far away from school and other resources.

- The *absent father* was also mentioned and can also be a reason why adolescent boys take the wrong path.

Recommendations

- More interventions with families are necessary to explain the role of the parents in the life of the adolescent. More parenting training is needed.

- Adolescents need to be aware of the influence that peers have on them.

- They should also be made aware of their own abilities and strengths.

- A "big brother" programme can be implemented to provide adolescents of positive role models – someone with positive influence to whom the adolescent can look up to.

- Violence in families should be addressed by using the media to make families aware of the consequences that goes with family violence.

- Adolescents need to be informed that gangsterism is a crime and in future people could be sentenced for belonging to a gang. They must also be made aware of the danger and negativity that goes along with gang involvement.

- The issue of the absent father needs to be addressed. Fathers need to get involved in the lives of their children. An awareness campaign can be hosted in communities to make fathers aware of their children's needs and their responsibilities toward their children.

5.2.2.2 *Drug of choice for adolescent boys*

Conclusions

In terms of *the drug of choice* it is clear from the findings that dagga, tobacco and alcohol are in most instances the drug of choice.

- In terms of *tobacco* from the findings it is clear that some participants regarded tobacco as the drug mostly used. The danger of tobacco as a gate away drug was also highlighted.

- *Alcohol* was also seen as a gate away drug by some participants. The fact that alcohol is so much part of some adolescents' lives was also mentioned.
- In terms of *cannabis* it is clear from the findings that most of the participants indicated that a number of adolescents use cannabis and already started at a very young age. Some participants also indicated that these adolescents do not regard cannabis as a drug and some of them refer to cannabis as an herb.
- Regarding m*andrax, inhalants and methamphetamines* some participants mentioned that certain adolescents already use the above mentioned drugs. As was mentioned earlier these adolescents often started at the gate away drugs and then moved to the stronger drugs.

Recommendations

- It is of importance that adolescents should be made aware of the consequences of *tobacco* use. The fact that it is an illegal drug should also be made clear and that it does not minimize the harm. Tobacco policies should be more visible in public venues and should be made part of parenting training as well.
- Parents should be more cautious with *alcohol.* It is clear that adolescents follow the example of parents, family members and also community members. Alcohol adverts should be banned from televisions, as adolescents are exposed to these adverts and believe whatever they see. Adolescents should be made aware of the dangers of alcohol use.
- There is a huge concern regarding *cannabis* use. Again adolescents should be educated about the consequences of cannabis use. Although there are controversial ideas regarding the use of cannabis, the danger of this drug should be made aware to adolescents.
- Social workers should realise their huge responsibility to educate communities on the dangers of drugs such as *mandrax and methamphetamine*.
- Adolescents do not see *inhalants* as that dangerous, but they need to be informed and educated about the consequences.

5.2.2.3 *The primary caretaker of the adolescent*

Conclusions

- In terms of the primary caretaker, most participants indicated the *single mother* as the primary caretaker of the adolescent boy. Participants also indicate the challenges single mothers face.

- *Family members* as caregivers are normally an *aunt or grandparents* according to some participants. The fact that adolescents could not stay with their own parents could have contributed to substance abuse.

- Three participants mentioned that *foster parents* could also be a primary caregiver. Problems with substance abuse often started during adolescence.

- One participant mentioned the *father* as primary caregiver and indicated the importance of involvement of a father in the life of the child.

Recommendations

- Support needs to be granted to single mothers and single fathers.
- It is important that family members should be involved in parental guidance programmes.
- Foster parents should be involved in programmes such as how to treat the foster child and how to deal with substance abuse.
- The children should also be involved in programmes regarding the home circumstances.
- Biological parents should take responsibility of their children as far as possible as this could prevent adolescents misusing substances.

5.2.2.4 *Reasons why adolescents leave school*

Conclusions

In terms of reasons why adolescent boys left school, drug abuse, crime, poverty and lack of future vision was considered.

- It is clear that most participants indicated that *drug usage* is the biggest reason why adolescents leave school. Adolescents who start using drugs, often become addicted and lose interest in school work as was discussed in chapter four.

- In terms of *criminal* charges laid against adolescents, some participants indicated that certain adolescents sell drugs on school premises. These adolescents need to attend court hearings and miss school that could lead to them leaving school.

- *Poverty and a lack of future vision.* A number of the participants said that some adolescents come from poor families and do not always have the necessary equipment that is needed for school. The participants mentioned that economic difficulties are often a major reason why many children drop out of school and this could also lead to substance abuse.

Recommendations

- The importance of education should be emphasized. Adolescents need to be motivated to dream about their future.

- Mentors should be provided for adolescents to assist them through difficult times.

- Parents should be encouraged to provide for their adolescent children as far as possible as a sense of belonging could reduce drug misuse.

- Parents should also motivate their adolescents to form a future vision and to dream about the future irrespective of difficult circumstances.

- Parents should make sure that there is supervision when the child comes from school in cases where the parents are working. They could be placed in an aftercare facility until they are ready to take care of themselves after school.

- Parents should also show interest in the child's school work and support the child in doing their homework. They must show overall interest in the child's schoolwork and his interests.

- Parents should motivate the children to dream big and to try new things and also to take part in sport.

5.2.3 Legislation

The Prevention of and Treatment for Substance Abuse Act was referred to in the research.

Conclusions

From the findings it is clear that a significant number of participants *do not have a thorough knowledge* about the said Act. It is clear that some participants do not realize that the Prevention of and Treatment for Substance Abuse Act 70 of 2008 serves as a guide and needs

to be used in their service delivery to addicted adolescents. The mentioned Act prescribed the different programmes, but some participants were not aware of this.

Recommendations

- Training regarding the said Act is needed for all social workers.
- Every social worker must be in possession of this Act.
- The importance of this Act needs to be emphasized.

5.2.4 Intervention

Intervention included the different programmes, the effectiveness of the programmes and the challenges when working with drug addicted adolescents.

5.2.4.1 Programmes

Conclusions

- One of the programmes that ten of the participants are rendering is *prevention programmes*. The ideal is that prevention programmes should be rendered to adolescents who were never exposed to or use drugs.
- *Early intervention* was used by several participants as the adolescents already were involved in drug use.
- *Rehabilitation* programmes were used by a few participants and the challenges of rehabilitation were also indicated.
- The *aftercare* programme, specifically for clients who completed the rehabilitation programme was used by three participants. The 12-Step programme was also mentioned as part of the aftercare programme.
- Only one participant indicated that she makes use of a *detox* programme. As was discussed, a detox programme is a very important part of the rehabilitation process. One of the possible reasons why rehabilitation is not successful, is because clients are not detoxified properly.
- The purpose of the *relapse prevention* programme is to prepare the adolescent what to expect and what to look out for after treatment, as was indicated by three participants.

Recommendations

- The research consists of programmes which can be used by social workers in practice.

- The Matrix Model can be presented in a workshop and provided to all social workers for use when rendering services to the drug addicted adolescent boy.

- Programmes need to address the issue of drug addiction in such a way that the adolescent does not feel confronted.

- Programmes need to be more youth friendly.

- Social workers need to address the complex issue of substance abuse.

- The whole family should be involved in intervention and not only the adolescent boy.

- Prevention programmes are of utmost importance, in order to make adolescents aware of the consequences of misusing substances before they've been exposed to drugs.

- Relapse prevention training is also very important, because clients need to be made aware of their weak points and also their strengths. They should know what pitfalls to look out for.

5.2.4.2   *Effectiveness of the programme*

Conclusions

- In terms of <u>*the effectiveness of the programmes*</u> most of the participants indicated that their programmes are not as effective as they would like them to be. Participants mentioned further that most of their adolescent clients remain sober only for 0-3 months before they relapse. They specifically referred to clients who completed rehabilitation programmes in a rehabilitation centre. Regarding home based rehabilitation very few participants indicated that they do that and they also mentioned very few positive results.

Recommendations

- The programmes must include the family of the adolescent, for them to gain insight and knowledge to handle or support the adolescent effectively.

- More Rehabilitation Centres are needed as well as programmes for the families.

- Families need to be educated about drugs in order for them to support the child.

- The ideal should be that each drug addicted adolescent boy should be seen by a disciplinary panel, with professional people who can address the emotional, physical, psychosocial and medical issues that resulted from drug use.

- The multi-disciplinary team should have a contingency plan and work according to it. One cannot work in isolation with adolescents. Family intervention is also crucial.

- Programmes should be more adolescent friendly and the venue should be chosen accordingly.
- Adolescents need to be involved in the facilitating of the programme.
- They should be respected as human beings and be considered as individuals.

5.2.4.3 Challenges when working with the adolescent

In terms of _the challenges_ social workers mentioned that it is very difficult to work with these adolescents. They refer to the lack of motivation, family support, lack of resources and community usage. Again the importance of involving the whole family is important.

Conclusions

- Regarding _lack of motivation_ most participants said that it is clear that adolescents are not motivated to make the right choices and often blame their family or the peer group for their addiction.
- _Family support_ was also mentioned by certain participants as a challenge. Family members were not found to be supportive or informed about substance abuse.
- Some adolescents have a _lack of resources_, as mentioned by four participants, and find it difficult to succeed in their work. Lack of resources included transport to school and resources.
- In terms of _community usage_ two participants indicated that the community also plays a big part in the drug use of the adolescent. Some community members were perceived as negative role models regarding substance abuse.

Recommendations

- In order for social workers to make an impact on the lives of these adolescents, it is important to build a good relationship with them.
- The social worker should act in a professional manner such as being on time and giving the adolescent the idea that he/she cares and establishes a trust relationship.
- Aftercare facilities need to be established in rural areas.
- Resources such as libraries and computer centres should be established in rural areas.

- Structures should be put in place where children can go for support in terms of school work, such as extra classes after school and teachers that are available to assist children, because private tutors are expensive.

- Police officers should be more visible in communities in order to combat the use of drugs and alcohol in public.

- Adults should be made aware of their role in the lives of the children of the communities.

5.3   RECOMMENDATIONS FOR FUTURE RESEARCH

The researcher is of opinion that main stream schools should make drug addiction programmes part of their curriculum and should start from the primary classes. From the findings it is clear that one of the reasons for adolescent drug use and addiction starts at the parent's home. Parents do not take time to teach their adolescents about the negative consequences of drug use. The school as an entity where the children spend most of the day should be more informed about legislation regarding drug addiction. As there are new developments each day regarding drugs, it is important that research regarding drugs and drug addiction continues.

5.4   FINAL CONCLUSIONS

Throughout the research it was clear that drug addiction is a huge problem in our communities. It destroys young children, while parents in most cases are also addicted and do not set a positive example to their adolescents. We all know that children do what they see and when it comes to drug addiction it is not an exception. The researcher investigated the reasons why adolescents use drugs and from these findings it is clear that drug addiction is only the symptom, but that there are usually other fundamental reasons for abusing drugs.

The family life plays a huge role. The absent father and the impact that it has on the adolescent's development should be seen in a serious light. In terms of the programmes it was clear that most social workers render early intervention services and also prevention programmes. Most social workers indicated that they do not facilitate the programme themselves and rather refer the clients to other units or to NGOs who specialize in this field. Social workers also refer the clients to rehabilitation centres and need to wait for long periods before clients can be admitted. The motivation levels of adolescents in the rehabilitation process are very low. It is clear that if a child has to live without the necessary care and

affection they seem to not have the ability to stand their grounds. They do not dream about a better life and do not try new things/challenges. They do not trust adults and cannot afford losing their friends, because their friends play a bigger part in their lives than their parents. Social workers need more intensive training regarding substance abuse and addiction. They also need programmes which address the adolescent boys in a way that can impact on their behaviour and the fundamental issues.

BIBLIOGRAPHY

Aaron, D.J. 2012. Early maladaptive schemes and substance use: implications for assessment and treatment. *Addictive Disorders and Their Treatment,* 12(4):193-199. Australia: Lippincott William & Wilkins.

Anton, R. 2010. Substance abuse is a disease of the human brain: focus on alcohol. *Journal of Law, Medicine & Ethics*, 38(4):722-884.

Apel, R. & Kaukinen, C. 2008. On the relationship between family structure and antisocial behaviour: parental cohabitation and blended households. *Criminology*, 46(1) 35-70.

Babbie, E. & Mouton, J.P. 2001. *The practice of social research*. Cape Town: Oxford University Press.

Barber, J.G. 2002. *Social work with addiction* (2nd ed). New York: Macmillan.

Barker, R.L. 2003. *The Social Work Dictionary* (5th ed). Washington DC: NASW Press.

Brendtro, L. & Du Toit, L. 2005. *Response ability pathways: restoring bonds of respect*. Cape Town: Pretext Publishers.

Biddulph, G.S. 2003. *Alcohol: What's a parent to believe*? Minnesota: Hazelden Publishing.

Bjerregaard, B. 2010. Gang membership and drug involvement: untangling the complex relationship. *Crime and Delinquency*, 56(1):3-34.

Blackman, S. 2004. *Chilling out: the cultural politics of substance consumption, youth and drug policy*. United Kingdom: Bell & Bain Ltd.

Bless, C. & Higson Smith, C. 2000. *Social research methods: an African perspective* (3rd ed). Cape Town: Juta Education.

Bless, C., Higson-Smith, C. & Kagee, A. 2006. *Fundamentals of social research methods: an African perspective* (4th ed). Cape Town: Juta & Co.

Bottorff, J.L., Johnson, J.L., Moffat, B.M. & Mulvogue, T. 2009. Relief-oriented use of marijuana by teens. *Substance Abuse Treatment Prevention and Policy*, 4(72).

Bushwell, J. 2011. *The proactive education group: the prevention and management of drug and alcohol abuse*. South-Africa: Rape Wise.

Carroll, K.M. & Onken, L.S. 2005. Behavioral therapies for drug abuse. *Am J Psychiatry,* 162(8):1452-1460.

Cheung, C. & Tse, J.W. 2010. Popularity among peers as a condition for a child's risk of substance abuse. *Journal of Drug Issues,* 40(3):577-608.

Choudhury, I. & Jabeen, S.F. 2008. *Perception of children on parenting practices*. Nepal: Save the Children Sweden.

Creswell, J.W. 2003. *Research design: qualitative, quantitative and mix methods approaches*. London: Sage Publications.

De La Rosa, M., Rice, C. & Rugh, D. 2007. Understanding Latino family attitudes in relation to Latino gang member' substance abuse. *Journal of Human Behavior in the Social Environment*, 16(4):1-18.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, S.S.L. 2011. *Research at Grassroots for the Social Sciences and Human Service Professions* (4th ed). Pretoria: Van Schaik Publishers.

Department of Social Development. 2009. *Recruitment and retention strategy for social workers*. Pretoria: Department of Social Development.

Dodgen, E. & Shea, W.M. 2000. *Substance use disorder: assessment and treatment.* USA: Academic Press.

Donovan, D.M. & Marlatt, G.A. 2005. *Assessment of addictive behaviours* (2nd ed). New York: The Guilford Press.

Doweiko, H.E. 2006. *Concepts of chemical dependency* (16th ed). Belmont: Thomson Brooks/Cole.

Erikson, E.H. 1995. *Childhood and society.* London: Vintage.

Fisher, G.L. & Harrison, T.C. 2013. *Substance abuse: information for school counselors, social workers, therapists and counselors* (5th ed). Boston: Pearson Education.

Fitzhugh, K. 2006. *Crystal Meth and other Amphetamines.* What's the deal? East Sussex: White-Thomson Publishing Ltd.

Flisher, A.J., Mathews, C., Mukoma, W., Ahmed, N. & Lombard, C.F. 2006. Secular trends in risk behaviour of Cape Town Grade 8 students. *South African Medical Journal*, 95:630-635.

Geldard, K. & Geldard, D. 2010. *Counselling adolescents – the proactive approach for young people* (3rd ed). Los Angeles: Sage Publications.

Gouws, E., Kruger, N., Burger, S. & Snyman, D. 2008. *The adolescent* (3rd ed). Johannesburg: Heinemann.

Graham, H.L. 2004. *Cognitive-behavioural integrated treatment (C-BIT):* a treatment manual for substance misuse on people with severe mental health problems. Chichester, UK: John Wiley & Sons.

Hadad, L., Shotar, A., Umlauf, M. & Al-Zyoud, S. 2010. Knowledge of substance abuse among high school students in Jordan. *Journal of Transcultural Nursing*, 21(2):143-150.

Hall, W. & Degenhard, L. 2009. Adverse health effects of non-medical cannabis use. *Lancet*, 374:1383-1391

Hall, W.D. 2006. Cannabis use and the mental health of young people. *Australian and New Zealand Journal of Psychiatry*, 40:105-113.

Harker, N., Kader, R., Myers, B., Fakier, N., Parry, C., Flisher, A.J., Peltzer, K. Ramiagan, S. & Davids, A. 2008. *Substance abuse trends in the Western Cape: a review of studies conducted since 2000*. Technical report. MRC. Graham, H.L. 2004. Cognitive-behavioural integrated treatment *(C-BIT):* A treatment manual for substance misuse on people with severe mental health problems. Chichester, UK: John Wiley & Sons.

Hawkins, A.J., Bradford, K.P., Palkovitz, R., Christiansen, S.L., Day, R.D. & Call, V.R.A. 2002. The inventory of father involvement: a pilot study of a new measure of father involvement. *The Journal of Men's Studies*, 10(2):183-196.

Higgins, S.T. & Wong, C.J. 2000. Contingent reinforcement increases cocaine abstinence during out-patient treatment and 1 year of follow-up. *J Consult Clin Psychol*, 68(1):64-72.

Hubbard, R.L. 2012. *Humanitarian rehabilitating a drug society*. California: Bridge Publications, Inc.

Integrated Health Service Plan. 2006. *Integration Priority and Action Plans: Integrating Mental Health and Addiction Servic*es. Mississauga Halton Local Health Integration Network. Section Appendix G.5.

Jarvis, T.J., Tebutt, J., Mattick, R.P. & Shand, F. 2005. *Treatment approaches for alcohol and drug dependence*. An Introductory Guide (2nd ed). England: John Wiley & Sons Ltd.

Johnson, L.C. & Yanca, S.J. 2010. *Social work practice: a generalist approach* (10th ed). Boston MA: Pearson Education, Inc.

Kelly, J.B. 2007. Children's living arrangement following separation and divorce: insight from empirical and clinical research. *Family Process*, 46(1):35-64.

Kilpatrick, D.G., Acierno, B.S., Resnick, H.S., Best, C.L. & Schnurr, P.P. 2000. Risk factors for adolescent substance abuse and dependence: data from a national sample. *Journal of Consulting and Clinical Psychology,* 68(1):19-30.

Kinnes, I. 2008. *Gang Culture in South Africa and its Impact.* Presented at African Human Security Round Table Meeting. 26th May 2008. Nairobi.

Kliewer, W. & Murrelle, L. 2007. Risk and protective factors for adolescent substance use: findings from a study in selected Central American countries. *Journal of Adolescent Health*, 40:448-455.

Koen, L., Jonathan, R. & Niehaus, D.J.H. 2009. *Cannabis use and abuse correlates in a homogeneous South African schizophrenia population*. Department of Psychiatry, Stellenbosch University and Stikland Hospital, Western Cape.

Kools, S.M. 2010. Adolescent identity development in foster care. *Family Relations*, 46(3):263-271.

Kruk, E. 2010. Parental and social institutional responsibilities to children's needs in the divorce transition: Fathers perspectives. *The Journal of Men's Studies*, 18(2):159-178.

Leach, D. & Kranzler, H.R. 2012. An interpersonal model of addiction relapse. *Addictive Disorders and Their Treatment,* 12(4):183-192. Philadelphia: Lippincott William & Wilkens. [Online] Available: www.iss.co.za. [Accessed: 05/06/2015].

Legget, T. 2002. *Drugs and crime in South Africa: a study in three cities*. Institute for Security Studies. Monograph 69. [Online] Available: www.iss.co.za. [Accessed: 10/08/2015].

Lennard-Brown, S. 2004. *Cannabis. Health issues*. East Sussex: White-Thomson Publishing Ltd.

Louw, D. & Louw, A. 2007. *Child and adolescent development*. Bloemfontein: The University of the Orange Free State.

Louw, D.A. & Edwards, D.J.A. 2005. *Psychology: an introduction for students in Southern Africa* (2nd ed). Sandton: Heinemann Higher & Further Education (Pty) Ltd.

Louw, D.A., Van Ede, D.M. & Louw, A.E. 1998. *Menslike ontwikkeling* (3de uitgawe). Kaapstad: CTP Boekdrukkers (Edms) Bpk.

Makusha,T., Richter, L.K.L., Van Rooyen, H. & Bhana, D. 2013. "*The good and the bad?" childhood experiences with fathers and their influence on women's expectations and men's experiences of fathering in rural Kwazulu-Natal*, South-Africa. 11(2):138-158.

Mans, P. 2000. *Drugs a streetwise guide. An ABC for parents and children*. Wellington: Lux Verbi.BM.

Marcus, M.T., Schmitz, Joy., Moeller, F.G., Liehr, P., Swank, P., Cron., S.G. & Carrol, D.D. 2012. *Stress and length of stay in Therapeutic Community Treatment for Adolescents with Substance Use Disorder*. Texas: Lippincott William & Wilkens.

Mbuya, J.C. 2002. *Drug abuse in Southern Africa*. South-Africa: D-zynit.

Merriam, S.B. 2009. *A guide to design and implementation*. San Francisco: Willey Publisher.

Meyer, M.F., Moore, C. & Viljoen, H.G. 2008. *Personology from individual to ecosystem*. Sandton: Heinemann Publishers (Pty) Ltd.

Meyerson, S. 2009. *Adolescence and breakdown*. London: George Allen & Unwin Ltd.

Moore, G.F., Rothwell, H. & Segrott, J. 2010. *An exploratory study of the relationship between parental attitude and behaviour and young people's consumption of alcohol*. Substance Abuse Treatment, Prevention and Policy, 5:6.

Mouton, J. 2001. *How to succeed in your master's and doctoral studies*. A South-African guide and resource book. Pretoria: Van Schaik Publishers.

National Institutes of Health, National Institute on Drug Abuse. 2003. *Preventing drug use among children and adolescents*: a Research Based Guide for Parents, Educators and Communities. NIH Publication No. 04-4212 (A).

Nevid, S., Jeffrey, R., Spencer, A. & Greene, B. 2006. *Abnormal Psychology in a changing world* (6th ed). New Jersey: Pearson Prentice Hall.

O'Sullivan, T. 2010. *Child and family social work: decision making in social work* (2nd ed). New York. Blackwell Publishing Ltd.

Parry, C. 2004. *The need for a science-based approach to addressing substance abuse in the Western Cape*. Medical Research Council. [Online] Available: www.sahelathinfo.org/ admodule/alcdrug.htm. [Accessed: 20/07/2015].

Parry, C.D.H., Pludderman, A. & Louw, L.T. 2004. Metros study of drugs and crime in South Africa. *The American Journal of Drug and Alcohol Abuse*, 30(1):167-185.

Perlesz, A. 2005. Deconstructing the fear of father absence. *Journal of Feminist Family Therapy*, 16(3):1-29.

Promises Rehabilitation Centre. 2013. [Online] Available: www.promises.com/articles/ teens/reasons-teens-abuse-alcohol-or-drugs October 24th, 2013. California Alcohol and drug Rehab. Centre. [Accessed: 15/07/2015].

Rawson, R.A. & McCann, M.J. 2005. *The Matrix Model Intensive Outpatient Alcohol and Drug Treatment Program*. A 16-week Individualizes Program. Center City. Minnesota: Hazelden.

Reddy, P. 2003. *Umthenthe Uhlaba Usamila – The South African Youth Risk Behaviour Survey* 2002. Cape Town: Medical Research Council.

Republic of South Africa. 2006. *The Integrated Service Delivery Model*. Pretoria: Government Gazette.

Republic of South Africa. 2008. *The Prevention of and Treatment for Substance Abuse Act 70 of 2008*. Pretoria: Government Printer.

Republic of South Africa. Department of Social Development. 1997. *The White Paper for Social Welfare*. Pretoria: Government Gazette.

Republic of South Africa. Department of Social Development. 2005. *Children's Act (Act no 38) of 2005*. Pretoria: Government Gazette.

Schurink,W., Fouché, C.B. & De Vos, A.S. 2011. Oualitative data analysis and interpretation. **In**: De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grassroots: for the Social Sciences and Human Service Professions*. Pretoria: Van Schaik Publishers (4th ed), 89-99.

Setlalentoa, B.M.P., Pisa, P.T., Thekisho, G.N., Ryke, E.H. & Loots, Du T. 2005. *The social aspects of alcohol misuse/abuse in South Africa.* Department of Social Work, North-West.

Sheafor, W. & Horejsi, R.C. 2010. *Techniques and guidelines for social work practice*. Boston: Pearson Education, Inc.

Smith, J.M. & Estefan, A. 2014. Families parenting adolescents with substance abuse – recovering the mothers voice: a narrative literature review. *Journal of Family Nursing,* 20(4):415-441.

Standing, A. 2003. *The social contradictions of organized crime on the Cape Flats.* Institute for Security Studies, 74:1-10.

Stoppard, M. 2000. *Drugs info file. From alcohol, tobacco to ecstasy and heroin*. Great Britain: Dorling Kindersley Limited.

Strang, J., Babor, T., Caulkins, J., Fischer, B., Foxcroft, D. & Humphreys, K. 2012. *Drug Policy and the public good: evidence for effective interventions*. (379) 71-83. Oxford: Oxford University Press.

Sussman, S. & Ames, S.L. 2001. *The social Psychology of drug abuse.* Great Britain: Biddles Limited.

Terre Blanche, M., Durrheim, K. & Painter, D. 2006. *Research in practice: applied methods for the social sciences*. Cape Town: University of Cape Town Press.

The Cape Town Drug Counselling Centre. 2004. *Conducting effective substance abuse prevention work among the youth in South-Africa*. Cape Town: Cape Town Press.

The Cape Town Drug Counselling Centre. 2007. *Families and drugs. It's closer to home than you think*. Cape Town: Cape Town Press.

United Nations Office On Drugs And Crime. The World Drug Report. 2010. United Nations Publication, Sales No. E.10 XI.13.

United Nations office On Drugs and Crime. The World Drug Report. 2014. United Nations Publication.

Van Der Westhuizen, J. 2008. *How to break the power of drug addiction*. Wellington: Lux Verbi.

Van Staden, C.W. 2012. *Epidemiology of substance use among secondary school learners in Atteridgeville Gauteng*. Pretoria: University of Pretoria.

Van Wormer, K. & Davids, D.R. 2003. *Addiction treatment: a strengths perspective*. Pacific Grove, CA: Brooks/Cole.

Vermeulen, A. 2008. *Understanding the work experiences, coping strategies and organizational retention of social workers in Gauteng in-patient substance abuse treatment clinics.* Johannesburg: University of the Witwatersrand.

Visser, M. & Routledge, L.A. 2007. Substance abuse and psychological well-being of South African adolescents. *South African Journal of Psychology*, 37(3):595-615.

Volkow, N. 2010. *The science of addiction. Drugs, brains and behaviour*. National Institute of Health. US Department of Health and Human Sciences.

Waldron, B.H., Slesnick, N., Brody, L.J., Turner, W.C. & Peterson, R.T. 2001. Treatment Outcomes for Adolescent Substance Abuse at 4 – and 7 – months Assessments. *Journal of Consulting and Clinical Psychology,* 69(5):802-813. America: The American Psychological Association.

Walker, S. 2009. *Dealing in death*: *Ellen Pakkies and* a *community struggle with tik*. KwaZulu-Natal: Pinetown Printers.

Walker, S. 2011. *The Social Workers Guide to Child and Adolescent Mental Health.* London: Jessica Kingsley Publisher.

Watson, J. & Kedge, J. 2004. *Drugs. Teens issues*. Oxford: Harcourt Education Ltd.

Winters, C.K. 2008. Scientific Advisor, Mentor Foundation Professor, Department of Psychiatry, University of Minnesota. *Adolescent brain development and drug abuse.* [Online] www.mentorfoundation.org. Support provided by Archie & Bertha Walker Foundation, RKMC Private Foundation, and Mentor Foundation. Accessed: 10 June 2015.

ANNEXURE A

Approval Notice

New Application

28-Mar-2015
Appollis, Elvira EK

Proposal #: DESC/Appollis/Mar2015/10

Title: **Rehabilitation of drug addicted adolescent boys: the contribution of social workers who are employed by the Department of Social Development.**

Dear Miss Elvira Appollis,

Your **New Application** received on **05-Mar-2015**, was reviewed

Please note the following information about your approved research proposal:

Proposal Approval Period: **12-Mar-2015** -**11-Mar-2016**

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number** (**DESC/Appollis/Mar2015/10**) on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).
This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.
National Health Research Ethics Committee (NHREC) registration number

REC-050411-032. We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.

Included Documents:

Research Proposal
and appendices
DESC Report

Sincerely,

Clarissa Graham
REC Coordinator
Research Ethics Committee: Human Research (Humanities)

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2.Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4.Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.<u>Adverse or Unanticipated Events.</u> Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch Universtiy Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7.<u>Research Record Keeping.</u> You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the   REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.<u>Provision of Counselling or emergency support.</u> When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9.<u>Final reports.</u> When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

10.<u>On-Site Evaluations, Inspections, or Audits.</u> If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

ANNEXURE B

Western Cape Government
Social Development

Research, Population and Knowledge Management

tel: +27 21 483 4512 fax: +27 21 483 5602

14 Queen Victoria Street, Cape Town, 8000

Reference: 12/1/2/4

Enquiries: Clinton Daniels/Petro Brink

Tel: 021 483 8658/483 4512

Ms E. Appollis

18 Becker Street

Riversdale

6670
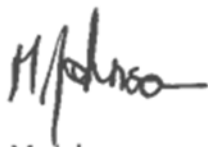
Dear Ms Appollis

RE: APPROVAL TO UNDERTAKE RESEARCH IN THE WESTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT

1. Your request for ethical approval to undertake research in respect of the *'Rehabilitation of drug addicted adolescent boys: The contribution of social workers who are employed by the department of social development'* refers.

2. It is a pleasure to inform you that your request has been approved by the Research Ethics Committee (REC) of the Department, subject to the following conditions:

   * That the Secretariat of the Research Ethics Committee be informed in writing of any changes made to your proposal after approval has been granted and be given the opportunity to respond to these changes.
   * That ethical standards and practices as contained in the Department's Research Ethics Policy be maintained throughout the research study, in particular that written informed consent be obtained from participants.
   * The confidentiality and anonymity of participants, who agree to participate in the research, should be maintained throughout the research process and should not be named in your research dissertation or any other publications that may emanate from your research.

- In the undertaking of the approved research, please ensure that any possible conflict of interest as well as influencing of participants to participate in view of your dual role as researcher and official, is avoided.
- The Department should have the opportunity to respond to the findings of the research. In view of this, the final draft of your dissertation should be send to the Secretariat of the REC for comment before further dissemination.
- That the Department be informed of any publications and presentations (at conferences and otherwise) of the research findings. This should be done in writing to the Secretariat of the REC.
- Please note that the Department supports the undertaking of research in order to contribute to the development of the body of knowledge as well as the publication and dissemination of the results of research. However, the manner in which research is undertaken and the findings of research reported should not result in the stigmatisation, labelling and/or victimisation of beneficiaries of its services.
- The Department should receive a copy of the final research dissertation and any subsequent publications resulting from the research.
- The Department should be acknowledged in all research papers and products that result from the data collected in the Department.
- Please note that the Department cannot guarantee that the intended sample size as described in your proposal will be realised.
- Logistical arrangements for the research must be made with your Regional Manager, subject to the operational requirements and service delivery priorities of the Department.
- Failure to comply with these conditions can result in this approval being revoked.

Yours sincerely

Ms M. Johnson

Chairperson: Research Ethics Committee

Date: 12/6/15

ANNEXURE C

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

_____

YOUR TITLE

You are asked to participate in a research study conducted by Mrs Elvira Appollis, a doctoral/masters student from the Social Work Department at the University of Stellenbosch. The results of this study will become part of a research report. You were selected as a possible participant in this study because you are A Social Worker who render services to drug addicted adolescent boys.

1. PURPOSE OF THE STUDY

The aim of the study is to gain an understanding of the contribution of social workers employed by the Department of Social Development to the rehabilitation of adolescent boys addicted to drugs.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following:

A semi-structured interview will be utilized to gather information confidentially. You need not indicate your name or any particulars on the interview schedule. The schedule will be completed during an interview conducted by a student-researcher.

3. POTENTIAL RISKS AND DISCOMFORTS

Any uncertainties on any of the aspects of the schedule you may experience during the interview can be discussed and clarified at any time.

4. POTENTIAL BENEFITS TO SUBJECTS AND / OR TO SOCIETY

The results of this study will inform welfare organisations about the effective rehabilitation of adolescent boys. This information could be used by welfare organisations for further planning in service delivery.

5. PAYMENT FOR PARTICIPATION

No payment in any form will be received for participating in this study.

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6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of coding where each questionnaire is numbered. All questionnaires will be managed, analyzed and processed by the researcher and will be kept in a safe place.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this research if circumstances arise which warrant doing so, eg should you influence other participants in the completion of their questionnaires.

8. IDENTIFICATION OF STUDENT-RESEARCHER

If you have any questions or concerns about the research, please feel free to contact:

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact …………………….. at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me the participant by Mrs Elvira Appollis in English and the participant is in command of this language or it was satisfactorily translated to him / her. The participant was given the opportunity to ask questions and these questions were answered to his / her satisfaction.

I hereby consent voluntarily to participate in this study.

_____

Name of Participant

_____   _____

Signature of Participant   **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____[name of subject/participant]. [He / She] was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

_____   _____

Signature of Investigator   **Date**

ANNEXURE D

UNIVERSITEIT STELLENBOSCH
INWILLIGING OM DEEL TE NEEM AAN NAVORSING

[Rehabilitasie van dwelm verslaafde adolesente seuns: Die bydrae van maatskaplike werker wat werksaam is by die Departement Maatskaplike Ontwikkeling.]

U word gevra om deel te neem aan 'n navorsingstudie uitgevoer te word deur [Elvira Appollis, BA Graad in maatskaplike werk [Maatskaplike werk] aan die Universiteit Stellenbosch. [Die resultate sal deel wees van 'n navorsingstesis.] U is as moontlike deelnemer aan die studie gekies omdat [u 'n maatskaplike werker is wat by die departement van maatskaplike ontwikkeling werk].

1. **DOEL VAN DIE STUDIE**
[Die doel van die studie is om aan maatskaplike werkers wat by die Departement van Maatskaplike Ontwikkeling werksaam is, inligting te verskaf wat hulle kan gebruik in die rehabilitering van dwelm verslaafde adolesente seuns*.*]

2. PROSEDURES
Indien u inwillig om aan die studie deel te neem, vra ons dat u die volgende moet doen:

[Dat u asseblief die vraelys so eerlik moontlik sal voltooi*.* Indien u enige vrae het is u welkom om my te vra. U het die reg om te weier om 'n vraag te beantwoord, sou u nie gemaklik voel om dit te beantwoord nie. Die navorser sal wag vir die vraelys en sodoende sal dit ook makliker wees vir deelnemers om vrae te vra ten einde die juiste inligting te weergee.]

MOONTLIKE RISIKO'S EN ONGEMAKLIKHEID

[Geen risiko's word voorsien, maar deelnemers is vry om te onttrek indien hulle nie gemaklik voel nie.]

3. MOONTLIKE VOORDELE VIR PROEFPERSONE EN/OF VIR DIE SAMELEWING
[Moontlike voordele vir deelnemers is dat hulle die inligting kan gebruik om hulle self te evalueer ten opsigte van hul dienslewering en sodoende hulle sterktes en leemtes kan bepaal. Geen ander voordele is betrokke nie].

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4.   VERGOEDING VIR DEELNAME

[Geen vergoeding sal ontvang word nie.)

5.   VERTROULIKHEID

Enige inligting wat deur middel van die navorsing verkry word en wat met u in verband gebring kan word, sal vertroulik bly en slegs met u toestemming bekend gemaak word of soos deur die wet vereis. Vertroulikheid sal gehandhaaf word deur middel van [Geen name sal gebruik word nie. Data sal in 'n veilig plek bewaar word, 'n kas wat kan toesluit. Dit sal ook vertroulik hanteer word en nie met ander behalwe my dosent bespreek word nie].

6.   DEELNAME EN ONTTREKKING

U kan self besluit of u aan die studie wil deelneem of nie. Indien u inwillig om aan die studie deel te neem, kan u te eniger tyd u daaraan onttrek sonder enige nadelige gevolge. U kan ook weier om op bepaalde vrae te antwoord, maar steeds aan die studie deelneem. Die ondersoeker kan u aan die studie onttrek indien omstandighede dit noodsaaklik maak.

7.   IDENTIFIKASIE VAN ONDERSOEKERS

Indien u enige vrae of besorgdheid omtrent die navorsing het, staan dit u vry om in verbinding te tree met [.............................*).*

 REGTE VAN PROEFPERSONE

U kan te eniger tyd u inwilliging terugtrek en u deelname beëindig, sonder enige nadelige gevolge vir u. Deur deel te neem aan die navorsing doen u geensins afstand van enige wetlike regte, eise of regsmiddel nie. Indien u vrae het oor u regte as proefpersoon by navorsing, skakel met .... Afdeling Navorsingsontwikkeling, Universiteit Stellenbosch.

VERKLARING DEUR PROEFPERSOON OF SY/HAAR REGSVERTEENWOORDIGER

Die bostaande inligting is aan my, [*naam van proefpersoon/deelnemer*], gegee en verduidelik deur [*naam van die betrokke persoon*] in [*Afrikaans/English/Xhosa/other]* en [*ek is/die proefpersoon is/die deelnemer is*] dié taal magtig of dit is bevredigend vir [*my/hom/haar*] vertaal. [*Ek/die deelnemer/die proefpersoon*] is die geleentheid gebied om vrae te stel en my/sy/haar vrae is tot my/sy/haar bevrediging beantwoord.

[*Ek willig hiermee vrywillig in om deel te neem aan die studie/Ek gee hiermee my toestemming dat die proefpersoon/deelnemer aan die studie mag deelneem.*] 'n Afskrif van hierdie vorm is aan my gegee.

_____

Naam van proefpersoon/deelnemer

_____

Naam van regsverteenwoordiger (indien van toepassing)

_____   _____

Handtekening van proefpersoon/deelnemer of regsverteenwoordiger   Datum

VERKLARING DEUR ONDERSOEKER

Ek verklaar dat ek die inligting in hierdie dokument vervat verduidelik het aan [*naam van die proefpersoon/deelnemer*] en/of sy/haar regsverteenwoordiger [*naam van die regsverteenwoordiger*]*.* Hy/sy is aangemoedig en oorgenoeg tyd gegee om vrae aan my te stel. Dié gesprek is in [*Afrikaans/*Engels*] gevoer en [*geen vertaler is gebruik nie/die gesprek is in* _____ *vertaal deur* _____].

_____   _____

Handtekening van ondersoeker   *Datum*

ANNEXURE E

STELLENBOSCH UNIVERSITY

DEPARTMENT OF SOCIAL WORK

QUESTIONNAIRE

Rehabilitation of drug addicted adolescents: The contribution of social workers who are employed by The Department of Social Development.

All the information recorded in the questionnaire will be regarded as confidential. Identity will further be concealed. Involvement in this study is voluntary, and the respondent has the right to refuse answering any question. Please answer all questions honestly. For the purpose of this study the focus will be on adolescent boys. The following substances are applicable: tobacco, cannabis (dagga), alcohol and Poly-drugs which mean – more than one substance are used.

1.   IDENTIFYING PARTICULARS OF PARTICIPANTS

1.1. Age of participants:

Age	Mark with an X
20 - 30 years	
31 - 40 years	
41 - 50 years	
51 - 60 years	
61+ years	

1.2. Indicate your highest qualification in social work.

	Mark with an X
Diploma in Social Work	
B. Social Work	

B.A. Social Work (3 years)	
B.A. Social Work (4 years)	
B.Diac. Social Work	
Honours B.A. Social Work	
M.A. Social Work	
D.Phil. Social Work	

1.3   How many years have you been practicing as a social worker? (**X**)

	0-5	6-10	11-15	16-20
Years of experience				

1.4 Did you have any training in drug addiction ? **(X)**

YES	NO

1.4.1   Indicate which training (**X**)

In service training	
Workshop	
Training at rehab centre	
Training at university	
Other	

2   ADOLESCENTS AND DRUGS

2.1   How would you define drug addiction?

....

....

2.2 What do you think are the reasons / risks why adolescents use drugs? (**X**)

Individual characteristics	
Exposure to violence	
Family involvement in drug use	
Peer group	
Exclusion from systems	
Gang involvement.	
Other	

2.3 According to your experience, what is the drug of choice for adolescent boys? (**X**)

Tobacco	
Cannabis	
Alcohol	
Mandrax	
Ecstacy	
Cocaine	
Methaphetamines	
Inhalants	
Other	

2.4 Who is the primary care taker of the adolescent ? (**X**)

Mother and Father	
Mother	
Father	
Family member	
Foster parent	
Other	

2.5 Are your clients still going school? **(X)**

Yes	No

2.5.1 If not, was the reasons for leaving drug related ? (Explain).

....

....

2.5.2 What grade did clients dropped out of school?

Grade 1-3	
Grade 4-6	
Grade 7-9	
Grade 10-12	
Other	

3. SOCIAL WORK INTERVENTION.

3.1 What programmes do you use in intervention with these adolescents? **(X)**

Prevention	
Early intervention	
Rehabilitation	
After care	
Other	

3.1.1 Do you think the programmes you use are effective ? **(X)**

Yes	No

3.1.2   Why do you say so?

....

....

....

3.2.1   What are the challenges when working with these adolescents? (**X**)

....

....

4   LEGISLATION

4.1.1   Are the Intervention and or Treatment of Alcohol and Drug Act 70/2008 helpful as a guide? (**X**)

Yes	No

4.1.2   How has the Alcohol and Drug Act (70/2008) impacted on the program?

....

....

....

....

4.1.3   Explain your answer.

....

....

....

....

5   REHABILITATION AND INTERVENTION OF ADOLESCENT BOYS.

5.1   Have you heard of the Matrix Model ?

Yes	No

5.1.1   Do you use the Matrix Model ?

Yes	No

5.1.2   Which of the programme components are most useful?

Individual Counseling	
Early recovery skills group	
Relapse prevention group.	
Family Education Group.	

5.2   How many clients have you supported to rehabilitate from drug use? **(X)**

1-10	11-15	16-20	21-25

5.2.1   How long after they have attended the programme has clients remain sober?

	0-3	4-6	7-9	10-
Months				

5.3   Do you think there are sufficient rehabilitation centres in South-Africa? **(X)**

Yes	No

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5.3.1   Explain your answer.

....

....

5.3.2   How do you handle the detox process? **(X)**

Out-patient	
In-patient	
Community based service	
Other	

5.4   Do you provide relapse prevention training ? **(X)**

Yes	No

6   Is there anything else you want to mention of your contribution regarding service delivery to adolescent boys who use drugs?

THANK YOU FOR PARTICIPATING, YOUR COOPERATION IS MUCH APPRECIATED!

ANNEXURE F

STELLENBOSCH UNIVERSITEIT

DEPARTEMENT VAN MAATSKAPLIKE ONTWIKKELING

VRAELYS

Rehabilitering van dwelmverslaafde adolesente: Die bydrae van Maatskaplike werkers wat aan diens van die Departement van Maatskaplike Ontwikkeling is.

Alle inligting wat hier vasgepen word, sal as vertroulik hanteer word. Deelname aan die studie is vrywilliglik en die respondent het die reg om te weier om enige vraag te beantwoord. Beantwoord asseblief vrae so eerlik moontlik. Vir die doel van hierdie studie sal ons fokus op die adolesente seun as die kliënt. Die dwelms wat ondersoek was, is tabak, dagga, alcohol en Poly-drug wat verwys na die gebruik van meer as een dwelm.

1.   **IDENTIFISERENDE BESONDERHEDE**

1.1   Hoe lank praktiseer u as maatskaplike werker ?

	0-5	6-10	11-15	16-20
Jare ondervinding				

1.2   Het u enige opleiding oor dwelmafhanklikheid deurloop ?

JA	NEE

1.2.1   Motiveer watter opleiding

....

....

2.   **ADOLESENTE EN DWELMS**

2.1   Hoe sal u dwelm verslawing definieer?

....

....

....

....

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2.2   Wat dink u is die oorsake hoekom adolesente dwelms gebruik?

....

....

....

....

2.3   Volgens u ervaring, watter dwelm word verkies deur adolesente seuns ?

....

....

2.4   Volgens u ervaring watter ander dwelms gebruik hulle ook?

....

....

....

3.   **GESINSLEWE**

3.1   Wie is die primêre versorging van die adolessent ?

....

3.2   Watter risiko faktore wat tot die gebruik van dwelm gebruik by adolesente lei, kan u identifiseer ?

....

....

....

3.3   Gebruik hul families ook dwelms? Verduidelik.

....

....

....

....

4.   **ADOLESSENT EN AKADEMIE**

4.1   Gaan u kliënte nog skool?

....

4.2   Indien nie, was die redes vir skool verlaat dwelm verwant ? (Verduidelik).

....

....

....

4.3   Watter graad het u kliënte skool verlaat en en op watter ouderdom het hulle begin gebruik?

....

5.   MAATSKAPLIKE WERK DIENSLEWERING.

5.1   Watter programme gebruik u in hulpverlening van hierdie adolesente ?

....

....

5.2   Hoe effektief is die programme wat u gebruik ?

....

....

....

5.3   Wat is die uitdagings wanneer u met hierdie adolesente werk ?

....

....

....

6.   WETGEWING

6.1   Watter impak het die Voorkoming van en Behandeling vir Alkohol en Dwelm Wet (70/2008) op die program?

....

....

....

6.2   Is die Voorkoming van en Behandeling vir Alkohol en Dwelm Wet 70/2008 insiggewend as 'n riglyn?

Ja	Nee

Verduidelik u antwoord.

....
....
....

6.3   Hoe implimenteer u bogenoemde Wet in hulpverlening?

....
....
....

7.   REHABILITASIE INTERVENSIE VAN ADOLESSENTE SEUNS

7.1   Gebruik u die Matrix Model ?

....
....
....

7.2   Hoeveel kliënte het u gehelp om van dwelm gebruik te rehabiliteer?

....

7.3   Hoe lank na kliente by die program ingeskakel het is hulle sober?

	0-3	4-6	7-9	10-
Maande				

7.4   Dink u daar is genoeg rehabilitasie sentrum in Suid-Afrika?

....
....

7.5   Hoe hanteer u die detoks proses?

....
....

7.6   Word kliënte ingeskakel by programme wat voorkom dat hulle weer dwelms gebruik ?

....
....

7.7   Watter metode is mees effektief ?

Individuele terapie	
Groepwerk	
Gemeenskapswerk	
Statutêre werk	

8   Is daar enige iets wat u nog wil noem oor u bydrae in dienslewering aan adolesente seuns wat dwelms gebruik?

....

....

DANKIE VIR U DEELNAME, U SAMEWERKING WORD HOOGS WAARDEER!