

**AFTERCARE TO CHEMICALLY ADDICTED ADOLESCENTS: PRACTICE  
GUIDELINES FROM A SOCIAL WORK PERSPECTIVE**

by

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I declare that "Aftercare to chemically addicted adolescents: Practice guidelines form a social work perspective", is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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Mrs. MA van der Westhuizen

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Date

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## ABSTRACT

The susceptibility of adolescents to chemical addiction has become a major international concern. Approximately 25% of people in Central Asia and Eastern Europe who inject chemical substances are under the age of 20 years (Youth at the United Nations, 2006), while up to 75% of unintentional injuries among adolescents in America are related to substance abuse (Page & Page, 2003:196). On the national level, approximately 25% of adolescents under the age of 20 are involved in substance abuse (Western Cape Department of Social Services and Poverty Alleviation Transformation Plan, 2006:13). Focusing on the Western Cape, a report from the South African Epidemiology Network (2007:3) highlights that the youngest patient in in-patient treatment was nine years of age, and among 2 798 persons who received in-patient treatment, 27% were under the age of 20, more than any other age group in treatment.

Treatment of adolescent chemical addiction should include preparation for treatment, treatment, and also aftercare services to ensure that the addicted adolescent develops skills to maintain sobriety (Meyer, 2005:292-293). Section Six of the South African Prevention and Treatment of Drug Dependency Act (1992) prescribes that chemically addicted persons should have access to professional aftercare services to ensure that treatment is not terminated prematurely. The motivation for this study was based on the fact that, despite this statutory requirement, the Western Cape Drug Forum (2005:3) identified the need for the development of aftercare services in 2005, indicating the lack of focus on aftercare as part of treatment. This concern was confirmed by practitioners in the field of adolescent chemical addiction and findings resulted from previous research regarding relapse experiences of chemically addicted adolescents (Van der Westhuizen, 2007:129-130).

Flowing from the research problem, described above, the **goal** for this research was to develop practice guidelines from a Social Work perspective relating to the provision of

aftercare services to chemically addicted adolescents. In order to operationalise this goal, the following task objectives guided this research study:

- To explore and describe the specific aftercare needs of relapsed chemically addicted adolescents following treatment relating to services by social workers;
- To explore and describe the perceptions and experiences of social workers regarding aftercare services chemically addicted adolescents;
- To review literature that relates to aftercare services to chemically addicted adolescents;
- Based on the above findings, to develop practice guidelines from a social work perspective relating to the rendering of aftercare services by social workers to chemically addicted adolescents following treatment.

The researcher made use of the **qualitative research approach** to explore and describe the participants' perceptions of the research problem. This research endeavour fell in the ambit of **applied research**, as it was aimed at the development of aftercare practice guidelines to address the identified lack of aftercare service delivery to chemically addicted adolescents. The researcher made use of the **intervention research design**, employing the Intervention Design and Development (IDD) Model of Rothman and Thomas (1994:3-51). For the purpose of this study, the researcher made use of Phases 1 and 2, Step 2 of Phase 3 and Step 1 of Phase 4 of the IDD-model, as summarised below.

**Phase 1: Problem analysis and project planning:** The **first step** conducted in this phase was to identify and involve the participants. The *populations* for the purpose of this study were: 1) all chemically addicted adolescents in the Western Cape who had relapsed after in-patient treatment, and 2) all Social Work service providers dealing with adolescent chemical addiction in the Western Cape. The *purposive sampling technique* enabled the researcher to access a sample for the specific reason to provide insight into

the particular field of interest. The *sample size* for this study was determined by data saturation.

During the **second step**, the researcher gained entry and cooperation from the settings. Access to the sample selected from the population of *chemically addicted adolescents* was obtained through contact with the adolescent in-patient treatment centres in the Western Cape. In order to gain access to the sample selected from the population of *social workers* rendering services to chemically addicted adolescents, the researcher negotiated entrée to the participants by means of an introduction letter to Social Work service providers working with chemically addicted adolescents. Interviews with willing participants/parents/guardians were arranged, during which time the purpose of the study and the research process were given to them.

Consent forms were signed prior to the commencement of the **third step**, identifying the concerns of the population. The researcher used the *exploratory, descriptive and contextual research designs* as a qualitative strategy of inquiry with both the adolescent and Social Work interest groups. The methods of data collection were *narratives* in order to explore and describe the needs of chemically addicted adolescents, and *focus groups* as a method of qualitative interviewing to promote understanding from the social workers' point of view. The method of *data recording* for the data obtained from the adolescents was their written narratives. Data obtained from the social workers was recorded by means of tape-recordings and field notes, which was transcribed later. The **fourth step** in the first phase was to analyse the identified concerns. Tesch's (in Creswell, 2009:186) eight steps for qualitative data analysis were implemented by both the researcher and an independent coder once data became repetitive and data saturation was reached.

Concluding from the themes and sub-themes emanating from the data obtained from the adolescent interest group, their previous experiences of social workers led to negative perceptions of aftercare workers due to: a disregard for and lack of assessment of their personal needs; a judgemental attitude of the social worker, and a perceived lack of passion for their work. Social workers who continued to motivate chemically addicted adolescents to re-enter treatment following a relapse were

perceived in a positive light. Chemically addicted adolescents have a need for a relationship with the social worker rendering aftercare services, and such a relationship should be characterised by trust, a belief that they can confide in the social worker, openness, genuine interest and a concern for the adolescent, the social worker acting as a role model, objectivity and a non-judgemental attitude. The unavailability and inaccessibility of Social Work aftercare services to chemically addicted adolescents is concerning, and this impacted negatively on the development of a personal, trusting relationship with aftercare workers. Chemically addicted adolescents have the need and expectation that social workers who render aftercare services should be knowledgeable about addiction and recovery, that they must be informed about the content of the treatment programmes which the adolescents attended, and be able to assist them to continue with the growth achieved during treatment. Aftercare needs in terms of the psychosocial functioning are diverse and multi-levelled. Services should therefore be aimed at intrapersonal and interpersonal functioning, as well as functioning in the environment (i.e. reintegration into families and communities). Lastly, aftercare services to chemically addicted adolescents must be pitched at their level of comprehension and in a language that will be clear and understandable to them.

Concluding from the themes and sub-themes emanating from the data obtained from the Social Work interest group, recovery from chemical addiction is a life-long process. The provision of aftercare services to chemically addicted adolescents is therefore essential, it should form part of the treatment regime, and should not be viewed as an optional service following treatment. There seems to be a lack of information amongst social workers about the “what” and the “know-how” relating to the aftercare component of the treatment of chemically addicted adolescents. Aftercare services to chemically addicted adolescents are perceived to be a “specialised field” of service delivery, but in practice this is not currently the case. Current service delivery to chemically addicted adolescents is mainly conducted through the case and group work methods of Social Work, and the services planned and rendered focus mainly on assisting the adolescent in acquiring life skills, development of insight into the consequences of the addiction, dealing with the various damages owing to the chemical addiction, reparation of relationships, and family therapy. Various obstacles hamper the delivering of current

aftercare services. These obstacles are situated within the social worker's own knowledge and skill components, the working conditions and work-related realities confronted by social workers and the disposition of the chemically addicted adolescent and his/her family network. There is a reported need for guidelines to assist social workers in practice to provide aftercare services to chemically addicted adolescents. Such guidelines should be standardised and structured in a step-by-step format, while being visual, in easy language and include practical and fun activities. Furthermore, treatment and aftercare services to chemically addicted adolescents should be coordinated, well managed and linking and networking between resources should take place.

The trustworthiness of the qualitative data obtained through this study was based on Guba's model (as cited in Krefting, 1991:214-222), addressing the truth value, applicability, consistency and neutrality of this research study. **Step 5** of the first step was to set the goals and task objectives, as provided above.

**Phase 2: Information gathering and synthesis:** The **first step** was to use existing information sources, assisting the researcher to obtain a knowledge base regarding the existing literature and technology related to the focus of this study. The implementation of this step assisted the researcher to obtain a knowledge base regarding the existing literature and technology related to the focus of this study, including addictive chemical substances; adolescence; aftercare and reintegration; chemical addiction; intervention research; practice guidelines; recovery; relapse and relapse prevention; Social Work intervention; and treatment programmes.

**Step 2** of this phase was to study natural examples, and overlapped with the activities as described in Phase 1, Step 3. During the **third step** of phase 2, the researcher identified the functional elements of successful models. The researcher explored different aftercare models, practice guidelines and suggestions, and evaluated their effectiveness in addressing the research problem. The features, advantages and limitations of the identified models, practice guidelines and suggestions were evaluated,



and compared with the specific aftercare needs of chemically addicted adolescents, as well as the perceptions and experiences of social workers in this field.

**Phase 3: Design of human technology and Phase 4: Early development:** The researcher implemented Step 2 of Phase 3 (i.e. specifying the procedural elements of the intervention) and Step 1 of Phase 4 (i.e. developing a prototype intervention) in an integrated manner in order to develop aftercare practice guidelines for chemically addicted adolescents from a Social Work perspective. Once all the information obtained from the literature review and empirical findings was analysed and interpreted, it provided the researcher with a framework for the development of the guidelines. The description of the guidelines entailed goal and objectives, as well as knowledge prerequisite and functional aids and concise strategies regarding the implementation thereof.

In concluding the report of the study, the researcher provided summaries of and conclusions related to the background rationale, research questions and goal and task objectives of the study; the research methodology implemented; the empirical findings; the literature consulted; and the developed guidelines. She concluded the document with recommendations related to the research methodology employed; practice, policy, training and education; and further research.

**Key words:** Addictive chemical substances; Adolescence; Aftercare services; Chemical addiction; Intervention research; Practice guidelines; Recovery; Reintegration services; Relapse; Relapse prevention; Social Work intervention; Treatment programmes

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**Acronyms**

Afrikaanse Christelike Vroue Vereniging	ACVV
Alcohol and Other Drugs	AOD
Alcoholics Anonymous	AA
Chemically addicted adolescent	CAA
Christelike Afhanklikheidsdiens	CAD
Christelike Afhanklikheidsbond	CAB
Design and Development	D&D
Intervention Development and Design Model	IDD-model
Knowledge Development	KD
Knowledge Utilisation	KU
Narcotics Anonymous:	NA
National Institute for Crime Prevention and Rehabilitation of Offenders	NICRO
National Institute on Drug Abuse	NIDA
Non-Governmental Social Work Organisations	NGO's
Relapse Prevention Therapy	RPT
South African National Council on Alcohol- and Drug Abuse:	SANCA
Texas Christian University	TCU



# AFTERCARE TO CHEMICALLY ADDICTED ADOLESCENTS: PRACTICE GUIDELINES FROM A SOCIAL WORK PERSPECTIVE

## CHAPTER 1

### INTRODUCTION AND GENERAL ORIENTATION TO THE STUDY

*“The addict’s success in maintaining change over time requires vigilance, hard work, and access to a variety of coping strategies”* (Lewis, Dana & Blevins, 2002:169).

#### 1.1 Theoretical background and rationale

**Chemical substances** are without a doubt a threat to human security (Mashaba, 2005:4). The susceptibility of **adolescents** to chemical addiction has become a major **international concern** in recent years. Approximately 25% of people in Central Asia and Eastern Europe who inject chemical substances are under the age of 20 years (Youth at the United Nations, 2006). In Eastern Europe, addiction to methamphetamine in the Czech Republic represents a serious medical and social problem (Hosak, Csémy, Preiss & Cermáková, 2005:31). Furthermore, a 2002 American National Survey by the National Institute on Drug Abuse (NIDA) has shown that 30% of high school students reported exposure to chemical substances. In 2006, a NIDA survey reported an increase in adolescent chemical addiction, pointing out that 50% of American schoolchildren used alcohol (known as a “gateway” substance that leads to the use of illegal substances) regularly, and 26% of them engaged in binge drinking (NIDA, 2006). Adolescent chemical addiction is related to a multitude of problems for the public health system, government, and American families (Dennis & McGeary, 1999; Adolescent Substance Abuse Knowledge Base, 2002; Friedman, 2001:2; Mc Whirter, Mc Whirter, Mc Whirter & Mc Whirter, 2004:117; Caroufek, 2007:4). Additionally, 33% of traffic fatalities among 16-24-year-olds are related to chemical substances, and there is a concern about the increase in adolescent substance abuse and chemical substance-related violence in America (Noguchi, 2006).

This international trend is also noted on the **national level**, as chemical addiction among South African adolescents is becoming increasingly prevalent. Approximately 25% of adolescents under the age of 20 are involved in chemical substance abuse (Western Cape Department of Social Services and Poverty Alleviation Transformation Plan, 2006:13). In Gauteng, a survey among adolescents has shown that 26.1% of Grades 8-11 learners engaged in binge-drinking (South Africa: Department of Health/Medical Research, 2003:102-103). Chemical substances are also readily available to South African adolescents (Van Niekerk & Prins, 2001:38; United Nations Office on Drugs and Crime, 2002:26; Zulu, 2006:1; Dimoff, 2007:2). Adolescents' use of hard-core chemical substances is increasing at an alarming rate (Friedman, 2001:1). In addition, there is an increase in the numbers of young people dying from chemical substance-abuse-related causes, and 40% of adolescents in treatment for chemical addiction suffer from dual diagnosis: addiction as the primary diagnosis and also a secondary psychiatric condition (Zulu, 2006:1).

The researcher is situated in the **Western Cape**, where adolescents' methamphetamine addiction in particular has taken Cape Town by storm. The most common chemical substances of choice among patients in treatment centres in the Western Cape are methamphetamine, alcohol, cannabis and heroin. Cape Town has been identified as the area with the highest growth in methamphetamine use in South Africa. A remarkable increase in patients giving methamphetamine as their primary chemical substance of choice has been noted (Caelters, 2005:1; Plüddeman, Parry, Cerff, Bhana, Pereira, Potgieter, Gerber, Nqini & Peterson, 2007:12).

A higher proportion of substance-related injuries in the Cape Town Metropole than in other sites in South Africa have also been reported (Matzoupolos, 2005:6; Western Cape Department of Social Services and Poverty Alleviation Transformation Plan, 2006:13). Chemical substance-related crimes in the Western Cape increased from 19 940 in 2003/2004 to 30 432 in 2004/2005. In addition, gang-related activities in the Cape Flats are linked with chemical-substance dealings. An analysis by the Drakenstein Police Service of their statistics indicates that an estimated 80% of housebreaking- and

theft-related cases were substance-related, and most of the arrested suspects were between 12 and 17 years of age (Mashaba, 2005:1; South African Police Service, 2006; Western Cape Department of Social Development Service Delivery Plan, 2007-2017:15).

Ganga (2007) refers to the concern regarding chemical substance supply, demand and addiction in the Western Cape, and explains that methamphetamine is popular among adolescents as it gives them self-confidence, energy and a sense of power. The <sup>1</sup>former Mayor of Cape Town, Me. Zille, as quoted by Essop (2007:11), voiced her concern regarding the methamphetamine epidemic in the Western Cape, and emphasised that the community and the treatment programmes should be supported in order to combat the present situation. In support of this sentiment, the former premier of the Western Cape, Mr. Rasool, as well as the former South African President, Mr. Mbeki, (in Azzakani, 2007:4) voiced their concerns regarding the situation, and indicated their support for services and actions that would address this pressing problem. The abovementioned information relating to the Western Cape indicates that the international concern about the threatening implications of addiction to chemical substances is particularly prevalent in the Western Cape.

In order to understand the problem of **chemical addiction**, it is important to consider the different etiological theories. The following theories, as identified by McNeece and DiNito (1998:23-33) and Fisher and Harrison (2005:37-52), were considered by the researcher while investigating the research problem:

- The Moral Model: This model is based on the perception that addiction is a moral weakness. According to this model, addiction is a choice, and the addict is able to make other choices (i.e. the choice to remain sober). It implies that the addiction is the result of poor choices only. This model of addiction has contributed to the stigma associated with chemical addiction as it implies that the addict prefers the addiction and its consequential harmful results.

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<sup>1</sup> South Africa's national election took place in April 2009, leading to a change in political leadership.

- The Psychological Model: This model is based on the assumption that the addiction can be attributed to external factors, such as socio-cultural and emotional problems. Fisher and Harrison (2005:37-52) warn that this model could lead to defocusing, meaning that the external problems receive attention during treatment, but that the powerful addictive nature of chemical substances is neglected.
- The Bio-Psychosocial Model: This model refers to addiction in terms of a predisposition to the development of addiction in certain individuals. It is based on explanations ranging from brain dysfunction to biochemical and genetic theories.
- The Disease Model: This research endeavour was based on the **conceptual framework** of the Disease Model of Addiction. It is founded on the notion that addiction is a primary disease and that it is not secondary to other diseases, and is based on research into brain chemistry and brain changes due to the addiction (McLellan, Lewis, O'Brien & Kleber, 2000:689). This model also acknowledges the progressive nature of chemical addiction, the "loss of control", and withdrawal when the use of chemical substances are terminated or interrupted.

In these descriptions, the Moral Model is the only one that refers to the chemically addicted person's ability to choose the addiction, while the Psychological Model attributes addiction to external factors only. The Bio-psychosocial and Disease Models both focus on biological causes of chemical addiction, while acknowledging the impact of external factors.

Fisher and Harrison (2005:49) refer to chemical addiction as a multivariate syndrome, i.e. "multiple patterns of dysfunctional substance use that occur in multiple types of personalities, with multiple combinations of adverse consequences". Another definition is that chemical addiction is "a maladaptive pattern of substance use, leading to clinically significant impairment or distress" in terms of changes in behaviour, mood and thought, and is associated with self-defeating behaviour (Barber, 2002:2; Schlebush, 2005:135).

On the one hand, **adolescence** is characterised by a search for independence and experimentation, which puts youngsters at risk for chemical addiction (Youth at the United Nations, 2006). Barrett and Ollendick (2004:330) are in agreement with this sentiment and add that it is normative for older adolescents to experiment with chemical substances. On the other hand, Louw, Van Eden and Louw (2001:385) stress that it is essential for adolescents to complete the relevant life tasks to ensure optimal functioning in adult life. These life tasks include obtaining knowledge, developing an identity, obtaining independence, preparing for a career, developing responsible social behaviour, and developing relationships and moral values. Gouws, Kruger and Burger (2000:3-7) support this line of thought and include movement towards psychological and economic maturity, and the completion of physical, cognitive, social, emotional, moral and religious developmental tasks.

**Adolescent chemical addiction** is a serious and growing epidemic. It is estimated that 20% of adolescents who experiment with chemical substances move to addiction (United Nations Office on Drugs and Crime, 2002:22). Gouws et al. (2000:182) postulate that adolescent chemical addiction now presents itself in almost all social environments, and is a lethal health hazard facing adolescents world-wide. It leads to ill health, overdosing, mental illness and hazardous reactions leading to delinquency. In addition, it interferes with the intellect and thought processes; impairs perception, coordination and thinking; and prevents normal functioning (Gouws et al., 2000:173-178). Seeking to explain this serious situation, Mans (2000:10) notes that some of the reasons behind adolescent chemical addiction are grounded in seeking excitement, economic reasons (poverty or access to too much money), negative peer pressure, family problems, a poor self-image, lack of knowledge regarding the impact of chemical substances, negative environmental factors, and the need to find a way to deal with problems.

It is therefore clear that adolescent chemical addiction tampers with one of the most important developmental stages in life (United Nations Office on Drugs and Crime, 2002:22). Noyoo, Patel and Lofell (2006:97) describe adolescent substance abuse as “a

vulnerability that begets other vulnerabilities such as HIV and AIDS". Adolescents suffering from chemical addiction are a major public health problem that puts them at risk for chemical substance-related accidents, risky sexual practices, poor academic performance, juvenile delinquency, developmental problems, chronic health problems, short-term biological health effects, and social consequences that are both acute and chronic (Gossop, 1998:77; World Health Organisation, 2004:12; Mental Health Touches, 2006). Bezuidenhout and Joubert (2003:26) warn that there is a relationship between behavioural problems and chemical substance abuse among adolescents. Plüddeman's study (2007:2) furthermore has indicated that 84% of adolescents who used methamphetamine were at risk of suffering from depression. Addiction to chemical substances among adolescents in South Africa is also linked to crime, violence and HIV and AIDS (Dodgen & Shea, 2000:59; Health Systems Trust, 2002; Noyoo et al., 2006:97; Louw, 2006:2; O'Connor, 2006:6).

As a result of the increase in adolescent chemical addiction, the **demand for treatment** of chemically addicted adolescents<sup>2</sup> (hereafter primarily referred to as CAAs) is also increasing. Admissions for substance abuse treatment in America increased from 28 000 in 1993 to 150 000 in 2005 (Smith, 2006). In South Africa, a study conducted by the Medical Research Council (quoted by the South African Community Epidemiology Network on Drug Use, 2007) determined that treatment demands for adolescents suffering from chemical addiction were also increasing. This study gave the following indications regarding treatment demands and the intake trend for treatment of adolescents in the Western Cape for the second half of 2007: Methamphetamine was the primary chemical substance of choice for 59% of patients. Heroin was the second most popular chemical substance of choice, followed by alcohol and cannabis (South African Community Epidemiology Network on Drug Use, 2007).

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<sup>2</sup> The researcher acknowledges that the terms "chemically addicted adolescents" and "relapsed chemically addicted adolescents" could be viewed as labelling. This could lead to negative expectations and could get in the way of seeing the potential for change and growth (Gambrill, 2006:395). The researcher concludes that continuous referral to "adolescents who are addicted to chemical substances" and "who had relapsed following treatment" would be tedious and could hamper the reading process. **It was therefore decided to use the shorter terms (i.e. "chemically addicted adolescents" abbreviated as "CAAs") from this stage on in this report.** No labelling, however, was intended.

Regarding **relapse potential** among chemically addicted persons, it is estimated that between 50% and 90% of chemically addicted persons do not obtain stable and sustainable sobriety after five years (Connors, Donovan & DiClemente, 2001:195; Meyer, 2005:292; Fisher & Harrison, 2005:156). Gorski (2001:1) indicates a relapse rate after treatment of 58% for adolescents. Exploring this high relapse potential, a study by Satre, Mertens, Aream and Weisner (2004:1296) found that young people experience more pressure to use chemical substances, and that their relapse potential is therefore higher.

Goldberg (1999:40-42) and Buddy (2003) describe **relapsing** as common, predictable and preventable, and explain that the addict assumes that earlier experiences will be repeated, owing to a lack of self-worth. Considering the Disease Model of Addiction, the relapse must be viewed within the context of the addictive cycle, increased tolerance and impaired control over intake associated with chemical addiction, as well as triggers in day-to-to-day living (Gossop, 1998:78; Goodwin, 2000:90-93; Malhotra, Basu & Gupta, 2007:6). Also, although early negative life events impact on the addict's response to daily stressors, current triggers are more relevant as causes of relapse (Waldrup, Back, Brady, Upadhaya & McRae, 2007:3024). Marlatt (as cited in Velleman, 2001:98) names five steps that lead to relapse: 1) a decision that is not beneficial for the life style of the addict in recovery, 2) a high-risk situation, 3) a no-coping response, 4) a feeling of helplessness and low self-control, and 5) an expectation that chemical substances will relieve the tension.

Regarding **effective treatment** to produce positive change, an adequate treatment period of between 8 and 18 months, and ongoing aftercare services are recommended (Gordon, 2003:18; Focus Adolescent Services, 2006). Adolescent treatment programmes in South Africa, however, vary between 3 weeks and 12 months (Fourie, Regional Director, South African National Council on Alcohol and Drug Abuse, Western Cape (SANCA), 2006). Treatment entails in-patient treatment programmes in treatment centres and out-patient treatment programmes at SANCA (Fourie, 2006). Stoppard (2000:124-125) also identifies Cape Town Drug Centre and Pharmacists against Drug

Abuse as useful support services. However, In Cape Town only 6% of social service delivery focuses on chemical addiction. These organisations have expressed feelings of incompetence brought about by restricted resources and a lack of funding (Bozalek, Henderson, Lambert, Collins & Green, 2007:33).

Related to the length of treatment, Fisher and Harrison (2005:147-148) refer to three different studies in 1997 indicating that different treatment programmes did not have a significant effect on the outcome of treatment. The relapse and recovery rates were, according to these studies, not determined by the treatment programmes, but rather by the quality of the maintenance of recovery. This sentiment is echoed by Meyer (2005:292-293), who differentiates between three phases in treatment, namely detoxification, treatment programmes and aftercare. McNeece and DiNito (1998:93) refer to **aftercare** as the maintenance of the changes made in treatment, while an aftercare period as part of treatment of between 12 and 24 months is advised in order to pursue lifetime recovery (Dodgen & Shea, 2000:139; Health Resources, 2004). In conclusion, Gorski (2001:4) concurs that ongoing treatment in the form of aftercare is vitally important in preventing adolescent relapse.

The researcher has concluded from the information given above that, in order to treat adolescent chemical addiction effectively, relapsing should be viewed as part of the addiction process, and should be addressed throughout the treatment process. The quality of maintenance of recovery will be determined by seeing detoxification and motivation for treatment, treatment programmes and aftercare as the complete treatment package. If aftercare is neglected, the addict does not complete the whole treatment process, which will impact negatively on the ability to maintain sobriety.

Ongoing services are provided by Narcotics Anonymous (NA), a peer self-help group (Brandt & Delport, 2005:168). Additionally, SANCA renders specialised Social Work services to CAAs. However, SANCA's current services in the Western Cape entail preventative services, in-patient treatment programmes and out-patient treatment programmes. No specific focus is placed on aftercare. Recognising this gap in service



delivery to chemically addicted persons, SANCA appointed a social worker in May 2008 to develop aftercare services (Fourie, 2008). Additionally, Van den Berg conducted a study regarding aftercare needs of CAAs in Pretoria during 2003. This study resulted in 11 topics, focusing on life skills, to be addressed during aftercare services by social workers (Van den Berg, 2003:156-196). However, practice guidelines for aftercare services, designed for the needs of chemically addicted persons in the Western Cape, do not exist (Fourie, 2008). The researcher made contact with relevant practitioners and role-players regarding the aftercare to CAAs in the Western Cape. The following statements indicate that a need was felt for aftercare services:

*“Aftercare is a neglected area and should receive more attention. Family and parents should also be included when aftercare services are planned”* (Kotze, 2008).

*“Social workers need to be empowered to develop and use networks to deal with the situation. Adolescents have different needs; therefore different programmes should be developed for them”* (Van Zyl, 2008).

*“Adolescent chemical addiction has been identified as a key area that should be addressed, but no guidelines are available to social workers. These guidelines are needed because social workers do not have time to develop them”* (Boshoff, 2008).

*“The Department of Social Development appointed an aftercare worker, but no guidelines exist to assist with the development of aftercare services. Guidelines should be user-friendly”* (De Smidt, 2008).

*“In-patient treatment programmes should be followed up with aftercare services that address the restoration of family relationships, internalisation of life skills and emotional coping skills. We do not have anywhere to refer our patients where these aspects receive attention”* (Du Toit, 2008).

In line with these statements, Gordon (2003:11) notes a 60% recovery rate when aftercare programmes are utilised. In addition, Pienaar (2000:11) postulates that one cannot predict who will relapse, but can assume that relapse potential is decreased through ongoing support after treatment. Aftercare is essential to assist CAAs to rebuild their lifestyle and to manage developmental tasks (Velleman, 2001:100-107; United

Nations Office on Drugs and Crime, 2002:22; Fisher & Harrison, 2005:153-170; Jarvis, Tebutt, Mattick & Sand, 2005:131-224).

Considering that aftercare forms an intrinsic part of the treatment process (Meyer, 2005:292-293), and based on the abovementioned comments from practice, the researcher identified a need for the development of practice guidelines from a Social Work perspective relating to this important part of treatment of adolescent chemical addiction. Addressing the role of social workers in aftercare services, Dodgen and Shea (2000:54, 124) assert that some professional resistance to relapse prevention services exists among social workers. The authors identify psycho-education, identification of warning signs, development of skills to deal with high risks, change in lifestyle and enhancing self-efficacy, as areas that need professional input after treatment. In addition, the family, schools, peers and the community must be involved in services aimed at building resilience among adolescents who recover from chemical addiction (Terblanche & Venter, 1999:177; Baron & Byrne, 2000:164; Fraser, 2002:267-273).

The researcher completed a research study for a Masters Degree at the University of South Africa in 2007, exploring the relapse experiences of CAAs following in-patient treatment. This study showed that the participants had **specific needs** that should be addressed through aftercare services. The following conclusions relevant to aftercare services were made:

- The participants experienced social, parental and emotional problems that led to relapse, and that needed to be addressed as part of relapse prevention;
- Abstinence played an important role in relapse prevention;
- The development of life skills was an important element in the ability to change lifestyles;
- The availability of chemical substances and the acceptability thereof in the communities were seen as precipitating factors in relapses;
- Participants expressed the need for Social Work intervention, and indicated that a lack of Social Work services led to their relapses;

- The participants identified that a balance was needed between spiritual, emotional, physical and social well-being;
- The participants explained that knowledge did not prevent them from relapsing, and suggested that knowledge should be internalised in order to have an impact on relapse prevention (Van der Westhuizen, 2007:129-130).

In line with the above conclusions, the special needs of CAAs in recovery should be addressed through professional aftercare services. However, the specific needs of CAAs are often unrecognised and unaddressed in treatment services (Dodgen & Shea, 2000:124). Lubman, Allen, Rogers, Cementon and Bonoma (2007:105) advise that co-morbid mood and anxiety disorders are highly prevalent among CAAs, and should be addressed during aftercare. Post-traumatic-stress-disorder symptoms should also be considered when working with addicts, and should be addressed when they re-adjust in society (Ford, Hawke, Alessi, Ledgerwood & Petry, 2007:2431). Allen-Meares and Garvin (2000:275) place emphasis on the need to work within the developmental framework of the client, while Saulnier (2003:65) remarks on the value of client self-determination in the treatment of chemical addiction. Aftercare services to CAAs should therefore be based on research regarding their needs.

The situation outlined above is receiving international recognition. Both the United Nations and American authorities have identified a definite need for social research regarding the treatment of adolescent substance abuse (Dennis & McGeary, 1999; Youth at the United Nations, 2006). On a national level, the White Paper of Social Welfare of South Africa (1997:43) asserts that more statistics and research are needed in order to improve services in relation to substance abuse among South African schoolchildren. Fourie (2006, 2008) concurs that there is a definite need for research regarding the aftercare needs of adolescents, in order to develop appropriate services in this regard. Additionally, the business plan of the Treatment and Aftercare Portfolio of the Western Cape Drug Forum (2005:3) has identified gaps and a need for research regarding aftercare services in the province.

The researcher did an Internet search, as well as a literature study on the subjects of adolescent chemical addiction, treatment options and aftercare services. Apart from the study conducted by Van den Berg (2003:156-196), the literature and previous studies, referred to in the discussion thus far, do not focus on aftercare programmes or practice guidelines that link aftercare services by social workers with the specific needs of CAAs (Terblanche & Venter, 1999:161-178; Department of Health/Medical Research, 2003:102-103; Brandt & Delport, 2005:163-174; Noyoo et al., 2006:97; South African Community Epidemiology Network on Drug Use, 2007, 2008, 2009). Consideration of the previously discussed gap in research related to aftercare, as well as the comments from role-players in the practice (quoted in the discussion above); lead one to the conclusion that effective and relevant aftercare services by the Social Work profession are essential. Therefore, the researcher identified a need to develop practice guidelines for aftercare services to CAAs from a Social Work perspective based on the exploration of current Social Work aftercare services in the Western Cape, as well as the aftercare needs of CAAs.

## **1.2 Problem statement**

Kumar (2005:36) states that one must have a clear idea regarding “what it is you want to find out *about* and not what you *think* you must find”. A specific research problem which is small enough to be investigated should emerge from the initial literature study (Bak, 2004:111; Welman, Kruger & Mitchell, 2005:13). Based on this theoretical background provided in the previous section, the problem statement for this study was expressed as follows:

In response to the feedback given by role-players in the practice, **there seems to be a clear lack of aftercare services, which impacts negatively on the relapse potential among CAAs following in- or out-patient treatment.** Considering that aftercare forms an integral part of the treatment process, serious attention must be given to it when addressing adolescent chemical addiction. Social Work intervention should therefore include a specific aftercare service following in- or out-patient treatment, in order to offer

adolescents suffering from chemical addiction ongoing and adequate support in an effort to maintain sobriety and to prevent relapse.

### **1.3 Motivation for research**

Huysamen (1997:3) asserts that South Africa has a wealth of practical problems “crying out for research”. Following up on this sentiment, Bless, Higson-Smith and Kagee (2006:6) state that the motivation for a research study should be related to a practical problem and to a wide population, and that it should fill a research gap. Babbie and Mouton (2007:14) describe the reason behind social research as a “critical interest”. Following the theoretical background and rationale, and problem statement provided above, the researcher’s motivation for this research study is presented in this section.

Adolescent chemical addiction is an international concern. Literature quoted under the sub-heading “theoretical background and rationale” in this chapter reveals statistical proof of the increase in addiction to chemical substances among adolescents, the harmful effect on their development and future, and the alarming indication of relapse potential. Adolescent chemical addiction leads to a social and economic burden (Friedman, 2001:2; Mc Whirter et al., 2004:117). The physical and emotional damage caused by chemical substances, treatment costs and the potential to impair functioning in the adult life cycle, are considerable. The increase in adolescent substance abuse places an extra burden on the workload of social workers, and poses a challenge to adapt services to address this problem effectively (Fisher & Harrison, 2005:148). Treatment should include detoxification, treatment programmes and aftercare (Meyer, 2005:292; Fisher & Harrison, 2005:156). However, aftercare services seem to be excluded from the current services provided to CAAs.

The need for further research in this field is recognised (White Paper of Social Welfare of South Africa, 1997:43; Treatment and Aftercare Portfolio of the Western Cape Drug Forum, 2005:3; Fourie, 2008). Research endeavours, focusing on the lack of existing aftercare programmes or practice guidelines, as well as the specific needs of CAAs

following treatment<sup>3</sup>, have the potential to address the concern regarding adolescent chemical addiction in a relevant manner. The researcher therefore proposes that practice guidelines for aftercare from a Social Work perspective should be developed by means of intervention research, in order to address this problem and to make a contribution to the field of adolescent chemical addiction.

As a social worker, the researcher hopes to make a helpful contribution to the planning of aftercare services, and thereby also to address the recovery potential of CAAs through the proposed research.

#### **1.4 Research question**

A research problem leads to a research question or hypothesis. Quantitative research makes use of a hypothesis or research question, while qualitative research mainly attempts to answer a research question. Research questions are “interrogative statements or questions that the investigator seeks to answer”, and relate to the quality, meaning, context and “images of reality in what people do” (Holloway & Wheeler, 2010:20; Leedy & Ormrod, 2005:4-5; Fouchè & De Vos, in De Vos, Strydom, Fouché & Delpont, 2005:103). Considering the aforementioned research problem and motivation for this research endeavour, the researcher focused on what is happening as experienced by the individual or group to whom the problem situation is related (Dick, 2000; Creswell, 2009:129), thus employing a research question.

Because the intention of the present researcher was to discover and come to an in-depth understanding of the specific aftercare needs of CAAs in order to develop practice guidelines for social workers rendering aftercare services to CAAs, the qualitative perspective was chosen. The following research questions flowed from the research problem stated above.

- What are the specific aftercare needs of CAAs following treatment?

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<sup>3</sup> For the purpose of this study, “treatment” refers to both in- and out-patient treatment programmes. The participants in this study, however, were involved only in in-patient treatment programmes.

- What are the perceptions and experiences of social workers involved in services to CAAs regarding aftercare services?
- Based on the perspectives of the CAAs and the social workers, what are the key elements that should be included in practice guidelines for aftercare services to CAAs?
- Based on the perspectives of the CAAs and the social workers, how should aftercare practice guidelines for services to these adolescents be implemented?

### **1.5 Goal and task objectives**

The goal of a research study should be clear and specific, and it should describe the intentions of the researcher (Holloway & Wheeler, 2010:27; Knight, 2002:4). The goal of research can therefore be described as “the end toward which effort or ambition is directed” (De Vos & Schulze, in De Vos, Strydom, Fouchè & Delport, 2002:7). Focusing on the goal of qualitative research, Welman et al. (2005:192) assert that the goal should provide a description of the field of interest. Following the research questions, the goal and task objectives of the proposed study were stated as follows:

The **goal** formulated for the study reads: **To develop practice guidelines from a Social Work perspective relating to the provision of aftercare services by social workers to CAA’s following treatment**

In order to achieve the goal of this study, the following **task objectives** were proposed:

- To explore and describe the specific aftercare needs of relapsed CAAs following treatment relating to services by social workers;
- To explore and describe the perceptions and experiences of social workers regarding aftercare services to CAAs;
- To review literature that relates to aftercare services to CAAs;
- Based on the above findings, to develop practice guidelines from a Social Work perspective relating to the rendering of aftercare services by social workers to CAAs following treatment.

## **1.6 Research methodology**

Welman et al. (2005:2) postulate that the research methodology explains the logic behind the methods and techniques employed in a research study. The choice of research methodology for a research study depends on the goals and objectives of the study (Babbie & Mouton, 2007:49).

The choice for the appropriate research methodology for this research study, based on the abovementioned goals and objectives, is explained in the next section of this chapter.

### **1.6.1 Research approach**

There are two possible approaches to research: quantitative and qualitative. The emphasis of quantitative research is on the quantification of constructs and the central role of variables. It is deductive in nature, where hypotheses are formulated and tested out in the data that has been gathered for the purpose of the research study. The deductive nature of such a study presupposes a constant, stable and measurable external reality. On the other hand, qualitative research attempts to understand rather than to explain human action from the perspective of the “insiders” to the situation. It is inductive in that it is data-driven; findings and conclusions are directly drawn from the data. The inductive nature of this approach means that there is a movement from the perspective of the individual or group to possible wider themes (Meadows, 2003:465; Donalek & Soldwisch, 2004:354; Babbie & Mouton, 2007:49-54). The objectives of the present study, based on the research questions, was to explore and describe the aftercare needs of CAAs following treatment, as well as to explore and describe the perceptions and experiences of social workers regarding aftercare services to such youngsters. In addition, the researcher proposed to do a literature review, focusing on existing aftercare models, guidelines and suggestions to develop aftercare practice guidelines for utilisation by social workers rendering aftercare services to CAAs. In order



to answer the relevant research questions, the researcher therefore concluded that the **qualitative research approach** should be employed.

This research study has complied with the following relevant characteristics related to the qualitative approach (Leedy & Ormrod, 2005:135). Each characteristic was followed intentionally in this particular study:

- Qualitative research is often **exploratory**. Exploratory research assists a researcher to identify the themes and issues related to the study when little knowledge about the area exists (Alston & Bowles, 2003:34). The researcher proposed to explore the aftercare needs of CAAs, as well as the perceptions and experiences relating to current aftercare services of social workers who render aftercare services to CAAs.
- Qualitative research is **descriptive**. Descriptive research enables a researcher to make inferences about some characteristics or behaviours of the population (Creswell, 2003:154). In order to realise one of the objectives of the research study, the researcher described the specific aftercare needs of CAAs. She also described the perceptions and experiences of social workers regarding current aftercare services to CAAs.
- The qualitative approach is concerned with **interpretation and meaning**. Alston and Bowles (2003:207) state that interpretation of qualitative data includes identifying patterns and explanations that lead to conclusions. These conclusions can be tested through further data collection, reduction and interpretation. This study has explored the meaning social workers attach to current aftercare services to CAAs following treatment, and has interpreted the relevance of the data obtained to the aftercare needs as identified by CAAs.
- Qualitative research involves **verification**. Qualitative research is often criticised as being biased. It is therefore important to verify qualitative data (Denzin & Lincoln, 2003:12). The researcher verified the aftercare needs of CAAs, as well as the content of current aftercare services by social workers with the relevant literature (i.e. undertook a literature control).
- Qualitative research involves **evaluation**. Denzin and Lincoln (2003:35) describe evaluation in qualitative research as reflective and multi-voiced text that is grounded

in the experiences of the population of the study. Through this research, the researcher attempted to reflect on the experiences described by the populations of this study in order to inform the practice guideline development, focusing on aftercare services to CAAs by social workers, with the hope of preventing relapse.

In order to address the research problem and to answer the research questions, the researcher attempted to gain an understanding of the nature of current aftercare services rendered by social workers. She planned to compare this data with the identified aftercare needs of CAAs in recovery, as well as with the literature. A qualitative approach was therefore appropriate.

### **1.6.2 Research design**

A research design is the procedural plan of a researcher to answer the research question (which flows from the research problem) validly, objectively and economically (Kumar, 2005:74). It can be described as a “blueprint”, referring to a detailed research plan, structure and strategy of investigation in order to answer the research question (Mouton, 2001:55). Ploeg (1999:36) advises that the qualitative research design should describe, explore and explain the research problem being studied. The focus of qualitative research is therefore on the perceptions of the “actors in a situation” (Lester, 2006:1).

In order to achieve the goal of this research study, the researcher made use of the **intervention research design, employing the Intervention Design and Development (IDD) Model of Rothman and Thomas (1994:3-51)**. According to these authors, intervention research consists of six phases, accompanied by steps as presented in Table 1.1 below (as conceptualised by Fawcett et al., in Rothman & Thomas, 1994:28):

**Table 1.1:** Phases and steps of the Intervention Design and Development process of intervention research (Source: Rothman & Thomas, 1994:28)

PHASE 1	PHASE 2	PHASE 3	PHASE 4	PHASE 5	PHASE 6
<b>PROBLEM ANALYSIS AND PROJECT PLANNING</b>	<b>INFORMATION GATHERING AND SYNTHESIS</b>	<b>DESIGN</b>	<b>EARLY DEVELOPMENT AND PILOT TESTING</b>	<b>EVALUATION AND ADVANCED DEVELOPMENT</b>	<b>DISSEMINATION</b>
OPERATION 1 (STEP 1)	OPERATION 1 (STEP 1)	OPERATION 1 (STEP 1)	OPERATION 1 (STEP 1)	OPERATION 1 (STEP 1)	OPERATION 1 (STEP 1)
Identifying and involving clients	Using existing information sources	Designing an observational system	Developing a prototype or preliminary intervention	Selecting an experimental design	Preparing the product for dissemination
OPERATION 2 (STEP 2)	OPERATION 2 (STEP 2)	OPERATION 2 (STEP 2)	OPERATION 2 (STEP 2)	OPERATION 2 (STEP 2)	OPERATION 2 (STEP 2)
Gaining entry and cooperation from settings	Studying natural examples	Specifying procedural elements of the intervention	Conducting a pilot test	Collecting and analysing data	Identifying potential markets for the intervention
OPERATION 3 (STEP 3)	OPERATION 3 (STEP 3)	OPERATION 3 (STEP 3)	OPERATION 3 (STEP 3)	OPERATION 3 (STEP 3)	OPERATION 3 (STEP 3)
Identifying concerns of the population	Identifying functional elements of successful models		Applying design criteria to the preliminary intervention concept	Replicating the intervention under field conditions	Creating a demand for the intervention
OPERATION 4 (STEP 4)	OPERATION 4 (STEP 4)	OPERATION 4 (STEP 4)	OPERATION 4 (STEP 4)	OPERATION 4 (STEP 4)	OPERATION 4 (STEP 4)
Analysing identified concerns				Refining the intervention	Encouraging appropriate adaptation
OPERATION 5 (STEP 5)	OPERATION 5 (STEP 5)	OPERATION 5 (STEP 5)	OPERATION 5 (STEP 5)	OPERATION 5 (STEP 5)	OPERATION 5 (STEP 5)
Setting goals and objectives					Providing technical support for adopters

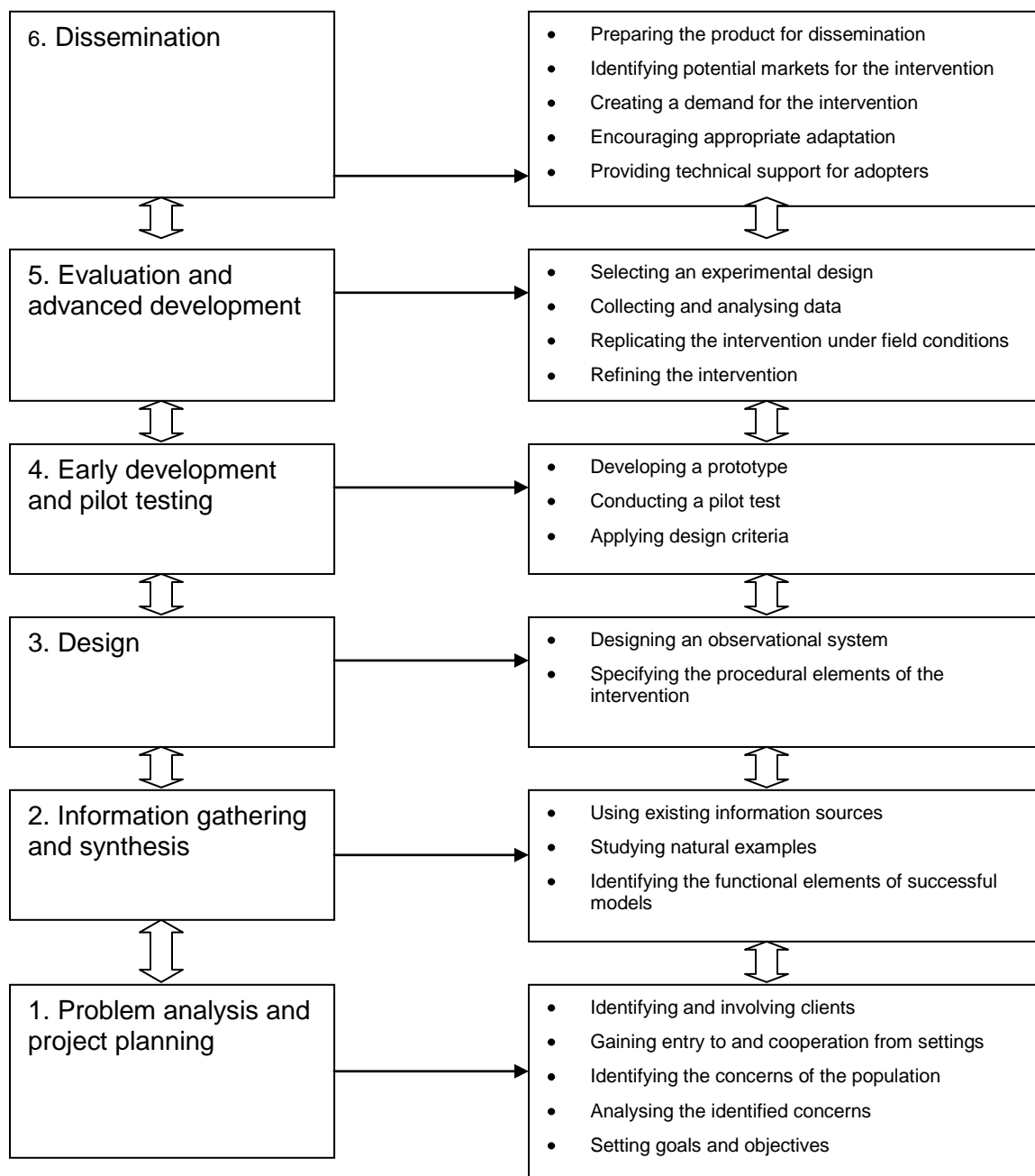
Intervention research is a flexible design which values the insights of the practitioners (Comer, Meier & Galinsky, 2004:250). The IDD-model of Rothman and Thomas (1994:3-51) aims to develop new interventions and human technologies, including strategies, techniques, methods and guidelines that can be implemented to assist social service delivery (De Vos, in De Vos et al., 2005:393). The relevance of this research design in this study was that the goal and objectives of this study were to contribute to the professional knowledge base, as it would explore and describe the views of CAAs regarding their aftercare needs, as well as the views of social workers involved in services to such adolescents regarding current aftercare services. It therefore provided

the opportunity to develop insight regarding the research problem. Based on the abovementioned explorations and the consequent insights, the researcher developed guidelines for Social Work aftercare services to CAAs by also incorporating information available in this regard from consulted literature. The study also focused on the utilisation of knowledge, as the proposed practice guidelines should improve social workers' understanding of aftercare services to CAAs (Rothman & Thomas, 1994:3-4).

**Applied research** plays an important role in planning, management, implementation and evaluation of projects, programmes and services (Bless et al., 2006:53). Seen on the continuum of “basic” and “applied” research, this research endeavour fell in the ambit of “applied research”, as it was intended to increase scientific knowledge by designing practical applications to improve services (Fox & Bayat, 2007:10). The exploration, and objective and systematic description of the nature of current Social Work aftercare services, and the subsequent comparison with the specific aftercare needs of CAAs in recovery, was followed by a literature study relating to aftercare services. Emanating from these steps, the researcher developed, from a Social Work perspective, aftercare practice guidelines aiding aftercare services to CAAs in recovery, in order to prevent relapse.

The research process is seldom a linear process and should not be seen as rigid, but rather as a guideline to assist a researcher with the execution of the research (Babbie, 2005:207). Figure 1.1 illustrates the interconnectedness of the phases and steps of the IDD-model of Rothman and Thomas (1994:3-51), as adapted and described by Bender (2007:68-84), and indicates how a researcher can return to previous phases when needed, when new information is obtained or when a shortcoming is identified.

**Figure 1.1:** Interconnected nature of the phases and steps of intervention research



For the purpose of this study, the researcher decided to make use of Phases 1 and 2 of the IDD-model, Step 2 of Phase 3 and Step 1 of Phase 4. The motivation for using only the identified steps in Phases 3 and 4, namely: “specifying procedural elements of the intervention” (Phase 3: Step 2) and “develop a prototype of preliminary intervention” (Phase 4: Step 1) is that these two steps in Phases 3 and 4 are interrelated, in that the prototype (Phase 4: Step 1) must be complemented by specific procedures (Phase 3:

Step 2) on how to operationalise the guidelines in practice. Time, financial and logistical constraints contributed to this decision. This intention of this research endeavour was to obtain a post-graduate qualification. The researcher proposed to disseminate the results to social workers and organisations involved in services to CAAs. It was also envisaged that the last two phases, namely evaluation and advanced development and dissemination, would form part of a post-doctoral research project.

In the section to follow, a description will be provided on how the phases and steps (referred to above) have been adapted for this research study.

**The intervention design and development model** (as adapted for this research study)

### **1.6.3 Phase 1: Problem analysis and project planning**

Rothman and Thomas (1994:27) identify five steps that contribute to the successful completion of the first phase of the IDD-model. These steps are: 1) Identifying and involving clients; 2) Gaining entry and cooperation from settings; 3) Identifying concerns of the population; 4) Analysing identified concerns; and 5) Setting goals and objectives.

In the next section of this chapter these steps will be introduced and the proposed implementation thereof described.

#### **1.6.3.1 Step 1: Identifying and involving clients**

This operation is the first step of the IDD-model of Rothman and Thomas (1994:27). A research problem may relate to a specific **population**, which can be described as the “electorates” from whom a researcher selects participants for the research study. In a qualitative research study, the population includes all the persons about whom the inferences are to be drawn (Kumar, 2005:149; Welman et al., 2005:52; Leedy & Ormrod, 2005:206).

In order to explore and describe the specific aftercare needs of CAAs following treatment relating to services by social workers, as well as the perceptions and experiences of social workers involved in services to CAAs regarding current aftercare services, **the interest groups that formed the basis for the choice of the populations for the purpose of this study were defined as follows:**

- All chemically addicted adolescents in the Western Cape who had relapsed after in-patient treatment
- All Social Work service providers dealing with adolescent chemical addiction in the Western Cape.

The motivation behind the focus on the Western Cape was the following: The researcher was situated in the Western Cape; therefore it would be time- and cost-effective to focus on this geographical area. The researcher also considered the fact that adolescent chemical addiction was particularly prevalent in the Western Cape (Caelers, 2005:1; Plúddeman et al., 2007:12). This research endeavour therefore addressed a specific need in the area where the researcher was working and living.

The **purposive sampling technique** is used when a sample is chosen for a specific reason to provide insight into a particular field of interest, and is determined by the research topic (Alston & Bowles, 2003:90; Bless et al., 2006:121). Leedy and Ormrod (2005:206) propose this sampling technique as suitable for qualitative research. Welman et al. (2005:69), however, question the level of representation from the population of this sampling technique. In order to combat this limitation, Leedy and Ormrod (2004:206) advise that a researcher be clear about the reason why the sample is viewed as relevant to the research problem and research question. Purposive sampling was employed in this qualitative research study to provide the researcher with a sample from whom to access a specialised insight into the nature of current Social Work aftercare services by the relevant role-players in the Western Cape, as well as the aftercare needs of CAAs following treatment in the Western Cape.

A **sample** is a subset of measurements drawn from the population in which a researcher is interested, and should be representative of the population of the study (Strydom & Venter, in De Vos et al., 2002:199; Welman et al., 2005:55). A sample for inclusion in this study was selected from the abovementioned two populations. In order to explore and describe the specific aftercare needs of CAAs following treatment relating to services by social workers, **the criteria for inclusion for the chemically addicted adolescent interest group** were as follows:

- Chemically addicted adolescents
- having previously undergone in-patient treatment
- having had contact with a social worker following treatment
- having relapsed thereafter
- were back in in-patient treatment programmes
- in the Western Cape.

In order to explore and describe the perceptions and experiences of social workers involved in services to CAAs regarding aftercare services, **the criteria for inclusion of the Social Work interest group** were defined as follows:

- Registered social workers
- employed by the Department of Social Development
- also employed by Non-Governmental Social Work Organisations (NGOs)
- providing aftercare services to chemically addicted adolescents
- in the Western Cape.

Cherry (2000:54) states that a major difference between quantitative and qualitative research is the **sample size**. Dick (2000) advises that a qualitative researcher add to the sampling until the information being gathered becomes repetitive. A sample size for this study could therefore not be determined in the beginning of the research, but was determined by data saturation, which enhanced external reliability (Strydom & Delport, in De Vos et al., 2002:335). The researcher and the study's promoters decided to cease the process of continuing to procure further participants to be included in the sample



when data saturation was detected after 31 narratives (obtained from CAAs) and seven focus groups (with social workers involved with aftercare to CAAs).

### **1.6.3.2 Step 2: Gaining entry and cooperation from settings**

The researcher made use of “gatekeepers” prior to the identification and involvement of the research populations (as stated in Step 1 above). The purpose was to gain entry and cooperation from the settings where data would be collected. According to Neuman (2003:338), a gatekeeper is someone with the formal and informal authority to control access to a site (cf. Creswell, 2009:178).

In order to gain access to the sample selected from the population of **chemically addicted adolescents** in the Western Cape who had relapsed after treatment, the researcher established contact with the adolescent in-patient treatment centres in the Western Cape by means of a written invitation (see Annexure A, p. 453). A meeting was arranged with the interested centres, at which time the purpose of this study was explained to the relevant staff members. They were requested to participate in the study and to identify possible participants. The participating treatment centres acted as gatekeepers, regulating the researcher’s access to the participants (Leedy & Ormrod, 2005:137).

Following this, the researcher obtained from the participating centres the names of possible participants who complied with the inclusion criteria. She established contact with these adolescents and their parents/guardians by means of an introduction interview at the relevant centres, to explain to them the purpose and the process of this research study (see Annexure B, p. 455 and Annexure C, p. 457). Their willingness to participate in the research was determined during this time. Willing and interested participants were then provided with a description of the theme that would be the focus of their narratives. Confidentiality and consent were discussed, and consent forms were signed (see Annexure D, p. 459 and Annexure F, p. 466). Following this, an appointment was made for the data to be collected.

In order to gain access to the sample selected from the population of **social workers** rendering services to CAAs regarding aftercare services, the researcher followed the following procedures. She contacted SANCA and the Western Cape Department of Social Development in order to obtain names and contact numbers of Social Work service providers who rendered aftercare services to CAAs. She then made contact with these service providers by means of an introduction letter (see Annexure E, p.463). Following these letters, the researcher contacted the service providers telephonically in order to establish their willingness to participate in the study.

Interviews with willing participants were arranged, during which time the purpose of the research and the format of the study were discussed with them. The following information was shared with willing and interesting parties: The purpose of the study and the criteria for inclusion were explained, the method of data collection was given (focus groups), the location and duration of the focus groups were given, participants were assured of anonymity and confidentiality, and permission to tape-record the interviews was obtained. The researcher also informed the participants that only the researcher, the editor, an independent coder and the researcher's promoter and co-promoter would have access to the tape-recordings and transcripts. Those who agreed to participate were given consent forms to sign. A list of possible questions was provided to willing and interested participants, and confidentiality and consent were discussed and consent forms signed (see Annexure D, p. 459 and Annexure F, p. 466). Following this, an appointment was made for the data to be collected.

### **1.6.3.3 Step 3: Identifying the concerns of the populations**

Regarding a method to explore the concerns of the population, Rothman and Thomas (1994:29) recommend a qualitative research approach, as it allows a researcher the peculiar opportunity to gain data through informal contact with the participants. The researcher used face-to-face interviews with key role-players and practitioners in the field of chemical addiction to enquire about the state of the art (in terms of aftercare guidelines and services) available to CAAs in practice in view of underscoring the need

for the development of such practice guidelines (see “Theoretical background and rationale for the study” in the beginning of this chapter). Based on the outcome of this inquiry, pointing to the lack of aftercare guidelines and services specifically catering for CAAs following treatment, and for the purpose of comprehensively identifying the concerns of the population, the researcher used an exploratory, descriptive, contextual design as a qualitative strategy of inquiry with both samples taken from the populations of CAAs who relapsed following treatment and social workers who were involved in aftercare services to the abovementioned group. The following **research designs** were selected for the purpose of this study for the characteristics given below.

**Exploratory research** investigates a phenomenon where little knowledge exists (Kumar, 2005:9-10; Babbie & Mouton, 2007:79). The researcher established that the literature consulted and previous studies did not focus on aftercare programmes or practice guidelines based on social workers’ perceptions and experiences of existing aftercare programmes, as well as the specific aftercare needs as identified by CAAs. This particular study proposed to explore the content and format of aftercare practice guidelines aimed at such social workers and adolescents, and based upon their expressed needs in this regard.

**Descriptive research** attempts to describe a situation, problem, phenomenon, service or programme, making use of a research question, rather than a hypothesis (Kumar, 2005:9-10). Patton (2002:115) explains that the descriptive research design provides a detailed description of lived experiences of the participants in a research study (cf. Alston & Bowles, 2003:35). An advantage of this research design is that the description of a situation can lead to a better understanding of a research problem (Fox & Bayat, 2007:8). The researcher attempted to answer the research questions by describing the aftercare needs of CAAs, as well as the nature of current aftercare services by social workers to these young people following treatment.

**Contextual research** seeks to avoid the separation of participants from the larger context to which they may be related. This characteristic is in line with qualitative

research, which emphasises holism and everyday life (Kelly as cited in Terre Blanche & Durrheim, 1999:398; Shaw & Gould, 2001:17). The researcher explored the nature of aftercare services currently rendered to CAAs within the context of the social workers employed in this field of service delivery. In addition, the researcher explored and described the views of CAAs who returned to in-patient treatment centres in the context of previous exposure to Social Work aftercare services following previous in-patient treatment, and relapses after previous in-patient treatment.

The qualitative research method can assist a researcher to gain data through contact with the participants. A researcher should be careful not to impose on to the population his/her own perceptions of the research problem. The population should be encouraged and allowed to express their own thoughts, concerns and judgements regarding the research problem and research questions (Rothman & Thomas, 1994:29-30).

In order to explore and describe the needs of **chemically addicted adolescents** who had relapsed following previous in-patient treatment, the participants were asked to write narratives about their needs relating to aftercare services by social workers. According to Denzin and Lincoln (2003:217), narrative as a method of data collection in qualitative research is akin to biography. It discloses hidden details of private experiences. The benefit of **narrative inquiry** is that it provides a researcher with multi-faceted insights into the situation that is being investigated (Bell, 2005:23). It provided these participants with the opportunity to describe their perceptions of aftercare services by social workers that could assist them to prevent further relapses. They were asked to write narratives based on the theme: ***“The things social workers can help me with to maintain my sobriety after treatment.”***

In order to identify the concerns of **social workers** regarding aftercare services to CAAs, the researcher proposed to employ **qualitative interviewing**. Qualitative interviewing aims to promote understanding from the participants' point of view. It is in line with the abovementioned characteristics of the qualitative approach as it aims to explore, describe and evaluate (Leedy & Ormrod, 2005:135; Sewell, 2006:1). Sewell

(2006:1) warns that this form of data collection can be experienced as intrusive, and can react to moods and personalities, and that data analysis is time-consuming. However, the advantages of this method are that it is flexible, provides participants with the opportunity to describe what is meaningful to them, and provides a researcher with rich data. Babbie (2005:313) describes the advantages of qualitative interviewing as iterative and continuous, rather than prepared and “locked in stone”.

The researcher considered both the advantages and the disadvantages of this method of data collection, and concluded that qualitative interviews would enable her to explore the research problem most effectively, so that it was best suited to answer the research questions. Qualitative interviewing gave the participants the opportunity to share all the information they deemed relevant to their aftercare services, and prevented restriction to only the identified needs, as obtained from the researcher’s previous exploration of the relapse experiences of CAAs.

The **focus group** as a method of qualitative interviewing is essentially the collection of data through simultaneous questioning of several individuals (Denzin & Lincoln, 2003:71). Knight (2002:71) warns that a researcher must be aware that focus groups may result in some issues that receive only brief attention. However, Greeff (in De Vos et al., 2002:301) emphasises the value of focus groups in qualitative research when the intention is to explore a range of feelings and experiences.

In order to explore the nature of current Social Work aftercare services to CAAs, the researcher proposed to make use of qualitative interviewing in focus groups, as it provided an opportunity to promote self-disclosure among participants. Multiple viewpoints could be obtained, and shared experiences could form a platform for discussion. The use of focus groups was also cost- and time-effective (Greeff, in De Vos et al., 2002:306-307; Leedy & Ormrod, 2005:146).

Sewell (2006:4) describes an **interview guide** as an outline of topics or issues to be covered by the research. This author stresses that a researcher is free to vary the

wording and order of questions to some extent, but warns that the guide should not restrict participants only to answering the question. To encourage the present participants to explore the nature of current Social Work aftercare services to CAAs, the following questions were asked:

- What are your views in general regarding aftercare services to CAAs?
- Tell me about the services you employ to address aftercare to CAAs.
- What resources are available to you to support your work?
- What restrictions do you experience?
- If you were to compile practice guidelines for social workers in view of rendering aftercare services to CAAs, what would you include?

In order to explore the research question fully and to enhance communication during the focus groups, the researcher made use of the following communication techniques.

- **Minimal verbal responses** were used to show the participants that the researcher was listening and was interested in what they had to say (Greeff, in De Vos et al., 2002:289-290). The researcher, for example, said “Yes...” when a participant made a comment which the researcher hoped he/she would expand on. This technique also served as **encouragement**.
- **Clarification** brought vague data into sharper focus (Brammer & MacDonald, 1999:75). The researcher rephrased the participants’ sentences when she wanted to ensure that she understood the content of the sentence correctly, by saying “Did you mean...?” However, this technique was used with care, as the researcher wanted to avoid leading the participants.
- **Focusing** was used to ensure that the discussion remained related to the research question and to avoid wandering (Brammer & MacDonald, 1999:79; Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2006:148). The researcher repeated a question or the last relevant statement, when it appeared that the participants had lost the focus of the interview. For example, she said “Let’s focus again on what you said when....”
- **Summarising** was employed to link all the elements together and to encourage the participants to be sure that the information was correct and did not lack depth

(Hepworth et al., 2006:157). The researcher made use of comments such as “So what you were saying is...” to summarise information and to stimulate further discussion.

- **Probing** was used to ensure that the maximum amount of data was obtained (Niewenhuis, in Maree, 2007:88). The researcher asked for more detail by means of “Who?”, “Where?” and “What?” questions. She avoided “Why?” questions to enhance **reassurance**.

During the course of the data collection process, the researcher also made use of the role of clarifier in order to clarify the purpose of the study to participants (Creswell, 2009:178). In addition, she facilitated the focus groups. This involved focusing on creating a safe and comfortable environment for the groups (Greeff, in De Vos et al., 2002:317).

Welman et al. (2005:196) advise that a researcher must be careful not to allow **data recording** to become a disturbance during the interviews. The method of data recording for the data obtained from relapsed **chemically addicted adolescents** was their written narratives. Data obtained from the **social workers** was recorded by means of tape-recordings, which were transcribed later. The transcripts were kept as evidence of the research. The advantage of the use of tape-recordings is that a researcher can listen to them a number of times to ensure that data does not get lost (Kumar, 2005:108). Additional data was obtained by means of field notes, focusing on the content of the discussion, as well as aspects such as seating arrangements, communication patterns, dynamics and non-verbal communication to add to the transcripts in order to complete the data collection (Greeff, in De Vos et al., 2002:318). While focus group interviewing was the primary method of data collection, the researcher also employed participant observation as a complementary method of qualitative interviewing. The researcher completed the field notes directly after the focus groups, ensuring that she was able to recall the details.

#### 1.6.3.4 Step 4: Analysing the identified concerns

This step in Phase 1 of the IDD-model of Rothman and Thomas (1994:31) concerns itself with analysing the identified concerns as articulated by the participants in the previous step. Sarantakos (2000:210) describes data analysis as the process in which data reduction, presentation and interpretation take place. Qualitative data analysis involves the analysis of the content, the discovery of regularities, and the comprehension of the meaning of the data (Babbie & Mouton, 2007:490).

Once data became repetitive and data saturation was reached, data analysis was conducted. The researcher analysed the written narratives pertaining to the CAA's aftercare needs, as well as the transcripts pertaining to the participating social workers' perceptions and experiences, in order to address the research question.

The framework for data analysis for qualitative research by Tesch (in Creswell, 2009:186) was used to ensure a systematic manner of data analysis. This involved the following eight steps, conducted separately for the two sets of data collected.

**Step 1:** The researcher read all the narratives/transcripts in order to get a sense of the whole. Ideas that developed from reading the narratives/transcripts were noted.

**Step 2:** One narrative/transcript were chosen as the most interesting. It was studied, while the researcher made notes of the topics and themes identified.

**Step 3:** The researcher then repeated the second step with all the narratives/transcripts. Once all the topics were identified, they were clustered together and labelled according to their characteristics.

**Step 4:** The topics were given code words. The narratives/transcripts were then studied again, while the codes were placed in the narratives/transcripts at the relevant places.

**Step 5:** The researcher then categorised the topics, and certain topics with specific characteristics were placed into a category.

**Step 6:** A decision to include the categories was then made.

**Step 7:** The categories in each narrative/transcript were identified. All the information in one category was then collected.



**Step 8:** The researcher then proceeded to write the report, based on this analysis.

These eight steps ensured that the data analysis occurred in a comprehensive and systematic manner.

**Data verification** ensures that the findings of the research accurately represent what is happening in the situation being studied (Welman et al., 2005:142). It is essential to establish the trustworthiness of a study in order to validate the findings and subsequent conclusions. De Vos (in De Vos et al., 2005:345) refers to Guba's model (as cited in Krefting, 1991:214-222) as a "classic contribution to the methodology of qualitative research". The trustworthiness of the qualitative data obtained through this study was therefore based on Guba's model, and verified by other literature. The following four aspects, according to this model, were addressed.

**Truth value:** The meaning of truth in qualitative research can be described as a "fit", meaning that a statement can be viewed as more or less true, varying between a "loose and a good fit"; as well as the relationship between the statement and the context (Babbie & Mouton, 2007:9). The level of confidence in the truth of the findings, based on the research design, participants and the context in which the study was undertaken, will determine the truth value of a study (Krefting, 1991:215). The researcher therefore considered whether the findings were a true reflection of CAAs' aftercare needs and of social workers' perceptions and experiences of aftercare services to CAAs. She established confidence in the truth of the findings through the strategy of credibility, and by using the following criteria:

- **Interviewing techniques** such as encouragement, probing, reassurance, clarification, summarising, focusing and minimal verbal responses were used.
- **Triangulation** is the comparison of multiple perspectives by using different methods of data collection, different sources of data collection, and different theories (Krefting, 1991:219). Babbie and Mouton (2007:275) are of the opinion that triangulation in qualitative research is one of the best ways to enhance the reliability of a study. In the present study, using more than one focus group and selecting

participants from different Social Work organisations as well as written narratives by CAAs at different treatment centres created a triangulation of methods and sources of data collection in this study. Triangulation of theory was also employed as the findings were verified and compared with different theories related to the subject being studied.

- Krefting (1991:219) views **peer-examination** as a profitable criterion for data verification. The value of peer examination is that the work is questioned by people outside the context of the study, but who have an understanding of research in general and the nature of the study (Babbie & Mouton, 2007:277). Advice and guidance from colleagues who were experienced in the field of qualitative research were used throughout this research study.
- **Authority of the researcher:** Welman et al. (2005:3) accept the value of the authority of a researcher, but warn that the evidence on which statements are based must also be examined when the truth value of a study is considered. The researcher had specialised in the field of chemical addiction while working as a social worker in three different treatment centres over a period of ten years. During this time she formed part of multi-disciplinary teams, and was involved in writing three different in-patient treatment programmes, one of which was specifically focused on adolescents. Prior to the abovementioned employment, she also worked as a social worker in the field, when the impact of chemical addiction on the family and society was observed. In addition, the researcher conducted a qualitative research study for a Masters Degree through the University of South Africa, focusing on CAAs' experiences of relapsing after treatment. However, in order to prevent contamination of the data obtained through this study, she considered the previously obtained data only after the data from the study had been obtained and analysed.

**Applicability:** The degree to which the findings of a research study are applicable to other contexts or groups affects the trustworthiness of the research, according to Krefting (1991:216). Transferability is a strategy through which applicability can be established. Babbie and Mouton (2007:277) postulate that observations in qualitative research are defined by the specific contexts in which they occur. Therefore the

qualitative researcher does not claim that the specific context of the study is relevant to other contexts. On the other hand, these authors maintain that transferability in qualitative research is enhanced through the criterion of a “thick” description of the methodology and the purposive sampling technique. In order to enhance the applicability through transferability of this research, the purposive sampling technique was employed. The researcher also provided a dense description of the research methodology employed, in order to enhance transferability.

**Consistency:** Guba (as cited in Krefting, 1991:216) refers to consistency as “whether the findings would be consistent if the inquiry were replicated with the same subjects or in a similar context”. Agreeing with this sentiment, Leedy and Ormrod (2005:88) assert that the outcome of the research must be the same when “any other competent person” repeats the process. Dependability is the strategy through which consistency can be established. The researcher made use of a dense description of the research method, triangulation (of theory, multiple data collection choices, and multiple sources), peer examination and an independent coder, as known criteria to establish consistency.

**Neutrality:** Guba (as cited in Krefting, 1991:216-217) asserts that neutrality in qualitative research (referring to the degree to which the research findings are unbiased) should consider the neutrality of the required data, rather than that of the researcher. Neutrality can be achieved through the strategy of confirmability and by employing the following criteria: a confirmability audit based upon extensive field notes, combined with the transcripts of the interviews, findings, interpretations and recommendations (Krefting, 1991:221; Cherry, 2000:65; Babbie & Mouton, 2007:275). The findings therefore were based on the data obtained from the transcripts, which included the field notes, as well as the written narratives. It assisted the researcher to prevent subjective perspectives from guiding the process. Furthermore, triangulation of multiple data collection choices and sources assisted the researcher to achieve neutrality.

### 1.6.3.5 Step 5: Setting the goal and objectives

The final step in the first phase of the IDD-model focused on the identification of goals and objectives for the study. Rothman and Thomas (1994:31) describe the purpose of formulating goals and objectives as the aim to provide direction to the research study. The following **goal** was selected for the purpose of this research study: To develop practice guidelines from a Social Work perspective relating to the provision of aftercare services by social workers to CAA's following treatment.

In order to reach the goal of this study, the following **task objectives** were developed.

**Task objective 1** To explore and describe the specific aftercare needs of relapsed CAAs following treatment relating to services by social workers.

**Task objective 2** To explore and describe the perceptions and experiences of social workers regarding aftercare services to CAAs.

**Task objective 3** To review literature that relates to aftercare services to CAAs.

**Task objective 4** Based on the above findings, to develop practice guidelines from a Social Work perspective relating to the rendering of aftercare services by social workers to CAAs following treatment.

Subsequent to the setting of the goal and objectives of the study, the researcher proceeded to gather information on the field of interest.

### 1.6.4 Phase 2: Information gathering and synthesis

The discussion that follows introduces the three steps inherent to Phase 2 of the IDD-model as proposed by Rothman and Thomas (1994:32). These steps are: 1) Using existing information sources; 2) Studying natural examples; and 3) Identifying functional elements of successful models.

#### **1.6.4.1 Step 1: Using existing information sources**

This step is based on the examination of various resources which should provide the researcher with a greater understanding of the phenomena under investigation. It assisted the researcher to obtain a knowledge base regarding the technology related to the focus of this research endeavour, including adolescence, chemical addiction, and aftercare programmes/models (Rothman & Thomas, 1994:32). A literature review is an integrated summary of all available literature that focuses on a specific research problem and research question (Bless et al., 2006:183). Based on the latter comment, and for the purpose of this research, a library catalogue as well as an electronic search (scrutinising the following data basis: Nexus, The HRSC's data base, and the NRF's data base) was undertaken in order to explore the existing body of knowledge and state of technology available on the topic under investigation.

#### **1.6.4.2 Step 2: Studying natural examples**

According to Rothman and Thomas (1994:32), "studying natural examples" involves a process of gaining the population's perceptions on the social phenomenon being studied, in terms of how the population experiences the abovementioned, how they are affected by it, and what was, or is, being done to alleviate the problem.

The researcher made use of narrative writing (for the sample from the population of relapsed CAAs) and qualitative interviewing in focus groups (for the sample from the population of service providers to CAAs) in order to obtain the information, as described in Phase 1, Step 3 (see p. 26). The purposive sampling technique was employed. The data was analysed based on the data analysis process by Tesch (as cited in Creswell, 2009:186), while data verification was based on Guba's model (as cited in Krefting, 1991:214-222). In the table below, a summarising overview is provided of the research design and method that were chosen to explore the concerns of the interest groups relating to the social phenomenon under investigation.

**Table 1.2:** The research design and method

<b>Group</b>	<b>Population</b>	<b>Sample</b>	<b>Sampling method</b>	<b>Data collection method</b>	<b>Data analysis and data verification methods</b>	<b>Goals and objectives</b>
1	All chemically addicted adolescents in the Western Cape who had relapsed after treatment	Chemically addicted adolescents who previously underwent in-patient treatment, had contact with a social worker, relapsed thereafter, currently back in in-patient treatment programmes in the Western Cape	Purposive sampling	Narrative inquiry	Data analysis according to the framework of Tesch (as cited in Creswell, 2009:186)  Data verification based on Guba's model (as cited in Krefting, 1991:214-222)	Goal: To develop practice guidelines from a Social Work perspective relating to the provision of aftercare services by social workers to CAA's following treatment.  Objectives: To explore and describe the specific aftercare needs of relapsed CAAs following treatment relating to services by social workers.  To review literature that relates to aftercare services to CAAs.  Based on the above findings, to develop practice guidelines from a Social Work perspective relating to the rendering of aftercare services by social workers to CAAs following treatment.
<b>Group</b>	<b>Population</b>	<b>Sample</b>	<b>Sampling method</b>	<b>Data collection method</b>	<b>Data analysis and data verification methods</b>	<b>Goals and objectives</b>
2	All Social Work service providers to adolescent chemical addiction in the Western Cape	Social workers employed by the Department of Social Development and Non-Governmental Social Work Organisations (NGOs), providing aftercare services to chemically addicted adolescents in the Western Cape	Purposive sampling	Qualitative interviewing  Focus groups	Data analysis according to the framework of Tesch (as cited in Creswell, 2009:186)  Data verification based on Guba's model (as cited in Krefting, 1991:214-222)	Goal: To develop practice guidelines from a Social Work perspective relating to the provision of aftercare services by social workers to CAA's following treatment.  Objectives: To explore and describe the perceptions and experiences of social workers regarding aftercare services to CAAs.  To review literature that relates to aftercare services to CAAs.  Based on the above findings, to develop practice guidelines from a Social Work perspective relating to the rendering of aftercare services by social workers to CAAs following treatment.

### **1.6.4.3 Step 3: Identifying the functional elements of successful models**

This step in Phase 2 of the IDD-model addresses the importance of exploring different service programmes, practice guidelines and services, and evaluating their effectiveness in addressing the research problem (Rothman & Thomas, 1994:33). Focusing on aftercare programmes or practice guidelines to CAAs by social workers, the researcher determined which programmes or practice guidelines would be used through the data analyses obtained in Phase 1, Step 4 (see p. 32), as well as a literature study. The features, advantages and limitations of the identified programmes or practice guidelines were evaluated and verified with the literature, and compared with the specific aftercare needs expressed by the group of adolescents and by social workers in the field. This phase enabled the researcher to have a knowledge base when designing Social Work aftercare practice guidelines for similar young people.

### **1.6.5 Phase 3: Design of human service technology**

This phase consists of two steps, namely: 1) Design of an observational system, and 2) Specification of the procedural elements of the intervention. Considering that this research study did not include the fifth and sixth phases of the IDD-model, the design of an operational system was not relevant for the purpose of this study. The second step assisted the researcher to complete Task Objective 4 (see p. 36) and this will be referred to in the discussion that follows.

#### **1.6.5.1 Step 2: Specifying the procedural elements of the intervention**

This step enables a researcher to identify how the intervention (developed in Phase 4, Step 1) should be implemented (Rothman & Thomas, 1994:33) The researcher made use of the information gained from the literature review (task objective 3: see p. 36) and empirical findings (task objectives 1-2: see p. 36) to develop aftercare practice guidelines for CAAs following treatment, in order to assist social workers to provide relevant and effective interventions. Once all the information was analysed

and interpreted, it provided the researcher with a framework for the development of the guidelines.

#### **1.6.6 Phase 4: Early development**

This phase is characterised by the development of practice guidelines by means of a process where innovative intervention is implemented. Rothman and Thomas (1994:36-37) have identified three steps in this phase, namely: 1) Developing a prototype intervention, 2) Conducting a pilot study and 3) Applying design criteria to the prototype intervention concept. For the purpose of this research endeavour, the researcher concluded this study with the first step of this phase.

##### **1.6.6.1 Step 1: Developing a prototype intervention**

During this study, the researcher implemented Step 2 of Phase 3 and Step 1 of Phase 4 for the IDD-model of Rothman and Thomas (1994:36-39) in an integrated manner, in order to develop Social Work aftercare practice guidelines for CAAs. The latter entails describing an aftercare guideline targeting CAAs (as a prototype of human service technology) with the inclusion of how to operationalise the guidelines in a practical setting. The description of the programme entailed the goal and objectives of such guidelines, as well as prerequisite knowledge, functional aids and concise strategies regarding the implementation thereof.

The ethical considerations for this research endeavour are discussed in the next section of this chapter.

#### **1.7 Ethical considerations**

Ethics are the principles of conduct and behaviour that are considered by the profession as correct (Kumar, 2005:190). Leedy and Ormrod (2005:101) note that ethical implications should be carefully considered when human beings are the focus



of investigation. The researcher included the following ethical considerations in this research study.

### **1.7.1 Informed consent**

Participants should be informed about the purpose and nature of the research, and they should have a choice of either participating or not (Leedy & Ormrod, 2005:101). This information must be conveyed in clear and understandable language (Hepworth et al., 2005:65). Other information that the participants should receive is the goal of the research, the procedures that will be followed, the advantages and possible disadvantages and risks of participation, the credibility and role of the researcher, the assurance of self-determination, the availability of support after the data is collected, and the opportunity to ask questions (Luw & Edwards, 1998:50). Additionally, Cherry (2000:67) advises that a researcher should ask permission to tape-record the interviews, and that participants sign a consent form.

The researcher ensured that informed consent formed part of this study by addressing the following aspects. Participants were informed regarding the purpose and nature of the research and that they had a choice of either participating or not in clear and understandable language. Other information that the participants received was the goal of the research, the procedures that would be followed, the advantages and possible disadvantages and risks of participation, the credibility and role of the researcher, the assurance of self-determination, availability of support after the data was collected and the opportunity to ask questions. Additionally, the researcher asked permission to tape-record the interviews. The researcher shared this information with the participants during the introduction interviews. When it was certain that the participants and the parents or guardians of the CAAs had no further questions, all parties involved signed a consent form.

### **1.7.2 Protection from harm to participants**

Leedy and Ormrod (2005:101) suggest that the physical and emotional risks involved in a study should be no greater than risks of day-to-day living. The participants should be assured that their safety is valued by the researcher (Welman et al., 2005:201).

In order to explore the experiences of CAAs, the researcher attempted to ensure that the narrative inquiry formed part of their day-to-day programme at the treatment centres, to prevent physical and emotional disruption. In addition, arrangements were made to refer the participants to their therapists for debriefing, if needed, after writing the narratives.

In order to explore the current nature of Social Work aftercare services, the researcher attempted to arrange the focus groups at times and locations that would be convenient for the participants. They were also, if needed, referred to their supervisors for debriefing at the end of the focus groups.

### **1.7.3 Right to privacy and confidentiality of data**

Strydom (in De Vos et al., 2002:67) describes privacy as “aspects which are not normally accessible for others to observe and analyse”. In order to respect the participants’ right to self-determination as to what to share and whether to share, participants were not forced to share their experiences and they were informed that they could refuse to complete the written narratives or leave the focus groups at any time.

In addition, Louw and Edwards (1998:51) advise that confidentiality should also include the storage of data. Data was stored in a safe place and participants were informed that only the researcher, translator (if needed), editor, independent coder and the researcher’s promoters would have access to the tape-recordings and transcripts.

Finally, Hepworth et al. (2005:67) emphasise that all registered social workers are bound by a code of ethics, which ensures the respect of privacy and confidentiality, when working with people. The researcher is a social worker, registered at the South African Council for Social Service Professions in accordance with Act 110 of 1978, and thus held to a professional code of ethics.

In order to avoid misinterpretation, the following section provides the reader with definitions of the key concepts that were applicable to this study.

### **1.8 Clarification of key concepts**

In order to ensure clarity, the researcher defined the following key concepts of the discussion that would follow in the study:

#### **1.8.1 Addictive chemical substances**

Addictive chemical substances are substances which are physically and/or psychologically addictive in nature and cause clinically significant impairment or distress (Barber, 2002:2). Neuro-scientific studies show that different chemical substances have different effects on different areas of the brain (Fitzhugh, 2004:30). Regular use of chemical substances leads to neuro-adaptation, referring to changes in the chemistry of the brain to oppose the effects of the chemical substances, leading to tolerance.

**Tolerance** to chemical substances refers to the need for increased amounts of the chemical substance in order to obtain the same result. Tolerance develops as nerve cells counteract the psychoactive effects on the chemical and structural levels of the brain. It leads to **cravings**, and the addicted person continuously searches for the initial “high” feeling (Fitzhugh, 2004:30; Lessa & Scanlon, 2006:33; Perkinson, 2008:20). Explaining cravings, Keegan and Moss (2008:150) postulate that dopamine is a neurotransmitter (i.e. a chemical that acts as a messenger in the brain) that influences motivation and the perception of reality. Dopamine reinforces

behaviour and promotes survival modes, meaning that the brain acts as if the person's survival depends on the use of chemical substances, and leads to cravings (Matrix Institute on Addiction, 2008c:10). Thus, when an experience is evaluated by the brain as being positive, dopamine is produced to create a craving for more of the good experience. The body recycles dopamine, meaning that once it has been produced, it remains in the system. This causes functional and structural changes in the brain in order to adapt to the increased dopamine level (Matrix Institute on Addiction, 2008b:10). The focus of the present research endeavour was specifically on adolescent chemical addiction. In this regard, Fuller (2007:89) notes that dopamine levels are generally low during adolescence, which leads to concentration problems, unmotivated actions, and low self-worth. Positive ways to increase dopamine levels are sport, social activities and rewards, while abuse of chemical substances is a negative way to do so.

When the use of chemical substances is discontinued, the adaptations are no longer opposed, which disrupts the brain's homeostasis. This leads to physical and psychological **withdrawal**, referring to a bio-psychosocial syndrome caused by the cessation of use of chemical substances (Sussman & Ames, 2001:110), and adds to the vulnerability to relapses (Teesson, Degenhardt & Hall, 2002:33-39).

In addition, serotonin regulates the mood and controls the sleep cycles and appetite. Cocaine and methamphetamine disrupt these levels, leaving the CAA hungry and sleepy (Mbuya, 2002:7; Lennard-Brown, 2004b:27).

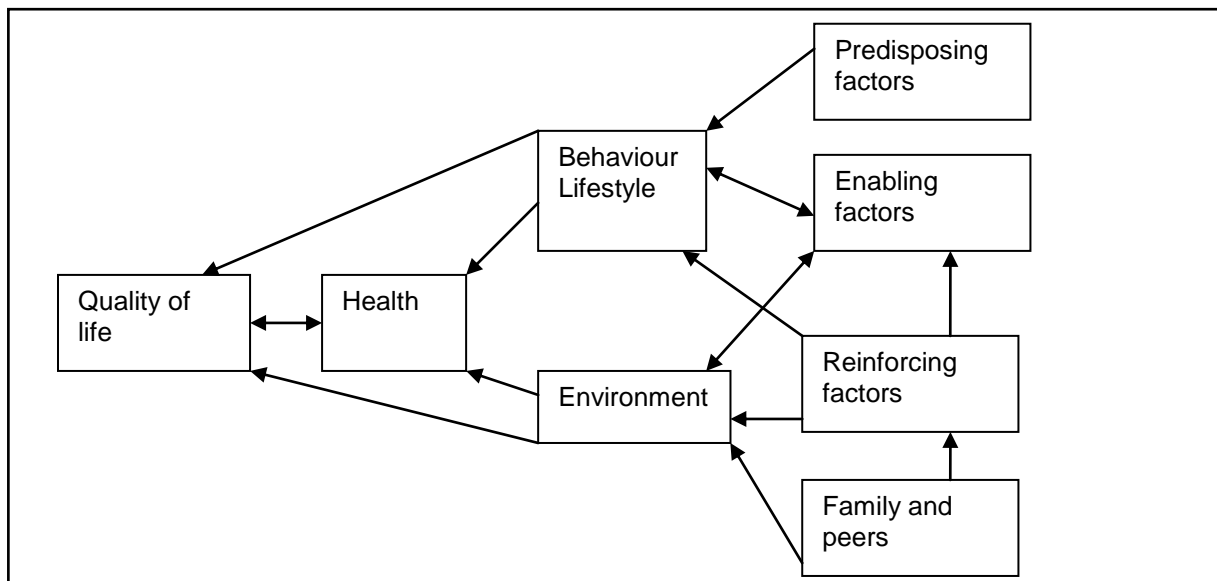
### **1.8.2 Adolescence**

For the purpose of this research, an adolescent will be defined as a person between the ages of 11 and 21 years (Louw et al., 2001:385). Adolescence is a universal phenomenon, and has been viewed as a "problematic life stage", characterised for centuries by "problematic behaviours" (Louw & Louw, 2007:281-282). Socrates (Rome, First Century BC) described adolescents as children who "contradict their parents, do not respect their elders, are indolent, eat gluttonously and tyrannise their

teachers” (Louw & Louw, 2007:281-282). Geldard and Geldard (2004:3-4) postulate that adolescence is currently still viewed as a challenging life stage. These authors describe adolescence as a developmental period during which a young person gradually moves from “dependency to independency, autonomy, and maturity”. The biological, cognitive, psychological, social and moral challenges during this developmental life stage impact on the adolescent’s ability to deal with problems such as chemical addiction. These challenges also relate to the adolescent’s ability to master adolescent life tasks such as acceptance of gender roles, development of cognitive skills and the gaining of knowledge; development of an own identity; development towards independence and preparation for a career, development of socially acceptable behaviour, forming relationships, and the development of moral understanding and a value system (Louw et al., 2001:385-388; Gouws et al., 2000:2-7).

Discussing the challenges of adolescence, Geldard and Geldard (2004:43) differentiate between healthy adolescents and unhealthy adolescents. The authors note that healthy adolescents are equipped with coping skills that assist them to master life tasks and to deal with challenges associated with adolescence. Also focusing on healthy adolescents, Houghton and Roche, (2001:169) assert that a healthy adolescent has a healthy self-image and is comfortable with shortcomings; has an individual, group and family identity; has an own value system; is able to act assertively in high-risk situations; and is able to make choices and decisions that are beneficial to his/her well-being. The following figure describes the factors that contribute to healthy adolescent development:

**Figure 1.2:** Factors influencing healthy adolescent development (Houghton & Roche, 2001:169)



The quality of life that leads to healthy adolescence therefore is related to physical and mental health, a lifestyle that promotes responsible and socially acceptable behaviours, and an environment that supports the adolescent to deal with the challenges of this developmental stage. Family and peers play an important role in reinforcing the environmental support, and in enabling the adolescent to develop a healthy lifestyle that promotes responsible behaviour (Houghton & Roche, 2001:169).

On the other hand, focusing on unhealthy adolescents, Geldard and Geldard (2004:43) concur that unhealthy adolescents lack coping skills that assist them to master life tasks and to deal with challenges associated with adolescence. With specific reference to adolescent chemical addiction, Bryan and Stallings (2002:288) note that the combination of typical adolescent characteristics such as the testing of boundaries and impulsive behaviour, as well as the characteristics of substance abuse such as the inability to inhibit inappropriate behaviour, put adolescents at risk of being attracted to chemical substances. Perkinson (2008:229) elaborates further and states that CAAs do not trust themselves or others, and find acceptance from deviant peers. Their moral, cognitive and social development processes stop when

they start using chemical substances, and therefore they find it difficult to resume a healthy age-appropriate lifestyle once they move towards recovery. The latter author concurs that these characteristics also make it harder for the CAAs to meet goals in recovery.

Relating the description of unhealthy adolescents (with the emphasis on adolescent chemical addiction) to aftercare to this client-system, Bryan and Stallings (2002:388) note that aftercare appears to be not only essential, but also vital to ensure recovery and to prevent relapses. Adding to this, the United Nations (2003:4) advises that aftercare to CAAs should be based on the consideration of factors precipitating adolescent chemical substance use, as described in the following table.

**Table 1.3:** Reasons for adolescent chemical substance use (United Nations, 2003:4)

Functional reasons	Symbolic reasons
<ul style="list-style-type: none"> <li>• Sensation-seeking</li> <li>• Curiosity</li> <li>• Social bonding</li> <li>• Attaining peer status</li> <li>• Alleviating boredom</li> <li>• Escaping reality and painful emotions</li> </ul>	<ul style="list-style-type: none"> <li>• Demarcation of boundaries between peer group and authority figures</li> <li>• Expression of solidarity with chemical substance-using peers</li> </ul>

A social worker involved with services to CAAs must be aware of the challenges of this life stage, while allowing and encouraging a client to be a “typical, but healthy adolescent” (Louw & Louw, 2007:281-282).

### 1.8.3 Aftercare services

For the purpose of this study, “aftercare services” will refer to professional Social Work services to the CAA in recovery, aiming to assist CAAs with the maintenance of sobriety (Gorski, 2001:4). Rosenberg (2008:126) argues that aftercare services to chemically addicted persons and their families increase the recovery potential, and thereby limit the need for re-admission to treatment centres.

Research results illuminate the fact that in-patient and out-patient treatment programmes which are shorter than 90 days (preferably three months) show limited

effectiveness (Florentine & Hillhouse, 2000:73). It is therefore advised that, following detoxification, a treatment period of three months must be attended. This will ensure that the chemically addicted person (in this case adolescent) is ready and able to participate actively in aftercare services. In addition, research results show that attendance of aftercare services decreases the relapse potential among chemically addicted persons (Florentine & Hillhouse, 2000:73; Elssheik, 2008:307-308).

A longer treatment period is suggested for adolescents, because of the challenges they face inherent to their developmental stage (Alberta Adolescent Recovery Centre, 2007:1). Not only do they have to recover from chemical addiction and become comfortable with the challenges of a sober lifestyle, but they also have not achieved some of the most important life tasks that are needed for growth towards maturity. It is therefore recommended that they must be chemical substance-free for at least three months before they can begin to address the challenges of recovery and internalise the needed changes in thought and behaviour (Alberta Adolescent Recovery Centre, 2007:1). However, treatment programmes in the Western Cape have an average treatment period of 4 to 8 weeks (Fourie, 2006). Statements from practice (as discussed earlier in this chapter) also highlight the need to focus on aftercare services in order to prevent relapses among CAAs.

Perkinson (2008:126) postulates that the purpose of an aftercare plan is to provide the CAA in recovery with a practical “to do” list. The list is used to ensure that the objectives through which a new lifestyle must be developed are attended to. Objectives for aftercare include the maintenance of recovery, prevention of relapses, and the improvement of social and psychological functioning (United Nations, 2003:14).

In conclusion, treatment of adolescent chemical addiction must not be viewed as a “quick fix”. It is important to acknowledge that the detoxification and in- or out-patient treatment are only the beginning actions of dealing with the addiction, and that aftercare remains an important part of treatment. Relapse potential must always be considered. Therefore, a recovery plan should include ways to deal with a relapse



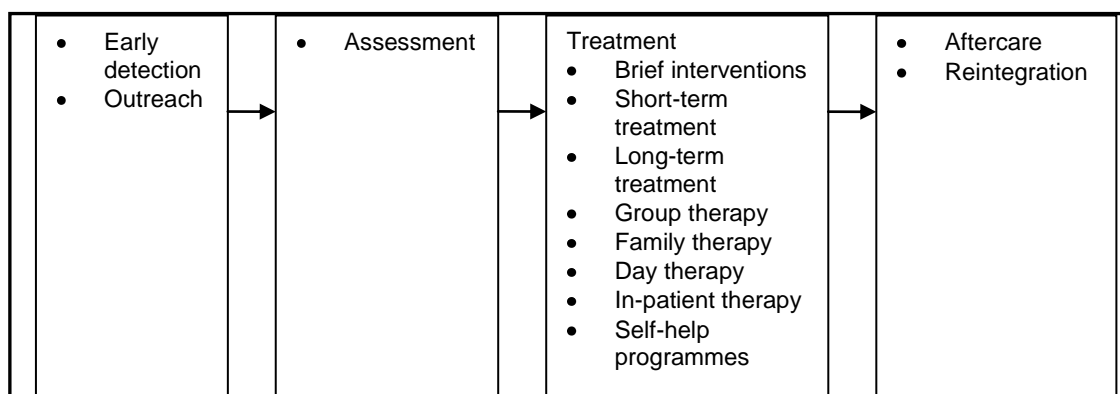
(Arterburn & Burns, 2007:168). In line with this sentiment, Malhotra et al. (2007:1) state that detoxification is relatively easy, but that the real challenge lies in the maintenance of change and the achievement of recovery tasks. These authors refer to the following statement by Mark Twain in support of this: “It is easy to stop smoking. I have done it a number of times”.

Aftercare consists of reintegration, as well as relapse prevention, as discussed in the sub-sections to follow.

### 1.8.3.1 Reintegration services to chemically addicted adolescents

The United Nations (2003:8) refers to the continuum of care for chemical addiction treatment (see Figure 1.3. below). Social Work services must address all the areas in the continuum of care for chemical addiction treatment, including reintegration and aftercare. These two areas of care, which are also the focus of this research endeavour, are closely related.

**Figure 1.3:** The continuum of care for chemical addiction treatment (United Nations, 2003:8)



“Social reintegration” refers to assistance to CAAs to re-establish themselves in the community. Networking with schools, churches, families and support groups is an essential component of aftercare and reintegration (United Nations, 2003:15). The Western Cape Department of Social Development (2008:17-19) developed a draft reintegration plan during 2008 which provides guidelines for the reintegration of the

individual (in this case the CAA) as well as the family following treatment. These guidelines will be discussed in Chapter 5.

### **1.8.3.2 Relapse prevention**

The Disease Model of Addiction refers to the addictive cycle, which indicates relapsing after treatment for chemical addiction as common, predictable and preventable (Goodwin, 2000:90; Buddy, 2003:1; Gordon, 2003:3). This cycle indicates relapsing as a normal part of addiction and recovery, acknowledging that addiction is a treatable disease.

However, treatment of chemical addiction should be viewed as more than just the interruption of use of chemical substances. It is a learning process where chemically addicted persons learn how to live without chemical substances, and to protect themselves from harmful situations, thereby preventing relapses. In-patient treatment, is often expensive (Myers, Louw & Fakier, 2007:1) and short-term in nature (Fourie, 2008). Aftercare should therefore include lifestyle programmes, which also address cravings and withdrawal symptoms, and which are cost-effective. These services are aimed at preventing relapses (Falkowski, 2003:43-44). Gorski (2001:2) is of the opinion that to focus only on the addiction in aftercare, and not address the development of life tasks, can lead to relapse. In order to adjust their lifestyle, the development of life skills leads to empowerment on individual, interpersonal and community levels (Van Niekerk & Prins, 2001:250).

McNeece and DiNito (1998:216) note that in order for relapse prevention programmes to be effective, the social worker should attempt to understand the social connection of adolescents with chemical substance abuse, and to gain insight into the expected influence of chemical substances in their social context. The social worker should therefore include peer influence, as well as the availability of and tolerance to chemical substances in the community, when rendering aftercare services to CAAs in an effort to prevent relapses.

In conclusion, Sussman and Ames, (2001:109) express the view that recovery from chemical addiction is a life-long process, during which relapsing is always a possibility. Lessa and Scanlon (2006:199) refer to the four dimensions of recovery that lead to prevention of relapses: 1) physical dimension (abstinence and detoxification); 2) mental dimension (adapting to changes in the brain chemistry, attitudes, belief systems and rational thought); 3) emotional dimension (honesty relating to emotions); and 4) spiritual dimension: sense of purpose and lifestyle.

#### **1.8.4 Chemical addiction**

Chemical addiction is a condition in which the use of chemical substances causes social/emotional/spiritual/physical impairment. Indicators to be measured are tolerance, progression, withdrawal symptoms, and loss of control (Gossop, 1998:78).

In terms of the Disease Model of Addiction, chemical addiction implies a condition that impairs functioning, and manifests in problems and harmful symptoms (Lessa & Scanlon, 2006:12-13; Keegan & Moss, 2008:149). Addiction to chemical substances is characterised by a compulsion to consume chemical substances, development of a tolerance for the chemical substances abused, and the experience of withdrawal symptoms when the abuse of substances is interrupted (Gossop, 1998:78). The addiction affects the physical, social, emotional and spiritual well-being of the addicted person.

#### **1.8.5 Intervention research**

Intervention research is an action undertaken to enhance or maintain the functioning and well-being of an individual, group or community by means of the social technology which is utilised by social service providers to facilitate the intervention process (Rothman & Thomas, 1994:63-164).

### **1.8.6 Practice guidelines**

Alston and Bowles (2003:169, 305) refer to “practice” as activities and projects undertaken as part of the Social Work professional role. Practice guidelines provide social workers with a strategy to address certain social problems through activities and projects. A “strategy” relates to what to do when addressing social problems, as well as how to do it, in terms of techniques to use (Hepworth et al., 2006:432).

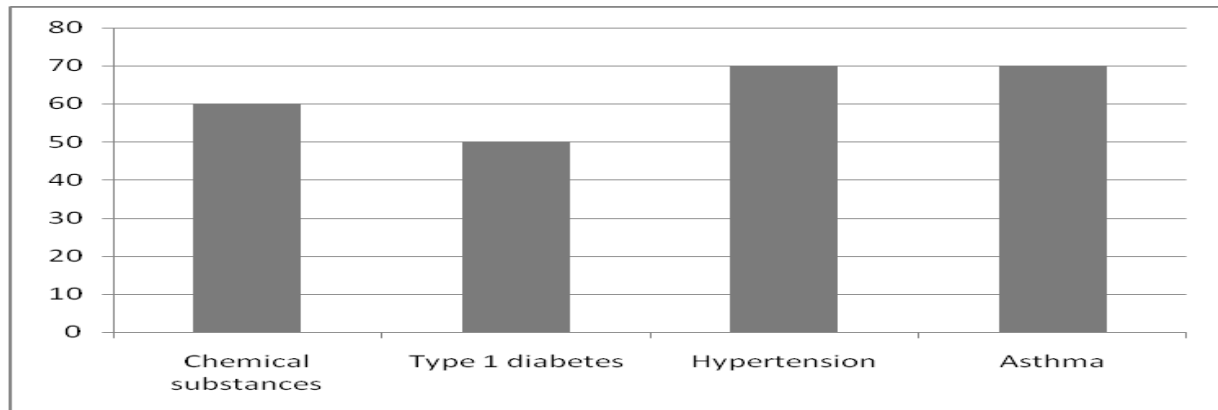
### **1.8.7 Recovery**

Recovery from chemical addiction includes the recognition of addiction, the recognition of a need for lifelong abstinence, the development and use of an ongoing recovery programme to maintain abstinence, and the treatment of other problems that may interfere with the recovery potential (Gorski as cited in Fisher & Harrison, 2005:158).

### **1.8.8 Relapse**

A relapse from recovery from chemical addiction is a return to uncontrolled use of chemical substances after a period of abstinence (Fisher & Harrison, 2005:156). Gorski (2001:3) indicates that relapsing after treatment often occurs when adolescents fail to recognise their addiction to chemical substances. When a relapse occurs, the adolescent receives confirmation regarding the addictive nature of the substance. In support of this, Buddy (2003:1) sees relapses as potentially a part of the learning process that eventually leads to recovery. In terms of the Disease Model of Addiction, Fisher and Harrison (2005:37-52) postulate that this model views relapses from chemical addiction as part of the addiction process. It is similar to the relapse potential of other chronic diseases, as described in the following figure.

**Figure 1.4:** Comparison of percentages of patients who relapse between chemical substance addiction and other chronic diseases (McLellan, Luborsky & Woody, 2004:5)

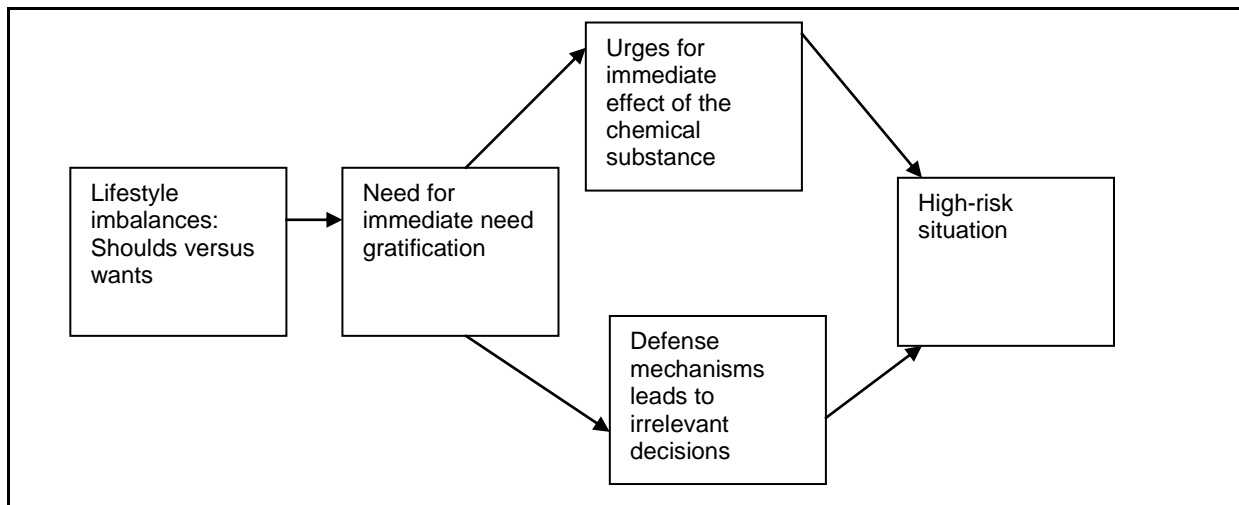


Fisher and Harrison (2005:156) and Barber (2002:133) distinguish between a “lapse” (also known as a slip) and a “relapse” as follows:

**Lapse/Slip** (“still living in the past”): A lapse occurs when the addict interrupts a sober period with a “drugging” episode, and then returns to abstinence. It is often the beginning of a relapse (Fisher & Harrison, 2005:156). According to Marlatt, Parks and Witkiewitz (2002:5), a “slip” can be referred to as a “lapse”, prior to a relapse. It does not necessarily lead to a relapse. It could be viewed as a learning and confirming experience, thus becoming a “breakthrough” instead of a “breakdown” in the recovery process.

**Relapse:** It is a process that occurs within the addict in recovery, and manifests itself in a progressive deterioration in the pattern of behaviour and symptoms, leading to the use of addictive substances (Fisher & Harrison, 2005:156). Marlatt and Gordon (1985:46) attribute relapses to the causes given in the figure below: 1) failure to avoid chemical substance-use settings; 2) failure to maintain effective coping mechanisms; 3) chemical substance craving and intrusive thoughts about using chemical substances; and 4) emotions, boredom, isolation and social pressures.

**Figure 1.5:** Covert antecedents of relapse (Marlatt & Gordon, 1985:46)



### 1.8.9 Social Work intervention

Roberts and Greene (2002:819) define Social Work intervention as “who we help, how we provide the services and the degree to which we encourage collaboration”. The Social Work profession is characterised by recognised professional education relating to knowledge, ethics and competencies. Services are sanctioned by society to provide specific services to vulnerable populations, with the purpose of helping to meet social needs, or the elimination of difficulties. Social Work, furthermore, aims to enhance optimal use of abilities, which can lead to satisfying lives and the ability to contribute to society (Sheafor & Horejsi, 2006:1).

The focus of Social Work is to improve social functioning, and to provide care (referring to the provision of access to resources), treatment (referring to modifying of correcting dysfunctional patterns), and enhancement (Sheafor & Horejsi, 2006:5). Morales and Sheafor (2004:16) discuss “enhancement”, describing it as the facilitation of growth and development of the client’s functioning in a specific area, for example aftercare services to CAAs, and relapse prevention programmes.

In order to address chemical addiction, Sheafor and Horejsi (2006:112) postulate that Social Work intervention should assist the chemically addicted person to

improve social functioning by helping him/her to overcome compulsive behaviour patterns.

### **1.8.10 Treatment programmes**

For the purpose of this study, treatment programmes will refer to in-patient managed care and therapy towards recovery of the CAA (McNeece & DiNito, 1998:217). While standard out-patient treatment programmes are usually less frequent, in-patient programmes are provided in a residential setting. A multi-disciplinary team provides services that are focused on physical, emotional, social and spiritual well-being, and recovery from chemical addiction (Alcohol and Drug Treatment Referrals, 2009:7).

## **1.9 Outline of the research report**

The research report will comprise of seven chapters. The content and focus of each chapter is referred to in the discussion below:

The content of this first chapter has provided the reader with a background rationale, as well as the motivation for this research endeavour. An outline of the methodology that was included in this study has been provided, as well as ethical considerations and the key concepts that relate to this study.

In Chapter 2, the researcher will continue to describe the application of the research methodology process followed in this study, as well as the limitations experienced during this research endeavour.

The aftercare needs of CAAs regarding services by social workers, as well as the relevant literature will be discussed in Chapter 3.

The perceptions and experiences of the social workers regarding aftercare services to CAAs following treatment, together with the relevant literature, will be discussed in Chapter 4.

A discussion of existing models, guidelines and suggestions regarding aftercare to chemically addicted persons found in the literature will follow in Chapter 5.

Chapters 3, 4 and 5 inform the content of Chapter 6. The practice guidelines developed from a Social Work perspective for aftercare service rendering to CAAs following treatment will be provided in Chapter 6.

The conclusions and recommendations drawn from this study will be discussed in Chapter 7.

### **1.10 Conclusion**

In the preceding chapter the reader was provided with a general orientation and introduction to the chapter, whilst it focussed on the theoretical background and rationale for the study as well as the motivation for this research endeavour. An outline of the methodology that was included in this study has been provided, as well as ethical considerations and the key concepts related to this study. Chapter-wise, an outline of the research report was also provided. In the chapter to follow, the researcher will describe how the research methodology was applied in this study, as well as the limitations experienced during this research endeavour.



## CHAPTER 2

### DESCRIPTION AND APPLICATION OF THE RESEARCH METHODOLOGY UTILISED IN THIS STUDY

#### 2.1 Introduction

Treatment of adolescent chemical addiction is a worldwide challenge. In America, up to 75% of unintentional injuries among adolescents are related to substance abuse (Page & Page, 2003:196). Falkowski (2003:8), also referring to the particular problem of adolescent chemical addiction, states that mood-altering substances are more likely to be used by younger people, thereby putting them at risk for HIV and AIDS, crime, violence and accidents.

On the local level, Parry (2007:4) provides a sombre scenario, explaining that, compared to 14 countries that were included in the World Mental Health survey; South Africa had the highest prevalence of substance-abuse disorders and also the lowest treatment of substance-abuse disorders. Bezuidenhout (2008:131) offers the opinion that the South African psychosocial climate is fairly conducive to adolescent chemical addiction, because of a number of risk factors such as family disorganisation, child abuse, crime, and poverty. Focusing on the situation in the Western Cape, an alarming report from the South African Epidemiology Network (2007:3) provides the following information regarding the situation for the second half of 2006: The youngest patient in in-patient treatment was only nine years of age. In addition, among 2 798 persons who received in-patient treatment during this period, 27% were under the age of 20, more than any other age group in treatment.

Treatment of adolescent chemical addiction should include preparation for treatment, treatment, and also aftercare services to ensure that the addicted person (in this case an adolescent) develops the relevant skills to maintain sobriety (Meyer, 2005:292-293). In addition, Myers et al. (2007:1) identified the following barriers regarding access to treatment centres in the Cape Town Metropole: affordability,

geographical accessibility, awareness, and negative perceptions regarding treatment. High costs of in-patient treatment programmes also put a time limitation on treatment. The rendering of aftercare services therefore becomes an important component of the treatment process to ensure that treatment is not terminated prematurely (Falkowski, 2003:44; Meyer, 2005:292-293). "Aftercare" refers to follow-up care that provides ongoing support to maintain sobriety and personal growth, and assists with the reintegration into the community and family life (Western Cape Resource Directory, 2007:104).

The motivation for this study stemmed from the lack of aftercare services directed at CAAs in the Western Cape as verbalised by practitioners, and from findings that resulted from the researcher's previous investigation (Van der Westhuizen, 2007:129-130). The relevance of this study is based on and confirmed by Section Six of the South African Prevention and Treatment of Drug Dependency Act (1992), as well as the objectives of the new Act on Prevention of and Treatment for Substance Abuse (Act 70/2008, to be implemented pending finalisation of regulations), which prescribes that CAAs should have access to professional aftercare services. However, there seems to be a serious problem with the implementing of this statutory requirement. The Western Cape Drug Forum (2005:3) identified the need for the development of aftercare services in 2005, indicating the lack of focus on aftercare as part of treatment. In the light of this serious matter of a statutory stipulation being disregarded by the service providers concerned, it is imperative that the matter of aftercare services to CAAs in the Western Cape receives attention. It is envisaged that this investigation will contribute to improving this situation.

Based on the abovementioned research problem and motivation for this research study (see Chapter 1, pp. 12-14), the researcher identified the need to develop practice guidelines for social workers in order to plan and execute effective and relevant aftercare services to CAAs following treatment. In Chapter 1, an overview has been given of the research methodology that formed the foundation for the structure and execution of this study. In this chapter, the reader is provided with a

discussion of the theory and implementation of the research methodology, as well as the limitations experienced.

## **2.2 Research methodology**

According to Leedy and Ormrod (2005:1-11), social research is typically characterised by the following:

- It is based on a research problem.
- It is based on certain critical assumptions.
- It is focused on a specific demarcated problem area.
- The research problem leads to a research question or hypothesis.
- The research problem and question or hypothesis lead to a clear goal.
- The research endeavour must be based on a specific plan.
- The research undertaking includes the collection and interpretation of data.
- Throughout the process the researcher follows specific steps.

The abovementioned characteristics and the implementation thereof entailed the following aspects.

- **Social research is based on a research problem**

A research problem stems from occurrences and trends observed in practice, a preliminary literature review, and a background rationale. It embodies a research question or hypothesis (Mouton, 2001:48-53; Rubin & Babbie, 2005:109). The present study stemmed from the research problem that was based on the increase in adolescent chemical addiction (Caelers, 2005:1; Matzoupolos, 2005:6; Western Cape Department of Social Services and Poverty Alleviation Transformation Plan, 2006:13), the high relapse rate among CAAs following treatment (Connors et al., 2001:195; Gorski, 2001:1; Meyer, 2005:292), and the reported lack of aftercare services in the Western Cape (Fourie, 2008). It resulted in the identified need for practice guidelines for social workers relating to the rendering of aftercare services to CAAs.

- **Social research is based on certain critical assumptions**

An “assumption” is the basic idea that what we believe is true. The assumptions that inform a research study assist the researcher to obtain a focus for the study (Bak, 2004:10). On the other hand, critical assumptions stem from critical thinking. This involves “consciously thinking about how we do our thinking” (Sheafor & Horejsi, 2006:127). The researcher must base assumptions on critical thinking that provides a rationale for the choice of the theoretical and conceptual frameworks on which the study is based. Assumptions influence research in that they provide a foundation for the choice of research question or hypothesis, research goals, and the research methodology to be employed.

A “paradigm” stems from critical thinking and can be described as a “system of ideas based on assumptions”. It is per definition an example that serves as a pattern or model for something, especially one that forms the basis of a methodology or theory, and assists the researcher to organise observations and to make sense of them (Fossey, Harvey, McDermott & Davidson, 2002:718). A paradigm in social research, and especially qualitative research, is needed to develop an understanding of certain real-life problems, and is often dependent on words (Niewenhuis, in Maree, 2007:47). Griffiths (1998:48) advises that the researcher has to be clear about his/her own understanding of the meaning attached to the relevant words used in a particular research study. In support of this, Niewenhuis (in Maree, 2007:47) warns that each word is “laden with its own complex set of meanings that are often particular to a specific setting”. A paradigm is therefore a set of assumptions about fundamental aspects relating to a particular world-view or phenomenon.

This research study was conducted within the paradigm of the Disease Model of Addiction (McNeece & DiNito, 1998:23-33). In this paradigm, addiction is described as a progressive primary disease, and relapse is viewed as part of the addictive cycle (Fisher & Harrison, 2005:37-52). This provided the researcher with a clear understanding of the meaning of the words “addiction”, “loss of control”, “withdrawal”, “tolerance” and “relapse”, and assisted her to avoid misinterpretation relating to relapsing after treatment.

Terre Blanche and Durrheim's (1999:3-5) identify three dimensions on which the paradigm of a research study is based, namely: ontological and epistemological assumptions, and methodology. These dimensions informed this study as follows.

- *Ontological assumptions:* Ontological assumptions are based on the researcher's idea or belief (without any proof) about the nature and characteristics of the reality of a field of study (D'Cruz & Jones, 2004:49-50). The ontological assumption of this study was based on the researcher's own experiences as a social worker dealing client-systems with chemical addiction. From her experience in practice, she came to the conclusion that persons suffering from addiction have a high relapse potential, and that there is a correlation between relapsing and a lack of aftercare and continued support, also referred to as "the maintenance of recovery from chemical addiction" (Fisher & Harrison, 2005:147-148). The assumption was further informed by the researcher's previous research, exploring the relapse experiences of CAAs in which she found that the lack of aftercare contributed to the participants' relapses (Van der Westhuizen, 2007).

According to Niewenhuis (in Maree, 2007:48) an ontological assumption is derived from the "the knower" or researcher's own understanding, while the assumptions based on empirical findings (i.e. that which is "known") relates to "epistemological assumptions". This interrelatedness means that "ontology" refers to knowledge obtained in practice and is grounded in reality, whereas "epistemology" provides theoretical and empirical justification for the ontological assumptions (Cherry, 2000:5; D'Cruz & Jones, 2004:49-50).

- *Epistemological assumptions:* The term "epistemology" originates from the following Greek terms: Epistēmē (knowledge); epistasthai, epistē (to understand); and epi- and histasthai (to place, determine). It is a branch of philosophy that studies the nature of knowledge, its presuppositions and foundations, and its extent and validity (University Of Metaphysical Sciences, 2009). This term therefore refers to the logic behind our assumptions.

Epistemological assumptions are focused on how we can know or explain something based on the format and structure of our knowledge (Bak, 2004:10; Babbie & Mouton, 2007:4).

The researcher's ontological assumption is verified and confirmed by the epistemological assumption underpinning the Disease Model of Addiction. Epistemologically seen, this model is based on certain empirical findings, i.e. chemical addiction is progressive in nature, and relapse is explained through the occurrence of a loss of control and withdrawal when the use of chemical substances is terminated or interrupted (Fisher & Harrison, 2005:37-52). The researcher's previous research assisted her to relate the assumptions of the "knower" to the assumptions of the "known".

Theoretical explanations form the underlying foundation of epistemological assumptions provide a researcher with an understanding of the various concepts related to the research problem by means of, at its lowest level, summaries of empirical findings (Brewer, 2000:192; Bowling, 2002:139). According to Neuman (2003:49), theories are used to explain phenomena in a causal, a structural or an interpretive manner. When explaining a phenomenon in a *causal manner* one tries to illustrate that the cause leads to the effect, and that all other influences on the relationship between the cause and effect should be taken into consideration. *Structural explanations* illustrate or explain how the interrelated phenomena constitute a whole. It is a holistic explanation, and makes use of reduction to reduce all the data to a basic explanation. *Interpretive explanations* refer to the meaning attributed to a specific context in order to develop an understanding. Exploration and description of the perspectives of a group of insiders in a specific context lead to interpretive explanations.

Both the ontological and the epistemological assumptions that informed this study could be viewed as interpretive explanations, as it is based on the meaning attributed to relapses and aftercare services in the context of

adolescent chemical addiction. The epistemological assumption is also based on a structural explanation, as it explains addiction and relapsing as interrelated phenomena, providing a holistic explanation of the addictive cycle.

- *Methodology.* “Methodology” refers to the rules and procedures of research work, and focuses on how we gain knowledge about the world (Denzin & Lincoln, 2003:185; Babbie & Mouton, 2007:4). Drawing on the abovementioned ontological and epistemological assumptions, the researcher aimed to utilise specific social research methodologies in order to create a scientifically acceptable foundation for the findings of this study. The methodology included: a qualitative research approach; certain phases and steps of the IDD-model as research design and complementary hereto an explorative, descriptive, and contextual strategy of inquiry; narrative writing, focus group interviewing and participant observation as methods of qualitative data collection; Tesch’s steps (in Creswell, 2009:186) for analysing qualitative data; and Guba’s model (in Krefting, 1991:214-222) for the verification of data. An overview of the research methodology employed in this study was provided in Chapter 1. The description of how it was implemented and materialised will be the focus of discussion in a latter part of this chapter.

- **Social research is focused on a specific demarcated problem area**

A “unit of analysis” means the demarcated problem area on which the study will focus. It provides a clear description of what the researcher wants to investigate (Mouton, 2001:50; Rubin & Babbie, 2005:130-134).

The researcher aimed to investigate adolescents’ aftercare needs, as well as the views of social workers rendering aftercare services to CAAs. The motivation for this research, the research problem, the population, and the criteria for inclusion in this study by means of the purposive sampling technique (as described in Chapter 1) provided a clear focus for this research study.

- **The research problem leads to a research question or hypothesis**

When working from a qualitative perspective, relatively broad questions, rather than specific hypotheses to be tested, identify the initial focus of inquiry (Fossey et al., 2002:723). Niewenhuis (in Maree, 2007:68-69) postulates that the research question is the single most important measure of the quality of the research. The research questions specify what intrigues one and focuses on what one will study. It becomes the beacon that guides one over months and years of research, and one strives to find answers to the research question. A good research question directs a researcher to appropriate literature resources, and provides him/her with a focus for the data collection. It prevents one from drifting from the original purpose and keeps one focused on the original interests (Niewenhuis, in Maree, 2007:68-69). The research question therefore aims to assist the researcher to understand and describe the problem within the specific context in which it occurs (Crabtree & Miller, 1999:6-7; Cohen, Manion & Morrison, 2001:3; Strydom, Steyn & Strydom, 2007:334). In line with the aim of research questions, Mouton (2001:53-54) refers to the following types of empirical questions that enable the researcher to develop a better understanding of a real-life research problem.

**Table 2.1** Empirical questions in social research (Mouton, 2001:53-54)

Question	Nature
What?	Exploratory
How?	Descriptive
Why?	Causal
What was the outcome?	Evaluative
What is the impact of X on Y?	Predictive
What led to...?	Historical

Based on the problem of the high relapse rate among CAAs and the reported lack of aftercare services, and linked with the explorative and descriptive nature of this research endeavour, the researcher formulated the following “What?” and “How?” questions, referred to by Mouton (2001:53-54) as illustrated in the table above:

- What are the specific aftercare needs of CAAs following treatment?
- What are the perceptions and experiences of social workers involved in services to CAAs regarding aftercare services?



- Based on the perspectives of the CAAs and the social workers, what are the key elements that should be included in practice guidelines for aftercare services to CAAs?
- Based on the perspectives of the CAAs and the social workers, how should aftercare practice guidelines for services to these adolescents be implemented?

- **The research problem and question or hypothesis lead to a clear goal**

A research problem and research questions should lead to the clearly defined purpose of a research study, addressing the researcher's intentions, the focus of the study and the description of the participants to the study, and it should be clear about the types of understanding to be sought through the particular research study (Knight, 2002:5; Maree & Van der Westhuizen, in Maree, 2007:29).

The researcher aimed to develop an understanding of the aftercare needs of CAAs, as well as the perceptions and experiences relating to aftercare services of social workers rendering services in this field. In addition, existing literature was used to verify these needs and experiences. It was envisaged that this information would assist the researcher to develop practice guidelines to aid social workers in rendering aftercare services to CAAs following treatment.

Following the research questions, the goal and objectives for this study were formulated, as provided in Chapter 1 (see Chapter 1, p. 15).

- **The research endeavour must be based on a specific plan**

The "research plan" refers to the research design that is selected based on the research problem, question or hypothesis and goal (Mouton, 2001:55). Maree (2007:70) sees the research design as a "plan" which moves from the underlying philosophical assumptions to specifying the selection of respondents with whom the data-gathering techniques are to be done. Creswell (2009:3) holds a more elaborative view of what a research design is, stating that it refers to the entire process of research from conceptualising a problem to writing the narrative.

As stated in Chapter 1 of this paper, the researcher made use of the **intervention research design**, and in particular the Intervention Design and Development (IDD) model as proposed by Rothman and Thomas (1994:2-51). All the steps in Phases 1 and 2, Step 2 of Phase 3, and Step 1 of Phase 4 of the IDD-model formed the foundation for the execution of this research study. Table 1.1 (see p. 19) in Chapter 1 provides the reader with a layout of this model. How the mentioned phases and steps were applied in this research undertaking will be discussed later in this chapter.

- **The research undertaking includes the collection and interpretation of data**  
Grinnell and Unrau (2005:346-347) admit that the choice of a data collection method is a difficult task. They provide the following criteria that need to be considered when choosing the method of data collection: the size and scope of the study, data resources and time available, and previous research conducted in the specific field of interest. The methods of data collection and data analysis were discussed in Chapter 1 (see pp. 26-32), and will be elaborated upon further in this chapter.

Regarding the interpretation of data, Alston and Bowles (2003:68) note that the success or failure of a research study is determined by the researcher's ability to actively "generate understandable theoretical arguments" based on the data collected. The data collected in this study, as well as the subsequent verification with literature, will be discussed in Chapters 3 and 4.

- **Throughout the research process the researcher follows specific steps**  
Research can be viewed as a stepwise activity and a structured process, which commences with: 1) defining the problem to be investigated, based on a literature review and/or occurrences and trends in practice; 2) identifying a research question/hypothesis; 3) choosing a research approach and a design inherent to this approach; 4) producing a sample; 5) obtaining the information through a process of data collection; 6) analysing and interpreting the data; and 7) communicating results (Leedy & Ormrod, 2005:1-11).

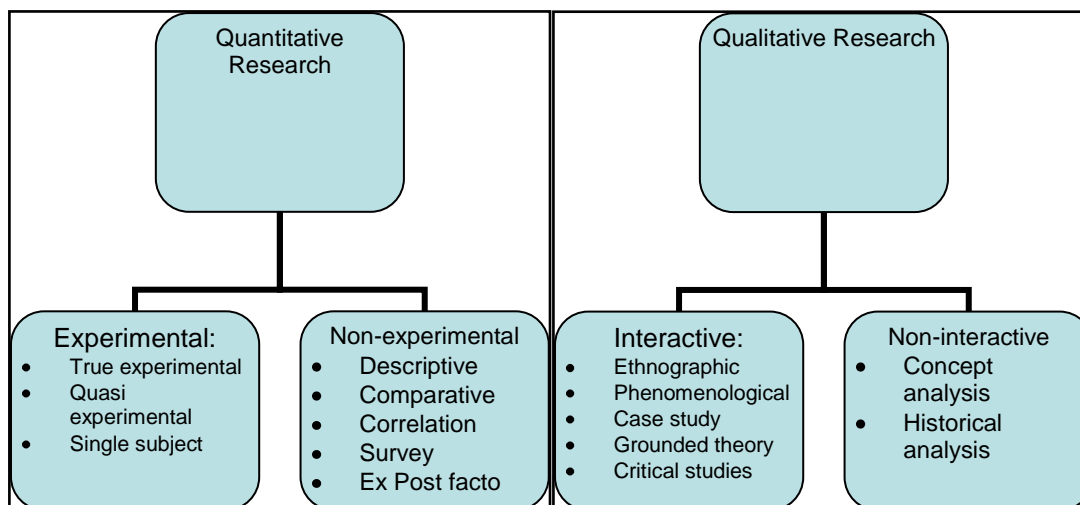
In the previous discussion (under the heading “research methodology”), the characteristics of social research as espoused by Leedy and Ormrod (2005:1-11) were indicated in an introductory manner. In the remaining part of this chapter, the research methodology employed during this research undertaking will be introduced by describing “how” it was implemented in this project.

In agreement with Leedy and Ormrod’s (2005:1-11) view that the researcher follows specific steps in the research process, the researcher started this project by identifying, demarcating, and defining the research problem to be investigated (see Chapter 1, p. 12). Based on the identified problem, she formulated four research questions (see p. 64-65). Founded on the identified research problems and research questions, a goal and objectives were formulated to aid the process of answering the research questions (see Chapter 1, p. 15). In synchronicity with the problem and the research question, the research methodology was chosen. In view of the fact that the research problem, the research questions, and the research goal and objectives were introduced and motivated in Chapter 1, and that some of these aspects were referred to in previous parts of this chapter, it will not be repeated and further elaborated upon here. The researcher will rather continue with the discussion on the research methods used, (especially the research approach and design).

### **2.2.1 Research approach**

According to Alston and Bowles (2003:7-9, 51), quantitative research stems from a natural science paradigm and is based on measurements through rigorous, objective research strategies. It begins at the top of the “pyramid of abstraction”, involving carefully planned research hypotheses and questions. On the other hand, qualitative research begins “close to the ground”; exploring and describing social problems that lead to further questions and hypotheses (cf. Bless et al., 2006:79). It is inductive in nature, moving from specific observations and interactions to general ideas and theories. Figure 2.1 below provides a description of the differences between quantitative and qualitative research, as cited in McMillan and Schumacher (2006:21-30):

**Figure 2.1:** Qualitative versus quantitative research (McMillan & Schumacher, 2006:21-30):



As stated previously, this study aimed to develop an understanding of the aftercare needs of CAAs, as well as of social workers' perceptions and experiences of aftercare services to this group. Based upon this information, the researcher aimed to develop practice guidelines that would aid the social workers in rendering aftercare services to CAAs and would address the needs of these youngsters. Ritchie and Lewis (2005:32) postulate that the purpose of a research endeavour and nature of information required will provide hints in respect of the research approach to be used in a specific research project. Where the purpose is to: 1) explore and describe an experience, a context, or a process; 2) discover or learn more about a phenomenon; 3) develop an understanding of an experience or context; and 4) report on an experience, context or process, a qualitative approach is recommended. This study stemmed from research questions that were exploratory and descriptive in nature. The researcher concluded that the **qualitative research approach** was suitable for the purpose of this research study.

Grinnell and Unrau (2005:62-78) relate the positivist approach to quantitative research and the interpretive approach to qualitative research. The positivist approach refers to the belief that we can discover realities through observable facts. These authors note that quantitative research identifies regularities, also referred to as "social laws", between events, and thus discovers the meaning of the relationship.

Positivism therefore aims to explain certain social events in order to be able to address problem areas. It implies that social laws should be viewed as probabilities (chance) rather than certainties (cf. Sarantakos, 2000:36). Working from this approach, qualitative research is criticised as it does not make use of standardised procedures that are unbiased and not influenced by the values of the researcher.

On the other hand, qualitative research is primarily based on the *interpretive approach*, and it aims to develop an understanding of how people make meaning of phenomena in their environment (Fossey et al., 2002:729; Niewenhuis, in Maree 2007:56). It emphasises the importance of the viewpoints of insiders in a situation and focuses on subjective perceptions of the group to which the research problem is related. It entails the social reality that is demonstrated by the meaningfulness of social interaction in a particular context. Qualitative research therefore is based on “What?” and “How?” questions, which are answered through observations and interviews in the natural environment of the participants. It focuses on the meanings and interpretations that the “insiders” attach to the topic that is being investigated (cf. Holloway & Wheeler, 2010:20).

Niewenhuis (in Maree 2007:51) continues the discussion of differences between quantitative and qualitative research as objective (*positivist approach*) versus subjective (*constructivist approach*). This author describes the constructivist approach as idiographic, concerned with the “uniqueness of each particular situation”. This approach is closely linked to the interpretive approach, which argues that social reality is inherently meaningful, based on certain constructs. It implies that the social researcher should be sensitive to the social context, and that research should be based on the way in which human beings construct the reality of their situation.

Drawing on the abovementioned distinction between the positivist approach on the one hand and the interpretive and constructivist approaches on the other, the researcher concluded that an **interpretive-constructivist approach** within the genre of **qualitative research** would be best suited for this research study, as the

focus was on the meanings and interpretations that the “insiders” in the situation attached to their situation. The “uniqueness” of CAAs, as well as the meaning that social workers attached to aftercare services, were investigated and addressed through this study.

Fox and Bayat (2007:10) assert that applied research increases scientific knowledge through the creative and systematic design of practical applications. This research endeavour falls in the ambit of **applied research** as it focuses on the specific problem of a lack of aftercare services to chemical addicted adolescents, and suggests solutions to this problem by means of the development of practice guidelines; it makes use of the exploratory, descriptive and contextual strategies of inquiry; and the advantage has been that the results have led to the ability to immediately implement the identified solution to the problem (Bless et al., 2006:44).

The next section focuses on the research design that enabled the researcher to develop practice guidelines for social workers to enable them to implement aftercare services to CAAs.

### **2.2.2 Research design**

A research design forms the foundation of a research study and determines its quality. It is a strategic framework, stemming from a research problem and hypothesis or/and research question, and describes the implementation of the research (Terre Blanche, Durrheim & Painter, 2006:34).

This study falls within the genre of intervention research. Rothman and Thomas (1994:4) note that intervention research has a specific intervention aim and seeks to promote a deeper understanding of, or provide a solution to, practical problems. According to these authors, intervention research has a three-faceted focus and can be utilised for the following purposes (Rothman & Thomas, 1994:3-8).

- 1) Knowledge development (KD), in that empirical research contributes to the knowledge base about human behaviour.

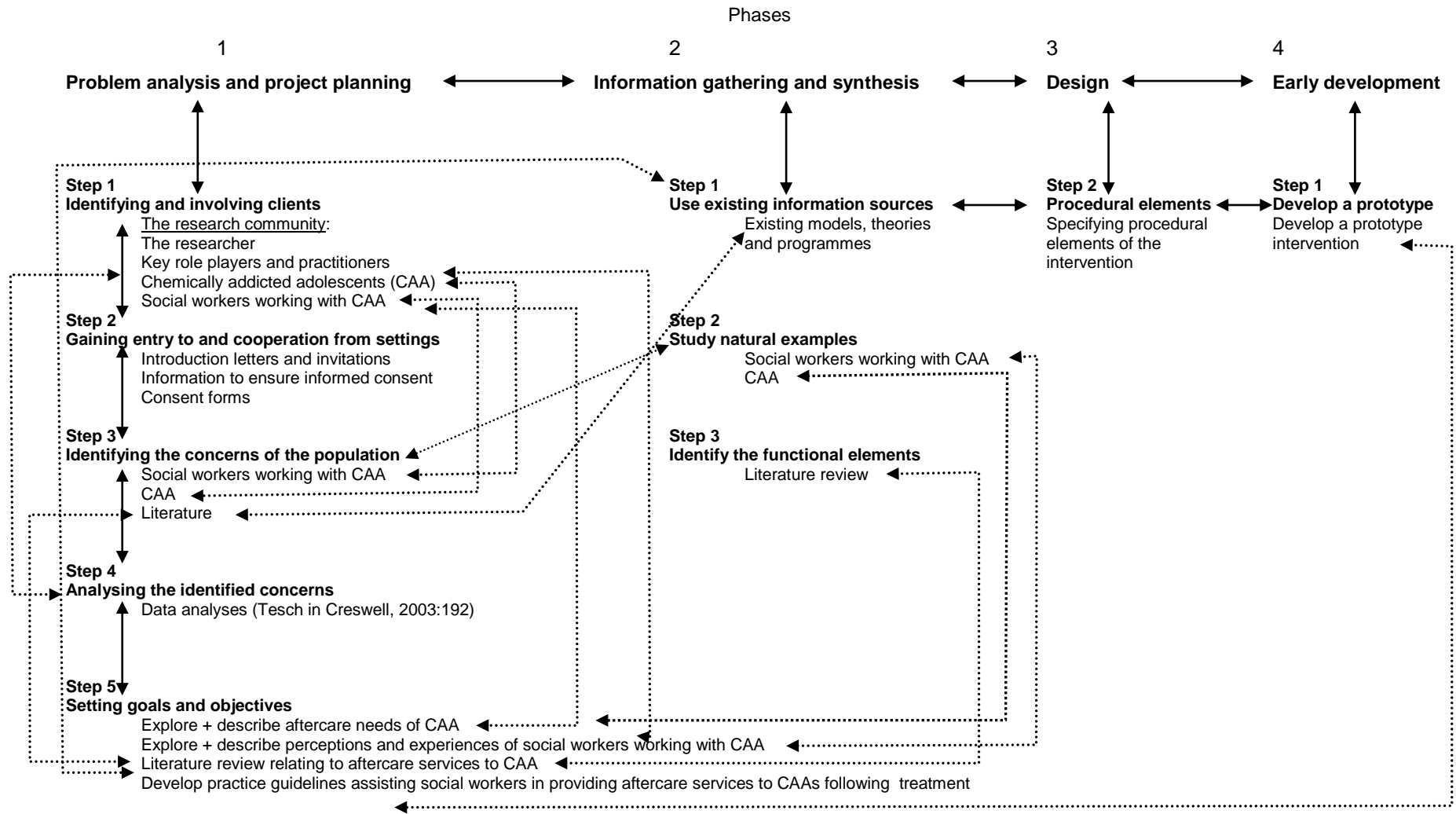
- 2) Knowledge utilisation (KU), in that the acquired knowledge is applied to change or enhance our understanding or practices relating to populations, problems relating to human behaviour, and our interventions in human service.
- 3) Design and development (D&D), in that literature and empirical research are utilised in designing and developing new human service technology (i.e. treatment methods, programmes, service systems, policies and guidelines).

In view of the researcher's intention with this research endeavour, namely to develop practice guidelines assisting social workers to render aftercare services to CAAs following treatment, she decided to use intervention research and specifically the facet of Design and Development (hereafter referred to as IDD). Comer et al. (2004:250) describe the value of the IDD-facet as appropriate for practice in the early stages, as it is more flexible than conventional experimental designs, capitalises on the availability of small samples, values the practitioners' insights, involves role-players, and aims to design and assess innovative human interventions or service technology (cf. Strydom et al., 2007:329-333).

The phases and steps of the IDD-model as proposed by Rothman and Thomas (1994:28), as well as their interrelatedness, were presented in Chapter 1. As previously explained, the researcher decided not to use all the phases of the IDD-model as proposed by Rothman and Thomas (1994:28) for this study, but used only Phases 1 and 2 of the IDD-model and Step 2 of Phase 3 and Step 1 of Phase 4. The motivation for using only the identified steps in Phases 3 and 4 was provided in Chapter 1 (see p. 21).

Figure 2:2 provides an outline of the implementation of the IDD-model, as well as the interconnectedness of the phases and steps. It will be followed by a discussion thereof.

**Figure 2.2:** Implementation of the IDD-model (as adapted from Rothman & Thomas, 1994:28)





### 2.2.3 Phase 1: Problem analysis and project planning

Rothman and Thomas (1994:27) identify the following five steps that contribute to the successful completion of Phase 1 of the intervention research design: 1) Identifying and involving clients, 2) Gaining entry to and cooperation from settings, 3) Identifying the concerns of the population, 4) Analysing the identified concerns, and 5) Setting goals and objectives. This phase enabled the researcher to develop a clear understanding of availability of aftercare services and guidelines for providing aftercare services in practice, the aftercare needs of CAAs, as well as the meaning that social workers involved in aftercare services to them attached to these services. The steps and their implementation are described below.

#### 2.2.3.1 Step 1: Identifying and involving clients

Fox and Bayat (2007:52) describe the **population** of a research study as the entire group of persons, objects or events of interest to the researcher. The individuals, objects or events included in a population share a common characteristic and are representative of the sum total of cases involved in a study. Providing an even clearer description of a population, Potter (2002:47) advises that a population should be clearly defined and should focus on a geographical area and characteristics that relate to the research problem. The interest groups that formed the basis for the choice of the populations for the purpose of this study were defined as follows:

- All chemically addicted adolescents in the Western Cape who had relapsed after in-patient treatment.
- All Social Work service providers dealing with adolescent chemical addiction in the Western Cape.

The motivation for choosing the Western Cape as the geographical area included in the population was discussed in Chapter 1 (see p. 23).

Fossey et al. (2002:726) assert that qualitative sampling is concerned with “information richness”, stressing the importance of the identification of

appropriate participants who can best inform the study, rather than concern for the generalisation of the results to other populations. Agreeing with this sentiment, Devers and Frankel (2000:2) advise that the sampling frame should assist the researcher to develop concrete criteria for selecting participants who are able to answer the research question. A **sample** is a subset of measurements drawn from the population in which the researcher is interested, and it should be representative of the population of the study, in order to permit generalisation of the results of the study (Welman et al., 2005:55). The abovementioned description of qualitative sampling by Fossey et al. (2002:726), however, indicates that generalisation of the results is not the primary aim of the qualitative researcher.

Desai and Potter (2006:117) distinguish between the **sampling techniques** in quantitative and qualitative research, describing sampling in quantitative research as random, stratified techniques, while qualitative research makes use of small purposive samples, who are the key informants relating the research problem (cf. Fox & Bayat, 2007:54). Continuing the discussion on the distinction between the sampling techniques in quantitative and qualitative research, Bless et al. (2006:101-108) concur that probability sampling, also known as “random sampling”, is typical of quantitative research. Its main feature is that it ensures that every element in the population has an equal chance of being selected for the sample. In qualitative research, the non-probability sampling technique is relevant because the probability of being selected into the sample cannot be determined. The sample size can therefore not be determined at the beginning of the research.

Bless et al. (2006:101-108) warn that a typical error in sampling during the qualitative research process is based on chance errors when a crucial element was not included in a sample. In line with this statement, Monnette, Sullivan & De Jong (2005:131) advise that the sampling frame should clearly describe and include all the elements that are relevant to the research problem. It is therefore important that the criteria for inclusion in the study are clear, and are focused on the research problem. Considering the qualitative nature of this research study, as well as the relevance of the non-probability

sampling technique, **purposive sampling** was chosen, as the researcher relied on her judgement regarding the required characteristics of the inclusion criteria for the sample from the population. This technique provided the researcher with a sample to access some specialised insights into the nature of current aftercare services by social workers in the Western Cape, as well as the aftercare needs of CAAs following treatment in the Western Cape (Bless et al., 2006:121).

The sample for inclusion in this study was selected from the abovementioned two populations and described in Chapter 1. The criteria for inclusion from the **adolescent population** interest group in the Western Cape were: chemically addicted adolescents, who had previously undergone in-patient treatment and had had contact with a social worker following treatment, who relapsed thereafter and were currently back in in-patient treatment programmes in the Western Cape. In order to prevent contamination of the data, the criteria for inclusion included the fact that the participants should previously have had contact with a social worker. This contact ensured that they had received Social Work services following their previous treatment efforts. The researcher hoped that the fact that she did not have to explain the term “social worker” to the participants would prevent the possibility of her explanation influencing the responses.

The criteria for inclusion from the population of **social workers** in the field of adolescent chemical addiction in the Western Cape were: registered social workers employed by the Department of Social Development and NGOs, providing aftercare services to chemically addicted adolescents in the Western Cape.

Niewenhuis (in Maree, 2007:92) postulates that the **sample size** in qualitative research is guided by convenience and availability, contrary to quantitative research, where a representative sample is determined by sample size. This author concludes that sample size in qualitative research is determined when no new information is emerging, referring to data saturation (cf. Cherry, 2000:54). Strydom and Delport (in De Vos et al., 2002:335) point out that data

saturation will enhance external validity, referring to the extent to which results can be generalised to other populations or circumstances. Other factors contributing to external validity relating to sampling are the criteria for inclusion in the sample and study conditions that must be as real and natural as normal, to enhance external validity (Leedy & Ormrod, 2005:97-99).

In order to address the issue of external validity, the sample size for this study was therefore determined by data saturation. For the purpose of this research, the aftercare needs of relapsed CAAs were explored in this study by means of narrative inquiries. In addition, the perceptions and experiences of social workers involved with aftercare services to CAAs were explored in focus groups. Data saturation was observed after 31 narratives and seven focus groups.

Making use of the sampling technique, the researcher proceeded to the next step in this phase in order to make contact with prospective participants.

### **2.2.3.2 Step 2: Gaining entry and cooperation from settings**

Devers and Frankel (2000:3) note that in qualitative research, the researcher is the research instrument. Therefore, the development and maintenance of good relationships are important for effective sampling and contact with participants. The researcher was a member of the SANCA Western Cape Management Board, as well as the Western Cape Drug Forum's portfolio for treatment and aftercare. This provided her with access to key role-players in the field of this research endeavour.

During this step, the researcher needed to gain access to more than one source of data (CAAs and social workers involved with services to CAAs). In order to gain access to the sample selected from the **population of chemically addicted adolescents** in the Western Cape who had relapsed after in-patient treatment; the researcher contacted the following treatment centres in the Western Cape: Hesketh King Treatment Centre (Joostenbergvlakte), Toevlug Treatment Centre (Worcester), Caro Clinic

(Cape Town), De Novo Treatment Centre (Kraaifontein) and Teen Challenge (Eersterivier). Only Hesketh King Treatment Centre and De Novo Treatment Centre accepted the invitation. Caro clinic and Teen Challenge's patients did not comply with the inclusion criterion (i.e. returning to treatment programmes following a relapse), and no response was received from Toevlug Treatment Centre.

The researcher made use of the proposed procedure to gain access to the **adolescent interest group**, as described in Chapter 1. The participating centres were requested to act as "gatekeepers", regulating the researcher's access to the participants (Leedy & Ormrod, 2005:137). Bourg, Broderick, Flagor, Kelly, Ervin and Butler (1999:65) note that gatekeepers should be used during preparation for interviews, and could be valuable to assist the participants during the collection of data.

The following information was shared with the potential CAA participants, gatekeepers and parents/guardians during the initial interviews, prior to the completion of consent forms: the purpose of the research, the format of the study, the criteria for inclusion, data collection through narrative inquiry, the location, the duration of the exercise, assurance of anonymity and confidentiality, and assurance that only the researcher, editor, independent coder and the researcher's promoter and co-promoter would have access to the narratives.

This information was also contained in a preamble letter requesting participants' participation in the research project (see Annexure B, p. 455). Upon the gatekeepers' permission to conduct the research at the respective centres, and the participants' willingness to partake in this research endeavour as well as their parent's/guardian's permission for them to be part of the research, the consent forms were signed (see Annexure D, p. 459). Following this, an appointment was made to collect the data consisting of the written narratives.

In order to gain access to the sample selected from the population of **social workers** rendering services to CAAs regarding aftercare services, the researcher made use of the procedure discussed in Chapter 1.

The researcher invited the South African National Council on Alcohol and Drug Abuse (SANCA), ABBA Network (a network of multidisciplinary role-players who are involved in the field of chemical addiction, and which employs social workers), Afrikaanse Christelike Vroue Vereniging (ACVV), Badisa (a Non-Government welfare Organisation of the Dutch Reformed Church's Benevolence Board) and the Department of Social Development, to take part in the study in a letter. Only Badisa did not accept the invitation to take part in this research. Table 2.2 provides an overview of the 29 participants from the four organisations who availed themselves as participants in the study, resulting in seven focus groups.

**Table 2.2:** Overview of the number of participants (the social worker interest group) from the respective organisations who availed themselves to participate in the study

Organisation	Participants
Department of Social Development	6
SANCA	11
ACVV	8
ABBA Network	4

Prior to formation of the focus groups, informal face-to-face interviews with willing participants were arranged, during which time the following information was shared and consent forms were signed: the purpose of the research; the format of the study; the criteria for inclusion; data collection through focus groups; the location; the duration of the focus groups; assurance of anonymity and confidentiality; permission to tape-record the interviews; the assurance that only the researcher, editor, independent coder and the researcher's promoter and co-promoter would have access to the tape-recordings and transcripts.

This information was also contained in a preamble letter requesting social workers' participation in the research project (see Annexure E, p. 463). When

participants had signified their willingness to partake in this research endeavour, each signed the consent form confirming his/her consent in writing (see Annexure D, p. 459). The participants provided the researcher with possible dates, times and venues for the focus groups that would be convenient for them. Following this, appointments were made for the data to be collected.

This step in the first phase of the IDD-model informed the third step and enabled the researcher to explore the concerns of the participants.

### **2.2.3.3 Step 3: Identifying the concerns of the populations**

During this step<sup>4</sup> of identifying the concerns of the population the researcher attempted to develop an understanding of the research problem. Understanding becomes possible when the population is allowed and encouraged to express their own thoughts, concerns and judgements regarding the research problem and research questions. The researcher should also use informal contact to obtain information related to the topic from experts in the field of interest (Strydom et al., 2007:335).

Apart for identifying the concerns from the sample groups taken from the populations of CAAs and social workers stated above, the researcher conducted informal interviews with key role-players and practitioners in the field of the treatment of chemical addiction to enquire about aftercare guidelines and services available to CAAs in practice. These practitioners were not included in the sample of social workers who participated in the focus group discussions. Concerns were also noted at meetings she attended as a member of the SANCA Regional Board and the Western Cape Drug

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<sup>4</sup> Within the context of this study, Step 3 of Phase 1 (Identifying the concerns of the population) overlapped with Step 2 of Phase 2 (Studying natural examples). The latter focuses on studying “people who have actually experienced the problem and/or are affected by the phenomenon under study”, while Step 3 of Phase 1 to a large extent concerns itself with the same (Strydom et al., 2007:335). The researcher concluded that while she was executing Step 3 of Phase 1 (i.e. identifying the concerns of the population); she was at the same time and to a very large extent performing the action of studying natural examples.

Forum. These concerns were highlighted in Chapter 1 (see “Theoretical background and rationale for the study”, p.9).

In order to assist the researcher in identifying the concerns of the population with specific reference to the chemically addicted adolescent participant group she formulated Task objective 1 (see the block below).

**Task objective 1:** To explore and describe the specific aftercare needs of relapsed chemically addicted adolescents following treatment relating to services by social workers

### **Description on how the concerns of the adolescent participant group were identified**

Desai and Porter (2006:52) quote Boyden and Ennew who stress that children’s voices are seldom heard, and that we need to know what they think before we can plan interventions. Taking note of this, the adolescent participant sample group was given an opportunity to provide the researcher with a better understanding of their aftercare needs following treatment, by means of **written narratives**. When engaging adolescent participants in a research project, Desai and Porter (2006:52) suggest that the qualitative researcher should acknowledge that adolescents have not yet completed the relevant life tasks to move to adulthood, and this can pose a challenge to the researcher (Desai & Potter, 2006:52). Addressing this, Patton (2002:49) postulates that interviews and observations are not the only legitimate ways to understand human experiences, but other means like writing can also be employed. A narrative inquiry in qualitative research, for instance, refers to a story relating to a specific experience or episode, as told by a participant in a research study (Schwandt, 2001:168; Fitzgerald & Rumrill, 2003:97). Roberts (2003:147) refers to written narratives as “an account by an individual of their life in written form”. Creswell (2009:177) acknowledges stories told by participants in research studies as a form of qualitative data collection. Gray (as quoted by Bell, 2005:21-22) points out that the advantage of written narratives is that it are less intrusive, as well as time- and cost-effective. Other advantages of this method of data collection include that it discloses hidden details of private experiences, and it assists the participants to answer



questions they have about their own lives (Merriam & Associates, 2002:293; Denzin & Lincoln, 2003:217).

The viewpoint of the authors referred to above and the advantages of written narratives informed the researcher's choice of this method of data collection. In this study, it provided the participants with the opportunity to describe their perceptions of aftercare services as social workers, which could assist them in preventing further relapses. They were asked to write narratives based on the following theme: *The things social workers can help me with to maintain my sobriety after treatment.*

Denzin and Lincoln (2003:511) advise that the writing process and the writing product should place the author in the centre. The process of writing the narratives was implemented as a "structured experience" in order to avoid contamination of the data. The term "structuring" refers to various arrangements that are made to manage human interaction (McNeece & DiNito, 1998:90; Sheafor & Horesji, 2006:138). This structured experience required that the researcher provide the participants with a set of specific orders, instructions, or prescriptions (cf. Anderson in Du Preez & Alpaslan, 1992:21) enabling them to compile their narratives (see Annexure G, p. 468). Because social interaction influences the individuals or groups involved in an interaction process, the researcher opted for administering the writing of the narrative as a structured experience, in order to curb the interaction amongst individuals in terms of what to share or not to share, and how to share it. The researcher also aimed to structure the experiences of the participants regarding the data collection in such a way that her own ideas and feelings were not transferred to the participants.

Data was collected immediately after the introduction interview. The participants completed the narratives in the recreation rooms of the facilities, and were seated at writing tables that were spread evenly throughout the rooms. In an effort to prevent participants from influencing one another, they did not interact with each other while writing the narratives.

In order to assist the researcher in identifying the concerns of the population with specific reference to social worker participant group she formulated Task objective 2 (see the block below).

**Task objective 2:** To explore and describe the experiences of social workers in relation to rendering aftercare services to chemically addicted adolescents

**Description on how the concerns of the social worker participant group were identified**

In order to explore the perceptions and experiences of the social worker participant group concerning aftercare services rendered to CAAs and current aftercare Social Work services available in this regard, the researcher made use of **qualitative interviewing in focus groups**<sup>5</sup>, as it provided the opportunity to promote self-disclosure among participants. Multiple viewpoints were obtained, and shared experiences formed a platform for discussion. Qualitative interviewing gave the participants the opportunity to share all the information they deemed relevant to aftercare services to CAAs (Sewell, 2006:1). Additional advantages of focus groups were that they gave the researcher the opportunity to obtain rich information and to clarify statements, and were time- and cost-effective (Welman et al., 2005:203).

When planning the focus groups, the researcher considered the venue (for privacy and comfort), the time and the questions. These considerations were addressed in terms of an introductory interview with the participants, as well as a letter introducing all the details about the research and containing an **interview guide** (see Annexure E, p. 463) as an outline of topics or issues to be covered by the research (Sewell, 2006:4).

The following questions were asked to explore the perceptions and experiences of the social worker participant group concerning aftercare services rendered to CAAs and the current aftercare Social Work services available in this regard:

- What are your views in general regarding aftercare services to CAAs?
- Tell me about the services you employ to address aftercare to CAAs.
- What resources are available to you to support your work?

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<sup>5</sup> The rationale for the choice of data collection strategy was discussed in Chapter 1.

- What restrictions do you experience?
- If you were to compile practice guidelines for social workers in view of rendering aftercare services to CAAs, what would you include?

Complementary to the focus group interviewing as qualitative data collection technique, the researcher also used participant observation as qualitative method of data collection, to observe the group dynamics and the non-verbal messages conveyed by the participants during the focus group discussions. While conducting the focus group interviews the researcher employed the interviewing techniques discussed in Chapter 1 (see p. 30).

The **method of data recording** for the data obtained from relapsed **chemically addicted adolescents** was their writing of narratives. Data obtained from this group of **social workers** was recorded by means of tape-recordings, which were transcribed later. The transcripts were kept as evidence of the research. Additional data was obtained by means of field notes, and was added to the transcripts in order to complete the data collection (Greeff, in De Vos et al., 2002:318).

The researcher subsequently proceeded with the analyses of the data collected in this step.

#### **2.2.3.4 Step 4: Analysing the identified concerns**

This step in the first phase of the IDD-model was based on the collection of the qualitative data obtained from relapsed CAAs, as well as the comments of social workers rendering services to CAAs.

Qualitative data analysis, according to Desai and Potter (2006:117), draws inferences from a detailed, systematic analysis of data obtained through qualitative data collection methods. Fox and Bayat (2007:106) refer to the following four strategies in qualitative data analysis:

- Data analysis, where qualitative data is analysed by means of coding.

- Synthesis, based on the qualitative data and not on theory.
- Induction, in order to relate the data to a larger whole by means of verification with literature.
- Deduction, where a conclusion is drawn based on the specific sample of the research study.

Fox and Bayat (2007:106) describe qualitative data analysis as the process where data is analysed to discover the content, regularities and meaning of the data obtained (cf. Babbie & Mouton, 2007:490). The key process is coding, which entails the categorising of data into a limited number of categories (Monnette et al., 2004:430; Fox & Bayat, 2007:532). Desai and Potter (2006:121) see the advantages of qualitative data analysis as being cumulative in nature and being “good at uncovering processes and causality”. These authors, however, advise that the researcher should guard against his/her biases, in order to prevent contamination of data analysis.

A different view from these qualitative data analysis strategies is provided by Monnette et al. (2005:430-433), who refer to three approaches to develop coding schemes. The first approach is the creation of a fairly complete coding scheme before entering the field, based on previous research and what the researcher expects to find. The second approach is that the researcher enters the field with no pre-established coding scheme. Evolving categories are based on the data as it emerges during the course of the research. A combination of the first two approaches results in the third approach, where the researcher makes use of a general coding scheme, but avoids being specific, in order to allow emerging categories to be included.

In the present qualitative research study, the process of data analysis was intended to enable the researcher to describe the data obtained during the exploration of the research questions in the data collection process. A pre-established coding scheme therefore would limit the richness of the data that was obtained. The researcher opted for the second approach in which no pre-established coding existed. The data analysis led to a synthesis and

induction, which will be described in Chapters 3, 4 and 5. Deduction took place by means of the conclusions relating to this study, as discussed in Chapter 7.

Data analysis took place once data became repetitive and data saturation was reached among both the samples included in this study. The written narratives were analysed in order to address the research question pertaining to the aftercare needs of CAAs. The analysis of the transcripts of the focus groups with social workers also brought about an understanding of their perceptions and experiences concerning aftercare services rendered to CAAs and current aftercare Social Work services available in this regard. The researcher made use of the framework for data analysis for qualitative research by Tesch (as cited in Creswell, 2009:186) to ensure a systematic manner of data analysis. The eight steps typical of this framework were discussed in Chapter 1. These steps ensured that the data analysis occurred in a comprehensive and systematic manner.

Terre Blanche and Durrheim (1999:214-221) suggest that the qualitative researcher should be aware of the fact that the researcher is influenced by the participants, and also influences them during data collection and data analysis. In view of this, the researcher also engaged herself in the process of data verification.

**Data verification** in qualitative research is founded in the quality of the data collection and data analysis processes (Alston & Bowles, 2003:48), and therefore data verification takes place during data collection, data analysis and the writing of the research report. This process ensures that the findings of the research accurately represent what is happening in the situation being studied, which leads to credible conclusions that can “bear the weight” of the interpretation of the data (cf. Welman et al., 2005:142). Both Merriam and Associates (2002:27) and De Vos (in De Vos et al., 2005:345) refer to Guba’s model (as cited in Krefting, 1991:214-222) as a “classic contribution to the methodology of qualitative research”. Guba’s model (in Krefting, 1991:214-222) was used as a measure to ensure the trustworthiness of the research

findings. According to Guba (in Krefting, 1992:215), the following four aspects of trustworthiness are relevant to both quantitative and qualitative studies, 1) truth value, 2) applicability, 3) consistency, and 4) neutrality.

- **Truth value:** This aspect assesses how confident the researcher is with the truth of the findings based on the research design, informants and the context. Babbie and Mouton (2007:9) describe the meaning of “truth” in qualitative research as the relationship between the data and the context. The research design, sampling technique, and a clear description of the context in which the research was conducted, determine the level of confidence in the truth of the findings (Krefting, 1991:215). Prolonged and varied field experience, time sampling, reflexivity (field journal), member checking, peer examination, interview techniques, and the authority of the researcher are some of the criteria that can be used to enhance the credibility and truth value of a study (Krefting, 1991:217; Merriam & Associates, 2002:27). In order to address the truth value of the present research, the researcher attempted to ensure that the findings were credible and a true reflection of these addicted adolescents’ aftercare needs and of social workers’ perceptions and experiences of aftercare services available/rendered to such adolescents, by employing triangulation of data sources and data methods. Maree and Van der Westhuizen (in Maree, 2007:39-40) view triangulation as “critical in facilitating interpretive validity” (cf. Babbie & Mouton, 2007:275). These authors refer to “crystallisation” as a technique to use in combination with triangulation, enabling the researcher with a “crystal clear” description of the phenomenon that is being studied. Janesick (2004:392) agrees with this statement and postulates that crystallisation assists the qualitative researcher to develop a deepened and complex understanding of the field of study. Triangulation is also viewed as a route to ensure that research meets the demands of science within the cost- and time-constraints of research practice. The disadvantages of triangulation include that it is more costly, it tends to generate masses of data, and it does not necessarily produce better results. On the other hand, the advantages are that it increases the completeness of the study, confirms trends, identifies inconsistencies, and improves the reliability and validity of a research study. (Sarantakos, 2000:169; Silverman, 2000:98-99; Weyers;

Strydom & Huysamen, 2008:207-210). It assists the researcher to obtain accurate representation of a specific situation of interest to the study by means of multiple theories, sources of data, or data collection methods (Brink, 2003:215). In the table below the strategy and criteria utilised to establish confidence in the truth of the findings are provided.

**Table 2.3:** Strategy and criteria employed to enhance the truth-value of the findings

STRATEGY	CRITERIA	APPLICABILITY
Credibility	<u>Interview technique:</u> The researcher employed the following interview techniques during the focus group discussions with the social worker sample/ interest group: clarification, summarising, focusing, probing, minimal verbal responses, encouragement	<ul style="list-style-type: none"> <li>• These skills were employed to lubricate and optimise the discussions during the focus group interviews to their full potential.</li> <li>• Interviewing skills enabled the researcher to assist participants to fully explore the research question.</li> <li>• The researcher encouraged the participants to share the perceptions and experiences, while feeling reassured.</li> <li>• These skills assisted the researcher to avoid guiding the responses of the participants, thus enhancing the truth value of the findings.</li> </ul>
	<u>Triangulation:</u> Guba (as cited in Krefting, 1991:219) describes triangulation as the comparison of multiple perspectives.	<ul style="list-style-type: none"> <li>• Triangulation of data sources: Various data sources were included in the study: <ul style="list-style-type: none"> <li>○ social workers representing different organisations rendering aftercare services to adolescents addicted to chemical substances, and</li> <li>○ adolescents addicted to chemical substances who had experienced a relapse.</li> </ul> </li> <li>• Triangulation of data collection methods: <ul style="list-style-type: none"> <li>○ Written narratives</li> <li>○ Focus group discussions</li> </ul> </li> <li>• Triangulation of theories: <ul style="list-style-type: none"> <li>○ Studying different theories relating to chemical addiction</li> </ul> </li> </ul> <p>The independent coder, promoters and researcher were involved in the analysis of the data.</p>
	<u>Peer examination:</u> Krefting (1991:219) explains the concept of peer examination as follows: “[It] involves the researcher discussing the research process and findings with impartial colleagues who have experience with qualitative methods”.	<ul style="list-style-type: none"> <li>• Advice and guidance from colleagues, who were experienced in the field of qualitative research, were used throughout this research study.</li> <li>• The fact that the researcher’s promoters and independent coder were well versed in qualitative methodology added to the credibility of the research endeavour.</li> </ul>
	<u>The authority of the researcher:</u> The authority of the researcher is assessed against the following criteria: 1) the degree of familiarity with the phenomenon under study, 2) a strong interest in conceptual knowledge, and the ability to conceptualise large amounts of qualitative data, 3) the ability to take a multidisciplinary approach, that	<ul style="list-style-type: none"> <li>• The researcher had specialised in the field of chemical addiction, while working as a social worker in this field over the past ten years.</li> <li>• During this time she formed part of multidisciplinary teams, and was involved in the development of three different in-patient treatment programmes, one of which specifically focused on adolescents.</li> <li>• The researcher also worked as a social worker in the field, where the impact of chemical addiction on the family and society was observed. However, she was careful not to make use of previous roles, and to focus on her role as facilitator and researcher, in</li> </ul>

	is, to look at the subject under investigation from a number of different perspectives, and 4) good investigative skills, which are developed through a literature review, course work, and experience in qualitative research methods (Krefting, 1991:220).	<p>order to prevent contamination or leading.</p> <ul style="list-style-type: none"> <li>In addition, the researcher conducted a qualitative research study for a Masters Degree through the University of South Africa, focusing on chemically addicted adolescents' experiences of relapsing after treatment.</li> </ul>
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- Applicability:** As stated in Chapter 1, “applicability” refers to the degree to which the findings of the research study are applicable to other contexts or groups, and can be achieved through the strategy of transferability and the following criteria: time sampling, a thick description of the research methodology employed, and nominated sampling (Krefting, 1991:216; D’Cruz & Jones, 2004:67; Fox & Bayat, 2007:108). In the table below, strategy and criteria utilised to enhance the applicability of the research findings to other contexts or groups are indicated:

**Table 2.4:** Strategy and criteria employed to enhance the applicability of the findings

STRATEGY	CRITERIA	APPLICABILITY
Transferability	Nominated Sampling: This occurs when the researcher uses experts or a panel of judges to select (nominate) informants representative of the phenomenon under study (Krefting, 1991:220).	<ul style="list-style-type: none"> <li>The researcher used social workers at the various centres to identify adolescents who fitted the criteria for inclusion in the study.</li> </ul>
	Transferability is enhanced through a dense description or a great deal of information about the participants and the findings (Guba as cited in Krefting, 1991:216).	<ul style="list-style-type: none"> <li>The demographic details of the participants were discussed and described in this chapter and in Chapters 3 and 4.</li> <li>The data obtained through semi-structured interviews, narrative inquiries and focus groups and comparison with the available and relevant literature, was discussed in Chapters 3 and 4.</li> <li>A description of the methodology, research design, and methods of data collection and analysis is provided in this chapter.</li> </ul>

- Consistency:** This aspect of trustworthiness considers whether the findings would be consistent if the research project was replicated with the same participants or in a similar context/setting (Krefting, 1992:216). Consistency is defined in terms of dependability (Guba, in Krefting, 1991:216). The following criteria can be employed to enhance the dependability of research findings: undertaking a dependability audit,



providing a dense description of the research methods, stepwise replication of data and the independent analysis thereof before comparing the results, triangulation, peer examination, and the code-recode procedure of the data during analysis (D’Cruz & Jones, 2004:67; Krefting, 1991:216; Merriam & Associates, 2002:27). In the table below, the strategy and criteria that were utilised to enhance the dependability of the research findings are given.

**Table 2.5:** Strategy and criteria employed to enhance the dependability of the findings

STRATEGY	CRITERIA	APPLICABILITY
Dependability	Triangulation	The discussion about the types of triangulation provided in Table 2.5 above under the column “applicability” applies here (see Table 2.5).
	Providing a dense description of the research method and procedures followed (Krefting, 1991:220)	The methodology used in this study is covered in detail in Chapters 1 and 2.
	Peer examination	The discussion about peer examination provided in Table 2.4 above under the column “applicability” applies here (see Table 2.4).
	Stepwise replication	The researcher and an independent coder, well versed in qualitative research, analysed the dataset independently from each other. On completion they engaged in a consensus discussion identifying the themes and sub-themes that emerged from the data.

- **Neutrality:** “Neutrality” as the fourth aspect of trustworthiness, refers to the degree to which the findings are a function solely of the informants and the conditions of the research and not of other biases, motivations and perspectives (Guba in Krefting, 1991:216). Neutrality is achieved through the strategy of confirmability, and by means of the following criteria:
  - A confirmability audit: This is where an external auditor tracks the natural history and progression of events in a project to try and understand how and why decisions were made. Auditability also implies that another researcher could arrive at comparable conclusions, given the same data and research context (Lincoln & Guba as cited in Krefting, 1991:221).
  - Triangulation of multiple data collection methods, data sources and theories.

- Reflexive analysis is also useful as it bring to the researcher's awareness his/her influence on the data (Krefting, 1991:221).

In the table below, the strategy and criterion that were utilised to confirm the neutrality of the research findings are given.

**Table 2.6:** Strategy and criteria employed to enhance the neutrality of the findings

STRATEGY	CRITERIA	APPLICABILITY
Conformability	Triangulation	The discussion about the types of triangulation provided in Table 2.4 above under the column "applicability" applies here (see Table 2.4).

On completion of the data analysis, the researcher proceeded with the setting of goals and objectives (to presented next) as the last step in the first phase of the IDD-model proposed by Rothman and Thomas (1994:31).

### 2.2.3.5 Step 5: Setting the goals and objectives

In order to direct the proposed outcome of the research, Rothman and Thomas (1994:30-31) advise researchers to formulate goals and objectives for this purpose. In the context of IDD-model, the "goal" refers to the "broad outcomes that are desired by the community of interest" (Fawcett et al., in Rothman & Thomas, 1994:72).

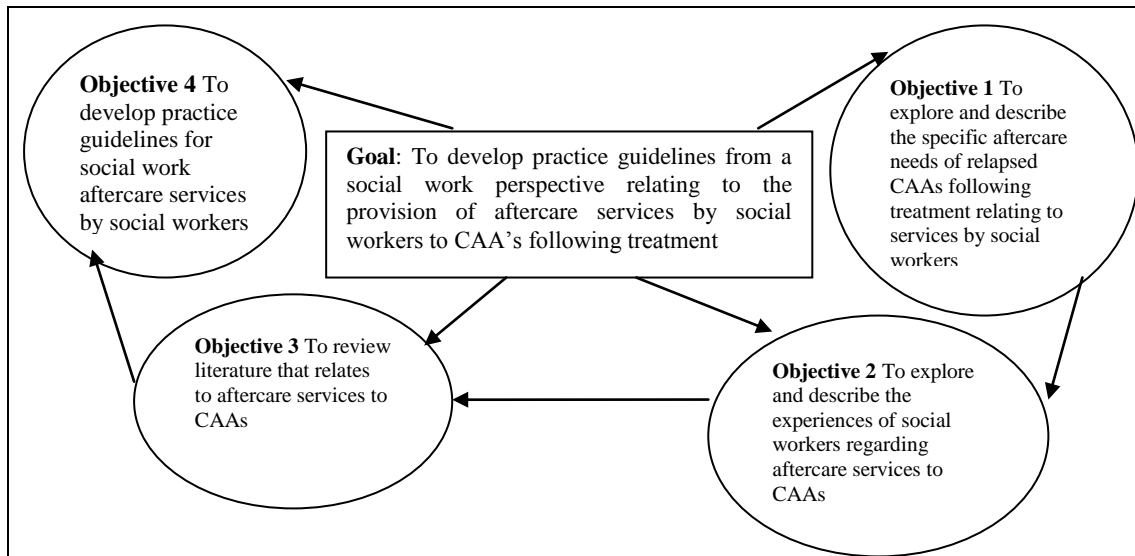
Fouché (in De Vos et al., 2002:107) writes that the terms "**goal**", "**purpose**" and "**aim**" are synonyms with one another, and defines them as follows: "Their meaning applies to the broader, more abstract conception of the end towards which effort or ambition is directed". Holloway and Wheeler (2010:27) view the "aim" as "a statement of the researcher's intentions", and advise that it must be clear and made very explicit.

According to Fouché (in De Vos et al., 2002:107-108), **the concept "objective"** denotes the more concrete, measurable and more speedily attainable conception of the end towards which the effort or ambition is directed. The one (goal, purpose or aim) is the "dream"; the other (objective) is the steps one has to take, one by one, realistically at grass-roots level,

within a certain time-span, in order to attain the dream. The objectives need to be an offspring of the goal and relate directly to it (Alpaslan, 2009:10-11).

The goal and task objectives formulated in this regard are depicted in the figure below.

**Figure 2.3:** The goals and task objectives of this study



On the conclusion of the first phase of the IDD-model, the researcher proceeded to the second phase, as proposed by Rothman and Thomas (1994:32), which will be presented in the following discussion.

## 2.2.4 Phase 2: Information gathering and synthesis

Rothman and Thomas (1994:32) advise that, in order to gather relevant information and to develop a synthesis, the researcher use the following steps during the second phase of the IDD-model: 1) Using existing information sources, 2) Studying natural examples, and 3) Identifying the functional elements. These steps were implemented in this study as follows:

### 2.2.4.1 Step 1: Using existing information sources

A review of the literature was necessary, not only for the purpose of determining the need for this research undertaking, and subsequently

identifying and framing the research problem, but also to assist the researcher to develop a greater understanding of the phenomena under investigation. This activity, using existing information resources and undertaking a literature review, was congruent with the view of Rothman and Thomas (1994:32) who describe this step as the process of discovery of existing material, as well as the integration thereof in the steps that follow. Based on this premise, Hayes (as cited in Rothman & Thomas, 1994:101) states that the researcher needs to determine the availability of information, and then continue to determine what information is relevant for the purpose of the particular study. The goal and objectives of the study direct this decision.

Bell (2005:79-83) identifies library searches (scrutinising information in books and journals on the topic or related to the topic) and computer literature searches as sources of information. Focusing specifically on the discovery of existing data as part of the IDD-model, Rothman and Thomas (1994:32) refer to selected empirical research, reported practice, and relevant innovations related to the topic under investigation, as relevant sources of information. These authors encourage researchers not only to make use of literature pertaining to their own fields, but also to adopt a multidisciplinary approach when accessing existing information sources pertaining to the topic. In view of this suggestion by Rothman and Thomas, 1994:32) the research formulated Task objective 3 stated in the block below:

**Task objective 3:** To review literature that relates to aftercare services to chemically addicted adolescents

Some advantages of a literature review in social research, congruent with the aims of this step in the IDD-model, include that it familiarises the researcher with the latest developments in the field of interest, identifies different viewpoints and theories, and reveals connections and contradictions relating to a specific field of interest (Bless et al., 2006:24; Leedy & Ormrod, 2005:69). Building on these advantages, Alston and Bowles (2003:190) assert that the researcher should evaluate the literature critically, and divide the information into themes and sub-themes, enabling the development of a synthesis that can inform the rest of the research process.

The different existing theories, models and programmes relating to aftercare services were incorporated in this study where it seemed necessary (Weyers et al., 2008:208). This step enabled the researcher to obtain a knowledge base regarding the technology related to the focus of this research (cf. Rothman & Thomas, 1994:32), including adolescence, chemical addiction, and aftercare programmes. The researcher made use of relevant literature and a library catalogue pertaining to relevant studies in the field under investigation, as well as an electronic search.

#### **2.2.4.2 Step 2: Studying natural examples**

Closely following on the first step of this phase, the researcher also obtained valuable data from the participants in this study. This step focused on the “people who have actually experienced the problem” (Strydom et al., 2007:335). In the context of this study, the former included the CAAs who had relapsed and articulated their aftercare needs in relation to maintaining sobriety following treatment. In addition, social workers involved with CAAs articulated their perceptions and experiences relating to providing aftercare services to these young people. This step overlapped and is interrelated with the “identifying the concerns of the population” as discussed under Step 3 of Phase 1 in this Chapter. The reader is therefore requested to revisit this section for the detailed discussion (see p. 79), as well Table 1.2 (see p. 38), which provides a summary of the research methods followed to study the natural examples.

Strydom et al. (2007:335) note that, while studying natural examples to identify the concerns of the population, the researcher becomes aware of the needs of the population and the impact of current services and programmes, in order to develop a better understanding of the current situation. This step assisted the researcher to learn as much as possible about the theoretical descriptions of adolescent chemical addiction and relapsing after treatment, as well as relapse prevention, which became part of the building material for the design of the practice guidelines (*Aftercare to chemically addicted adolescents: practice guidelines from a Social Work perspective*) design

phase of the IDD-model (Mohr, 1999:306). The data obtained from the participants (and verified by the literature) was therefore viewed as key to the development of practice guidelines, as it forced the researcher to be led by the felt needs as experienced by the insiders in the field of study, evaluating the relevance of the existing literature against these needs. Mohr (1999:206) stresses that it is essential that researchers ensure that the issue under investigation is understood before “meaningful interventions that will have real social consequences” can be produced. The information gathered from natural examples, as well as the verification with the literature, will be presented in depth in Chapters 3 and 4.

The data accessed from Step 1 (Using existing sources) in Phase 2 introduced the researcher to models, guidelines and suggestions focusing on aftercare services to CAAs, and enabled her to identify functional elements inherent to these models, guidelines and suggestions, which relates to the step discussed below.

#### **2.2.4.3 Step 3: Identifying the functional elements of successful models**

The information gained during the previous step and the step presented here enabled the researcher to develop a synthesis regarding the aftercare needs of CAAs in relation to the current situation, as well as the perceptions and experiences of social workers rendering aftercare services to this group. Because the researcher’s intention was to develop practice guidelines to aid aftercare service delivery to CAAs by social workers, the third step in Phase 2 of the IDD-model was to examine existing practice models, guidelines and suggestions (found as a result of accessing databases and using existing sources) related to aftercare to CAAs in terms of their strengths and weaknesses. The search for functional elements in successful aftercare models, guidelines and suggestions providing aftercare services to chemically addicted persons, and specifically to CAAs were already started to some extent in Step 1 of this phase, where the researcher utilised existing sources to help with the identification and uncovering of information about the topic

under investigation. This step informed Chapter 5, where the available models, guidelines and suggestions will be discussed. Strydom et al. (1007:335) and Bender (2007:77) concur that the identification of functional elements enables the researcher to design relevant interventions during the third phase of the IDD-model.

As a result of accessing various information sources (Step 1 of Phase 2 of the IDD-Model), the researcher identified the following relapse prevention models that are currently being used in the field of chemical addiction: the Cenaps Model for Relapse Prevention (Gorski, 1988), Relapse Prevention Therapy Model (Marlatt & Gordon, 1985:42), the Treatment Process Model (as adapted from Sussman and Ames, 2001:103), the Texas Christian University treatment model, and the Matrix Model of Relapse Prevention. In addition, the Draft Systems Model for Prevention and Aftercare of the Western Cape Department of Social Development (2008) was considered when the functional elements were identified during this step. Only the latter was specifically focused on the Social Work profession, while the other models were aimed at different helping professions, including psychology and theology. In addition to the literature search for models for aftercare, the researcher extended the search to literature and theories related to the following aspects (related to the empirical findings of this study as well as to the Disease Model of Addiction): task-orientated activities to increase resilience, the recovery process of chemical addiction, life skills associated with a recovery lifestyle, including families in aftercare services, motivational interviewing, and the NA 12-Steps programme. The functional elements that were identified during this step will be discussed in Chapter 5.

### **2.2.5 Phase 3: Design of human service technology**

To recapitulate, the design and development (D&D) facet of intervention research concerns itself with designing and developing new human service technology (i.e. treatment methods, programmes, service systems, policies and guidelines) (Rothman & Thomas, 1994:3-8). In view of this the research formulated Task objective 4 (see box below).

**Task objective 4: To develop aftercare practice guidelines for chemically addicted adolescents following treatment**

Bender (2007:78) is of the opinion that the phases of design of human service technology (Phase 3) and early development and pilot testing (Phase 4) are intertwined, and that the activities in each of these phases are difficult to separate.<sup>6</sup> Based on this view, the author refers to Rothman and Thomas (1994:33-34), who identify two products of intervention research, namely: 1) the research data that may demonstrate the correlations between the field of interest and the desired outcome of the interventions and 2) the intervention, including strategies, techniques and programmes. The following two steps are included in Phase 3: 1) Design of an operational system and 2) Specification of the procedural elements of the intervention (Rothman & Thomas, 1994:34-36). Considering that this research study did not include the fifth and sixth phases of the IDD, only the latter was included in this study as the implementation occurred as follows:

#### **2.2.5.1 Step 2: Specifying procedural elements of the intervention**

Strydom et al. (2007:335) note that this activity should include specified detail on the proposed procedures (i.e. the “how to”) to be included in the developed human service technology (i.e. treatment methods, programmes, service systems, policies and guidelines) to ensure that it is easy to understand and to implement in practice (i.e. user-friendly). The procedural elements should be detailed to enable practitioners to duplicate the practice guidelines in their different settings. In Chapter 6 of this report where the aftercare guidelines (packaged in a manual comprising of functional aids) for utilisation by social workers providing aftercare services to CAAs is described, strategies or procedures (i.e. procedural elements) on how to implement these functional aids are provided, including knowledge prerequisite pertaining to some of the aspect/areas focussed on.

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<sup>6</sup> In view of this intertwining and for the purpose of this research endeavour, Step 2 in Phase 3 (Specifying procedural elements of the intervention) and Step 1 of Phase 4 (Develop a prototype of preliminary intervention) were utilised in an integrated manner as the developed prototype intervention (i.e. the aftercare guidelines) (Phase 4: Step1) must be complemented by specific procedures (Phase 3: Step 2) on how to operationalise the guidelines in practice.



## **2.2.6 Phase 4: Early development**

This phase is characterised by the development of practice guidelines by means of a process in which innovative intervention is implemented (Strydom et al., 2007:335). Rothman and Thomas (1994:36-37) identify three steps in this phase, namely 1) Developing a prototype intervention, 2) Conducting a pilot study, and 3) Applying design criteria to the prototype intervention concept. For the purpose of this research endeavour, the researcher concluded this research study with the first step of this phase.

### **2.2.6.1 Step 1: Developing a prototype intervention**

Bender (2007:79) asserts that the development of a prototype intervention can be viewed as the process evolving from the design phase, in which a primitive design is developed to be evaluated under field conditions during the phase of early development and pilot testing (cf. Rothman & Thomas, 1994:36).

Based on the data obtained from the participants in this study and the literature control (See Chapters 3 and 4), as well as the outcome of Chapter 5 describing the information and functional elements obtained from studying models, guidelines and suggestions inherent and related to aftercare to chemical addicted persons, the researcher proceeded to develop aftercare guidelines for CAAs from a Social Work perspective. The content and the format of these practice guidelines will be provided in Chapter 6.

## **2.3 Ethical considerations**

In the context of research, ethical issues in general are concerned with whether the researcher's behaviour conforms to an approved or accepted code or set of principles or rules or laws that regulate behaviour. Ethics in research prevents abuse and misconduct, and assists researchers to act responsibly. The purpose of ethics is to prevent harm to participants in research studies (Neuman, 2003:116; Rubin & Babbie, 2005:71). Alston and

Bowles (2003:21) mention four ethical criteria for research, focusing on specific ethical practice regarding the researcher's relationship with the participants, namely self-determination, not doing harm, doing good, and the purposeful and positive contribution to knowledge. The following questions should therefore be asked when conducting qualitative research:

- Do participants understand potential risks and advantages stemming from their involvement in the research?
- Did they give informed consent?
- How does the researcher make provision for confidentiality/privacy?
- Does the process of data collection include debriefing?

The rationale for the choice of ethical considerations, namely informed consent, protection from harm to participants, and the right to privacy and confidentiality of the data, as well as the implementation thereof, was discussed in Chapter 1.

## **2.4 Limitations of the study**

The depth of the data obtained from this group of addicted adolescents may have been affected by the participants' ability to articulate their experiences and needs, as well as their concentration spans owing to the possible damage to thought and memory caused by the chemical substance abuse and its lingering presence in their system (Lessa & Scanlon, 2006:276). The participants in this research study were chemical substance-free for short periods, as 10 were sober for a period of six weeks, while 21 participants were sober for four weeks. Lessa and Scanlon (2006:276) state that the impact of chemical substances is present for up to 90 days after the last use of the substance, and that change is therefore internalised only after 90 days. The relapse potential up to this point is exceptionally higher (cf. Marlatt and Gordon, 1985:36). The researcher was cognisant of this situation when describing and verifying the data obtained from this group.

In addition, most of the participants were addicted to methamphetamine, followed by marijuana. Although the exact permanent damage caused by methamphetamine has not yet been determined, preliminary tests indicate speech problems, physical weakness and strokes as problems associated with the use of this substance (Yu in Pienaar, 2006:15). On the other hand, Volkov (2004) reports in the *Journal of Nuclear Medicine* that research is showing indications of brain recovery after nine months of sobriety. It is, however, important to consider the fact that the participants in this study had not reached nine months of sobriety when this study was conducted. In addition, the use of ephedrine, which is a component in methamphetamine, is associated with neurological damage such as impairment of memory and thought (Teesson et al., 2002:27; Berman; Setty; Steiner; Kaufman & Skotzke, 2006:45). Regarding addiction, Teesson et al. (2002:26) report that the chronic use of marijuana leads to cognitive impairment, affecting concentration and memory.

Another limitation was that only two treatment centres were able to provide the researcher access to participants. The reason for this was that the criteria for inclusion required that the participants had to have had previous treatment in in-patient treatment centres. Because of waiting lists, treatment centres tend to cater first for patients who have never had access to treatment (Du Toit, 2008).

All the participants were male, thus excluding the voice of female CAAs who had relapsed. One treatment centre admitted only male patients, while the other treatment centre had male only patients during the time of data collection.

## **2.5 Conclusion**

The researcher selected qualitative research as the suitable research approach to answer the research question, which flowed from the research problem. This method made it possible for the researcher to utilise a flexible approach in her attempt to explore the aftercare needs of CAAs, as well as

the perceptions and experiences of social workers who worked in the field of adolescent chemical addiction. The research fell in the ambit of applied research, as its outcome was to propose practical guidelines for social workers to assist them when rendering aftercare services to CAAs. Intervention research was elected as the research design. The IDD-model of intervention research, designed by Rothman and Thomas (1994:28), in particular all the steps in Phases 1 and 2; Step 2 of Phase 3; and Step 1 of Phase 4, proved to be relevant to the research question, and enabled the researcher to obtain the goal and objectives of this study. Purposive sampling enabled the researcher to include “insiders” in the context to which the study was related, answering the research question in a sample who could be seen as “experts” in the field of adolescents relapsing after in-patient treatment. Data collection included written narratives and focus groups. The interviews were tape-recorded, then transcribed, and field notes were added to the transcripts. Following this, Tesch’s descriptive data analysis method (as cited in Creswell, 2009:186) was employed to transform the data into a workable form. Trustworthiness was addressed through Guba’s model (as cited in Krefting, 1991:214-222). Ethical practice focusing on informed consent, protection from harm to participants, and the right to privacy and confidentiality of the data, received attention during the whole process.

Chapters 3 and 4 will discuss the findings of this research, based on the data analysis. Themes and sub-themes will be described, and data will be compared with the relevant literature.

## CHAPTER 3

### DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL: CHEMICALLY ADDICTED ADOLESCENTS' AFTERCARE NEEDS

*"Getting clean is like being born... It is painful, beautiful and scary all at the same time"* (Keegan & Moss, 2008:7).

#### 3.1 Introduction

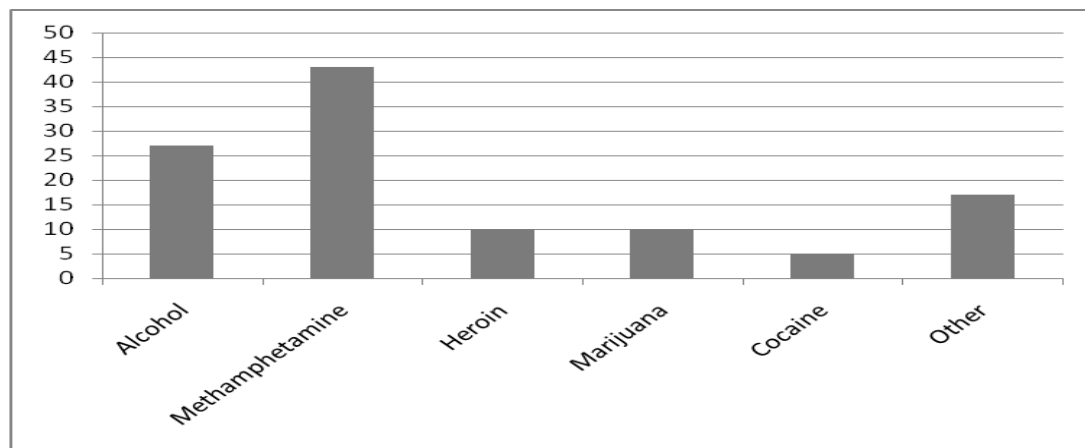
The abuse of chemical substances among adolescents remains an international concern (Falkowski, 2003:65). The harmful effects of chemical substances, as well as their addictive power, lead to individual problems such as impaired judgement, memory loss, health problems, learning problems, and the inability to make positive decisions. On a social level, chemical substance abuse and addiction lead to crime, accidents and violent behaviour (Falkowski, 2003:65).

On the international level, 84.9% of high school learners in America reported that they were able to obtain marijuana easily, while 52.9% were able to obtain methamphetamine, indicating an alarming rate of availability of chemical substances (Caroufek, 2007:6). This trend was also reported on the local level. A recent study conducted by Johnson and Lazarus (2008:20) at nine high schools in the Western Cape, where the present research was conducted, showed that 11.8% of the participants identified their homes, 21.3% identified parties, and 24.8% identified their schools as places where they were able to obtain chemical substances.

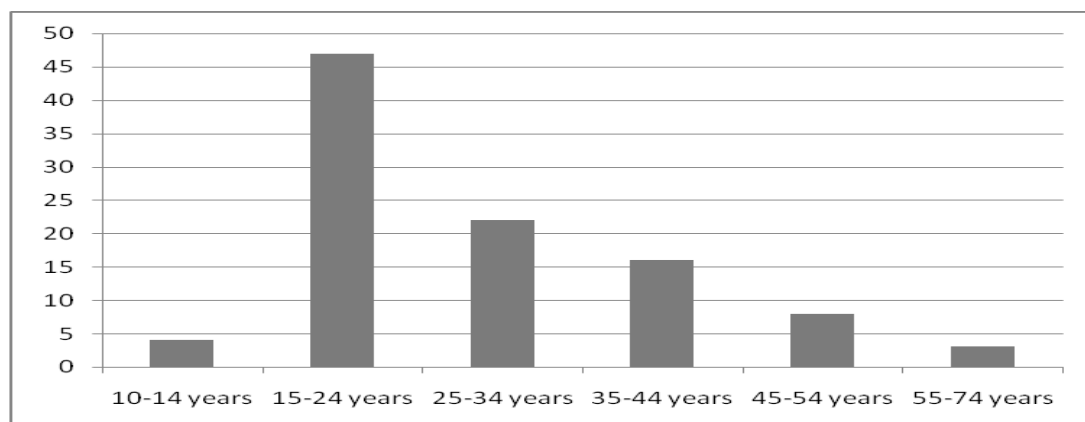
Focusing further on the Western Cape, the total number of chemically addicted persons who received out- and in-patient treatment during 2006 amounted to 2 798 (South African Community Epidemiology Network on Drug Use, 2007:1). This figure indicates only the tip of the iceberg, as it gives only those who received treatment, and not those who needed help, or who were

diagnosed with addiction to chemical substances. As indicated in Figure 3.1 below, alcohol and methamphetamine have been identified as the two primary chemical substances of choice among patients. Figure 3.2 below gives the age distribution among patients, and indicates that the majority of patients in treatment were in the age group of ten to 24 years, confirming the abovementioned concern regarding adolescent chemical substance abuse (South African Community Epidemiology Network on Drug Use, 2007:1).

**Figure 3.1:** Chemical substances of choice among patients in the Western Cape for the second half of 2006 (South African Community Epidemiology Network on Drug Use, 2007:1)



**Figure 3.2:** Age distribution among patients in the Western Cape for the second half of 2006 (South African Community Epidemiology Network on Drug Use, 2007:1)



Considering the increase in demands for treatment of adolescent chemical addiction (South African Community Epidemiology Network on Drug Use,

2007), and based on the conceptual framework of the Disease Model of Addiction (Fisher & Harrison, 2005:37-52) as described in Chapter 1, the addictive cycle should be kept in mind when services are planned. Goodwin (2000:90) notes that relapse should be seen as a characteristic of addiction, and treatment should therefore include relapse prevention and dealing with the occurrence of relapses. Supporting this line of thought, Gordon (2003:3) asserts that relapse following treatment is common, predictable and preventable. Buddy (2003:1) goes further to describe relapse potential as part of the chronic phase of addiction, and adds that it has the potential to become a learning process that eventually leads to recovery. Addressing the reality of the continued relapse potential following treatment, Meyer (2005:292-293) differentiates between three phases in treatment, namely detoxification; treatment programmes and aftercare.

The researcher concluded from this information that relapses remain a threat to CAAs after they leave treatment, and that aftercare services need to become an important part of their complete treatment regime. This research endeavour was further informed by statements from role-players in practice that there is a lack of focus on aftercare, as well as a lack of information pertaining to the contents of aftercare programmes (see Chapter 1, p. 9).

An initial literature review was conducted in order to develop a focus for this research by means of a clear description of the research problem. The research problem, questions emanating from the problem, the goal and objectives, and an outlay of the methodology to be implemented, were discussed in Chapter 1. This research was conducted within the paradigm of qualitative applied research, and was based on Rothman and Thomas' (1994: 3-51) Intervention Development and Design (IDD) Model (see Table 1.1, p. 19). The implementation of the IDD-model, the method of data verification, and the limitations of the study were discussed in Chapter 2.

Rothman and Thomas (1994:28) refer to the first phase of the IDD-model as "problem analysing and project planning". This chapter and Chapter 4 are based on the fourth step of the first phase of the IDD-model, (i.e. the analysis

of the identified concerns) and Step 2 of Phase 2 (i.e. studying natural examples). **This chapter relates to task objective 1 (see p. 36) of this research endeavour, namely to explore and describe the specific aftercare needs of chemically addicted adolescents relating to services by social workers.** Chapter 4 relates to task objective 2 (see p. 36), namely to explore and describe the perceptions and experiences regarding aftercare services of social workers rendering services to CAAs.

The criteria for inclusion with reference to the adolescent interest group were all chemically addicted adolescents who had previously undergone in-patient treatment and had had contact with social workers, relapsed thereafter, and were back in in-patient treatment programmes in the Western Cape. Data was collected and recorded by means of narratives written by the participants. Data saturation was observed after 31 narratives. The researcher made use of the eight steps of data analysis in qualitative research proposed by Tesch (in Creswell, 2009:186) to ensure a systematic manner of data analysis. Data verification was, among others, addressed through the use of an independent coder.

The themes, sub-themes and category that emerged from this study were subsequently compared with relevant literature. However, the literature control did not guide and direct the research process, but was rather used as an aid/verification tool to compare and contrast the themes that emerged from this study with existing theories and previous research reported in the relevant literature (Fouché & Delport, in De Vos et al., 2002:269).

In order to contextualise the findings emanating from the data analysis process, the following section of this chapter will provide a discussion of the demographic data of the CAAs who participated in this study.



### 3.2 Demographic data of chemically addicted adolescents who participated in this study

The biographical particulars of the chemically addicted adolescent sample group who participated in this study are presented in the table below.

**Table 3.1:** Demographic details of the chemically addicted adolescents who participated in this study

Gender						
Male						
31						
Age groups						
14 years	15 years	16 years	17 years	18 years	19 years	20 years
3	4	6	9	2	1	6
Racial group						
African		Coloured		Asian		White
5		21		3		2
Language						
English		Afrikaans		Xhosa		Sotho
6		20		3		2
Parental use of chemical substances						
Use of alcohol		Use of other chemical substances (marijuana, mandrax, methamphetamine)				
13		6				
Education completed						
Grade 4	Grade 5-7	Grade 8-10	Grade 11	Grade 12		
2	8	13	7	1		
Participants' chemical substances of choice						
Methamphetamine		Alcohol	Marijuana	Heroin	Cocaine	
18		4	7	1	1	
Treatment opportunity						
Second				Third		
29				2		

In the discussion to follow the biographical information of the 31 relapsed chemically addicted adolescents in the Western Cape who participated in this study, and depicted in the table above will be presented:

#### 3.2.1 Gender distribution

From the table above it becomes clear that all the participants in this study were male. One treatment centre admitted only male patients, while the other treatment centre had only male patients during the time of data collection. The centre was not able to indicate when female relapsed CAAs would be admitted. Globally, most treatment programmes are provided for male

persons of all ages. Statistics supporting this statement are as follows: 76% in Western Europe, 65% in Central America, 70% in Mexico, 76% in East Asia, and 99% in South Asia (Sussman & Ames, 2001:102). Consistent with these statistics, the South African Community Epidemiology Network on Drug Use (2008:2) has identified barriers to entering treatment for female youth as a topic to be researched in future.

### **3.2.2. Age distribution**

Most of the participants (nine) were 17 years old, while the age groups 20 years and 16 years were represented by six participants each. The youngest age group was 14 years of age (three participants). Other age groups were represented as follows: 15 years (four participants); 18 years (two participants); and 19 years (one participant).

Regarding the ages of the participants in this study, the ages between 14 and 18 years are described as the “middle adolescent phase”, while the ages between 18 and 21 years are described as the “late adolescent phase” (Louw et al., 2001:385-388; Gouws et al., 2000:2-7). Using these criteria, the researcher concluded that the participants in this study were busy with the developmental tasks of the middle- and late-adolescent phases. These tasks, as described by Louw et al. (2001:385-388) and Gouws et al. (2000:2-7), were discussed under the heading “Adolescence” in Chapter 1 (p. 44).

### **3.2.3 Cultural distribution**

Most of the participants, 21 to be exact, came from the Coloured community. Five participants came from the African community, three from the Asian community, and two from the White community.

### **3.2.4 Language distribution**

Twenty of the participants were Afrikaans-speaking, followed by six who indicated English as their first language; three spoke Xhosa and two spoke

Se-Sotho. The Xhosa- and Sotho-speaking participants were fluent in Afrikaans or English. The researcher gave them the option of writing the narratives in their first language, and planned to use a translator, but they indicated that they were comfortable with writing the narratives in either Afrikaans or English, as these were the languages they used in their schools.

### **3.2.5 Parental use of chemical substances**

Thirteen participants reported that their parents were using alcohol, while six participants reported parental use of other chemical substances, namely three parents using marijuana, two using mandrax and one parent using methamphetamine.

The literature studied by the researcher highlights the fact that children of alcoholics are more susceptible to chemical addiction. Parental addiction to alcohol also results in difficulty in building relationships, dealing with emotions, guilt, self-esteem and trust among their children (Goodwin, 2000:72; Fraser, 2002:122; Page & Page, 2003:236; McWhirter et al., 2004:119). Parental use and abuse of chemical substances lead to the adolescent's perception that the former is acceptable, and prevent the adolescent from learning healthy alternative lifestyles through parental modelling. Considering the many previously discussed life tasks that have to be mastered during adolescence, a healthily functioning family has a great advantage in that it provides an environment for successful development of its members (Gruber & Taylor, in Straussner & Fewell, 2006:5-6). Leichtling, Gabriel, Lewis and Vander Ley (in Straussner & Fewell, 2006:156) elaborate on this theme by explaining that parental abuse of chemical substances leads to dysfunctional home environments, lower cohesion and greater conflict. The authors concur that this environment makes it difficult for the CAA to develop a healthy lifestyle following treatment, therefore contributing to increased relapse potential.

### 3.2.6 Education completed

The abuse of chemical substances among South African schoolchildren, both rural and urban, is undermining the quality of education and development of the children of South Africa (Government Gazette, 2002:3 and Gouws et al., 2000:17). In confirmation of this statement, and considering the abovementioned ages of the participants, the majority of the participants completed Grades 8-10 (13), while two participants only completed Grade 4 and only one participant completed Grade 12. Other levels of education completed were: Grades 5-7 (eight participants) and Grade 11 (seven participants).

### 3.2.7 Chemical substances of choice consumed by the participants

Methamphetamine was the chemical substance of choice among 18 participants, followed by marijuana among seven participants. Alcohol (four participants), heroin (one participant) and cocaine (one participant) were also indicated as chemical substances of choice by six participants. This data therefore confirms statements that methamphetamine has now become the chemical substance of choice in the Western Cape (Louw, 2006; Mashaba, 2005; Caelers, 2005).

In the discussion to follow, the chemical substances of choice indicated by the participants will be explored in terms of its influence on the central nervous system, the potential to develop tolerance for the chemical substances, and their withdrawal symptoms.

- **The influence of chemical substances on the central nervous system**

The participants reported two **central nervous system stimulants** as chemical substances of choice, namely *methamphetamine* and *cocaine*. *Heroin* and *alcohol*, classified as **central nervous system depressants** (Mans, 2000:7-8), were also identified as chemical substances of choice by the participants. The last chemical substance of choice that was identified by

the participants was *marijuana* which is classified under **cannabinols** (Fisher & Harrison, 2005:28-29).

**Central nervous system stimulants** result in increased respiration, heart rate and motor activity. With specific reference to *cocaine*, Mans (2000:45) notes that it causes the user to feel energetic and self-assured. *Methamphetamine* acts as a neurotoxin and therefore is a source of prolonged brain damage, leading to mood disturbances, psychosis and paranoia. Methamphetamine binds dopamine, noradrenalin and serotonin transportants. It causes the blockage of dopamine re-uptake and the enhancement of the release of dopamine, resulting in high craving levels (NIDA, 2007). In addition, this substance is a highly physical and psychological addictive chemical substance (Mbuya, 2003:12; Fitzhugh, 2004:30-31; Lessa & Scanlon, 2006:33; Perkinson, 2008:20). Erdmann (2006:2, 25) postulates that 10% of persons who use alcohol become addicted, while 98% of persons using methamphetamine become addicted. This chemical substance mainly attracts younger users. Agreeing with this conclusion, Shrem and Halikitis (2008:669-670) describe methamphetamine as highly addictive, with a noticeable effect even when a small amount is consumed. Furthermore, clinical studies indicate permanent neurological damage leading to the following: changes in movement, thoughts and mood, as well as the ability to derive pleasure from normal day-to-day activities; impaired speech; loss of memory; anxiety; paranoia, and depression (Teesson et al., 2002:27; Fitzhugh, 2004:36). The social nature of this addiction puts the addict at risk owing to risky sexual practices and high levels of aggression, leading to involvement in violent encounters. Showing particular concern regarding the impact of methamphetamine, Falkowski (2003:190) describes it as a chemical substance that leads to “profound physical deterioration”.

On the other hand, **central nervous system depressants** induce sedation, drowsiness and coma (Fisher & Harrison, 2005:16-19). Stoppard (2000:83) describes *heroin* as a forceful chemical substance which slows down the heartbeat, with a subsequent drop in blood pressure. *Alcohol* causes a feeling

of self-assurance, and inhibitions tend to disappear. Alcohol used in combination with other chemical substances accounted for 33% of chemical substance-related deaths in the United States during 2002 (Substance Abuse and Mental Health Administration, 2003). The acute and chronic effects of alcohol addiction include organ damage, permanent loss of memory, and high blood pressure (Fisher & Harrison, 2005:16-19).

Concluding this discussion, *Marijuana (cannabinol)* addiction prevents the uptake of dopamine and serotonin (Fitzhugh, 2004:30; Lessa & Scanlon, 2006:33; Perkinson, 2008:20). Teesson et al. (2002:79) assert that marijuana is the most widely abused chemical substance in the world. It is, similar to alcohol, known as a “gateway” chemical substance, often leading to the use of other chemical substances (Arterburn & Burns, 2007:76). Perkel (2005:25) highlights the possibility that marijuana use among adolescents may over time sensitise the brain’s reward system. This leads to an increase of pleasurable responses to other substances and the acceleration of the process of loss of control. The use of marijuana leads to learning problems, impaired memory and respiratory problems; influences mood; harms the immune system; can cause panic levels to rise, and leads to anxiety attacks (Falkowski, 2003:171; Lennard-Brown, 2004a:27). There is an association between the use of marijuana and schizophrenia and depression. An a-motivational syndrome has also been cited with persons who regularly use marijuana (Perkel, 2005:29).

- **The potential to develop tolerance for the chemical substance**

Lessa and Scanlon (2006:33) and Perkinson (2008:20) note that tolerance for **central nervous system stimulants** develops rapidly. Tolerance for **central nervous system depressants** is described as a craving for more of the chemical substance that leads to a loss of control. Alcohol addiction leads to both tolerance and cross-tolerance, when tolerance for one type of chemical substance in a group of chemical substances also leads to a tolerance for other chemical substances in the same group (Page & Page, 2003:233). The development of tolerance for **cannabinols**, on the other hand, is

controversial. Inaba and Cohen (2000) assert that tolerance occurs rapidly, while Palfai and Jankiewicz (1997) refer to tolerance for cannabinoids as mild. The latter authors report cross-tolerance to central nervous system depressants.

- **Withdrawal symptoms**

Withdrawal from **central nervous system stimulants** is painful, and includes headaches, anxiety, irritability, depression and suicidal ideation. Acute and chronic withdrawal effects include heart attacks, strokes, seizures, respiratory depression, paranoid schizophrenia, perforation of the nasal septum, and malnutrition (Mans, 2000:7-8; Fisher & Harrison, 2005:19-23). *Cocaine* use is associated with intense feelings of euphoria, which causes long-lasting cravings, and depression and lethargy when the use is interrupted ((Mans, 2000:45; Page & Page, 2003:241; Falkowski, 2003:107). Withdrawal from *methamphetamine* is associated with agitation, an intense need for sleep, depression, damage to the nerve terminals in dopamine-containing regions of the brain, confusion, aggression, paranoia, mood disturbances, and delusions (Page & Page, 2003:243).

Regarding withdrawal symptoms associated with **central nervous system depressants**, *heroin* is highly addictive on a physical and a psychological level. The withdrawal symptoms of heroin last longer than those of most other chemical substances. The user of *alcohol* suffers from anxiety and depression when discontinuing the use thereof (Page & Page, 2003:233). Withdrawal from alcohol could be medically dangerous. Symptoms include anxiety, irritability, loss of appetite, tremors, insomnia, seizures, fever, and hallucinations. As regarding **cannabinols**, withdrawal from *marijuana* includes irritability, insomnia and a decreased appetite (Fisher & Harrison, 2005:28).

Most of the participants in this study indicated methamphetamine as their chemical substance of choice, Shrem and Halikitis (2008:669-670) assert that the traditional evidence-based treatments have limited success in the treatment of methamphetamine, and conclude that treatment should adapt to

the special needs associated with methamphetamine addiction. In order to understand the methamphetamine user's actions and emotional state, the process of the methamphetamine experience as described in Table 3.2 below should be considered (Perkinson, 2008:25-26).

**Table 3.2:** The process of a methamphetamine experience (Perkinson, 2008:25-26)

High lasts 8-12 hours	Crash lasts 12-24 hours	Withdrawal
<ul style="list-style-type: none"> <li>• "Rush" (vibration in head)</li> <li>• Twitches and blinking</li> <li>• High energy levels</li> <li>• Loss of appetite</li> <li>• Heightened libido</li> <li>• Feels awake, focused and aggressive</li> <li>• Increased sensitivity for colours and sounds</li> <li>• Increased agitation levels</li> <li>• No need to sleep</li> <li>• Tremors</li> <li>• Increase heart beat and blood pressure</li> <li>• Teeth grinding</li> </ul>	<ul style="list-style-type: none"> <li>• Agitated</li> <li>• Depression</li> <li>• Extreme tiredness</li> <li>• Binging – increased appetite</li> <li>• Users often attempt to control this with dagga</li> </ul>	<ul style="list-style-type: none"> <li>• In need of sleep and constant availability of food</li> <li>• Depression (temporary or permanently)</li> <li>• High anxiety levels</li> <li>• Suicidal ideation</li> <li>• Duration: 3 – 18 months</li> </ul>

Because of the long-lasting effects of this chemical substance, treatment and therapy should be conducted over a much longer period (Matrix Institute on Addiction, 2008c:24).

### 3.2.8 Treatment opportunity

The inclusion criteria for the sample from relapsed CAAs specified that the participants had previously received treatment, had relapsed thereafter, and were back in treatment centres. The majority of the participants (29) were in the treatment centres for the second time, while two were returned for the third time. A contributing factor to this distribution could be the fact that treatment demands for CAAs are increasing. When admission is considered for addicts applying to enter treatment centres, persons who have not previously had access to treatment are admitted first (Du Toit, 2008).

Following the demographic data, the next section will consist of a discussion of the findings emanating from the data-analysis process, and based on the conclusions of the researcher and the independent coder.



### 3.3 Findings relating to the aftercare needs of chemically addicted adolescents

The data obtained from the 31 narratives was analysed based on the framework for data analysis in qualitative research by Tesch (in Creswell, 2009:186) by both the researcher and the independent coder. Consensus discussions between the researcher, the independent coder and the promoters followed, after which a final decision was made regarding the themes and sub-themes. Greeff (in De Vos et al., 2002:273) advises that a researcher should avoid the separation of the various themes and sub-themes from the larger context to which they are related. Therefore, although the themes and sub-themes are discussed separately in both Chapters 3 and 4, the information will overlap in order to relate back to the larger context, owing to the contextual nature of this study. Table 3.3 presents the themes and sub-themes that emerged from the data.

**Table 3.3:** Findings relating to the aftercare needs of relapsed chemically addicted adolescents

Themes	Sub-themes/ Categories
<b>Unique theme:</b> Chemically addicted adolescents' previous experiences with social workers	<b>Sub-theme 1:</b> Chemically addicted adolescents' negative previous experiences with social workers
	<b>Sub-theme 2:</b> Chemically addicted adolescents reported positive previous experiences with social workers
<b>Theme 1:</b> Chemically addicted adolescents have specific expectations of social workers rendering aftercare services	<b>Sub-theme 1.1:</b> Chemically addicted adolescents expressed the need and have the expectation for a personal relationship with social workers who render aftercare services to them
	<b>Category 1:</b> Chemically addicted adolescents' expectations about the relationship qualities to be demonstrated by social workers rendering aftercare services to this client-system
	<b>Sub-theme 1.2:</b> Chemically addicted adolescents expect social workers to be knowledgeable about addiction and recovery from addiction
	<b>Sub-theme 1.3:</b> Chemically addicted adolescents requested regular contact with, and availability of, social workers during aftercare
<b>Theme 2:</b> Aspects chemically addicted adolescents would like to be assisted with during aftercare	<b>Sub-theme 2.1:</b> Participants' need for assistance and skills regarding how to change the old habits relating to their addiction
	<b>Sub-theme 2.2:</b> Participants need assistance and skills regarding how to break down defence mechanisms
	<b>Sub-theme 2.3:</b> Participants' need for assistance and skills regarding how to deal with old friends and make new ones
	<b>Sub-theme 2.4:</b> Participants' need for assistance and skills regarding how to act assertively in an interpersonal context, and how to manage anger and stress

	<b>Sub-theme 2.5:</b> Participants' need for assistance and skills regarding how to solve problems and make decisions
	<b>Sub-theme 2.6:</b> Participants' need for assistance and skills regarding how to deal with emotions
	<b>Sub-theme 2.7:</b> Participants' need for assistance and skills with budgeting
	<b>Sub-theme 2.8:</b> Participants' need for assistance with regard to planning an after-treatment recovery plan that will prevent relapses, maintain sobriety, and teach how to manage their time
	<b>Sub-theme 2.9:</b> Participants' need for assistance and skills regarding how to deal with cravings and temptations
	<b>Sub-theme 2.10:</b> Participants' need for assistance and skills regarding how to develop a realistic self-image
	<b>Sub-theme 2.11:</b> Participants' need for assistance in relation to their spirituality
	<b>Sub-theme 2.12:</b> Participants' need for assistance regarding implementation of the NA's 12-Steps Programme
	<b>Sub-theme 2.13:</b> Participants' need for assistance with finding employment and/or returning to school
	<b>Sub-theme 2.14:</b> Participants' need for assistance to help rebuild their relationships with their parents and to be reintegrated into their families
	<b>Sub-theme 2.15:</b> Participants' need for assistance in becoming integrated into their communities

### **3.3.1 A thematic discussion of the aftercare needs of chemically addicted adolescents**

Two major themes and one unique theme were identified. The two major themes relate directly to the relapsed CAA's aftercare needs. They are:

- Chemically addicted adolescents have specific expectations of social workers rendering aftercare services.
- Aspects chemically addicted adolescents would like to be assisted with during aftercare.

From the participants' narratives a unique theme surfaced that was subsequent to consensus discussions, labelled as: "Chemically addicted adolescents' previous experiences of social workers". The following discussions will be illustrated with verbatim statements from the written narratives.

### **Unique theme: Chemically addicted adolescents' previous experiences with social workers**

To be included in the sample, participants from the population had to have contact with social workers following previous treatment. This specification enabled them to respond to the following statement by means of narrative writing: **The things social workers can help me with to maintain my sobriety after treatment.**

When responding to this statement, the participants also wrote about their experiences with social workers, and in so doing gave rise to this unique theme under discussion. In analysing the data independently from one another, the researcher and the independent coder did not only identify this as a unique theme, but based on the narratives from the participants concluded that the experiences of participants relating to previous encounters with the social workers could be grouped into “positive” and “negative” experiences, with the negative experiences seeming to outnumber the positive experiences. In the next section, the participants' negative and positive experiences relating to their previous contact with social workers will be presented.

#### **Sub-theme 1: Chemically addicted adolescents' negative previous experiences with social workers**

While participants reported both positive and negative previous encounters with their social workers, the negative experiences, however, were noted in the majority of the written narratives. The following discussion, supported by utterances from the participants, illustrates these negative experiences.

Although some of the participants had regular contact with their respective social workers, it appears that it did not lead to a “positive experience”. The following statements underscore this:

*“Ek het nie 'n 'plug' vir die vrou nie.”*

*“I have seen my social worker a lot of times. I hate her.”*

*“Ek ‘like’ nie baie van my ‘social worker’ nie...”*

*“I don’t think she likes me.”*

*“Ek wil nie teruggaan na haar [referring to his previous social worker] toe nie. Ek soek een wat omgee.”*

This negative relationship experience might be attributed to the fact that the participants were not clear about the social workers’ motives and roles in relation to service rendering to them, as articulated in the following utterances:

*“I never worried much about social workers. I saw them around and just thought they make you weak and that they send you away.”*

*“Sy is net vir my ma-hulle.”*

*“My ‘social worker’ speel met my kop. Sy vra ‘n klomp vrae om jou uit te vang en jou af te druk.”*

*“I thought she was just going to pimp me with the boere.”*

*“Ek weet nie wat hulle van jou wil hê nie.”*

These statements reveal a perception that the social workers were judging them, and that the participants felt that the social workers did not act in their interest (i.e. displaying a moralistic attitude towards the participants). On the other hand, social workers are often “thrown into” the field of addiction by their clients’ needs. Juhnke and Hagedorn (2006:68-70) are of the view that this is a challenging field, and social workers who do not specifically specialise in addiction often believe that their clients have made the wrong choices, ignoring the impact of physical and emotional addiction on the behaviour of their clients (i.e. a moralistic attitude). Taleff (2006:2) elaborates on this viewpoint and notes that the lack of knowledge and understanding leads to premature conclusions. The author concurs that this influences the social worker’s attitude towards the clients, impacting on the relationship.

Discussing the fact that he did not know what the social worker’s role and motive was, the following utterance made by a participant shows that there was a lack of communication regarding what the intervention would imply, and that it led to a lack of understanding regarding the purpose of the intervention process: *“Toe kom sy net weer en sê ‘ok fine’ ek kan nou hiernatoe kom.”*

This statement relates to the social work value of client self-determination. Hepworth et al. (2006:61-72) describe this value as follows: Self-determination is a result of a proper assessment, during which time the social worker and client build a professional relationship and where roles and motives are clarified. The assessment leads to the identification of the specific needs of the client, which results in an intervention plan to address these needs. Self-determination during the planning phase implicates that the client understands the different options relating to addressing the identified needs, and that he or she is involved in the decision regarding what option would best address these needs. This value is relevant even when the client is unable to make the correct choices, as might be the case with neurological damage owing to the chemical substances. The client is still part of the decision process in order to understand the motives behind them.

Referring to another aspect, a lack of open communication, some participants indicated that they did not trust their social workers as they did not understand their motives.

*“Sy het ook gesê sy gaan my weer sien as ek uitkom, maar ek glo nie sy sal seker weer na my toe kom nie.”*

*“Ek weet nog nie wat sy nou kan doen nie.”*

*“I did not know what social workers do.”*

*“My ‘file’ by die ‘social worker’ is dik. Ek weet nie wat daarin staan nie, maar dit maak my baie kwaad.”*

The last statement indicates that recordkeeping impacted negatively on trust in the relationship with the social worker. On the one hand, Sheafor and Horejsi (2006:72-81) and Hepworth et al. (2006:54-60) are of the opinion that recordkeeping is an essential part of Social Work practice. These authors describe the purpose as ensuring continuity, assisting supervisors to monitor progress, and assisting social workers to work systematically while measuring progress. On the other hand, Hepworth et al. (2006:60) note that confidentiality should not be compromised. The above quote, however, indicates that the participant felt threatened by these files and reports. In order to address this, the Draft Systems Model for Prevention and Aftercare

(Department of Social Development Western Cape, 2008:14-15) advises that CAAs should have access to the files, the reason for recordkeeping should be discussed with them, and they should be involved in the planning and evaluation of the intervention process.

Related to recordkeeping, the literature highlights the importance of consulting CAAs when planning for services, as well as when services are being evaluated. Clear, understandable and logical terms must be used (Sheafor & Horejsi, 2006:72-81; Hepworth et al., 2006:54-60; Department of Social Development Western Cape, 2008:14-15). The following comment reveals that, in order to experience the social worker as trustworthy, the participant needed him/her to build the relationship on his level of functioning: *"I did not know what the social worker was talking about. Sulke hoë tale."*

This poor communication caused by, among others, unsuitably formal language impacted on how the participants responded to their social workers, as highlighted by the following statement: *"I just said 'yes' and 'no'. I thought she wanted to catch me out or something."*

The researcher acknowledged the fact that CAAs could feel resistance toward social workers owing to a lack of readiness for change (Miller & Rollnick, 1991:133). In this regard, Juhnke and Hagedorn (2006:25) state that CAAs often have limited access to resources that assist them in dealing with their addictions. The authors agree that it has to be considered that chemically addicted persons often do not react positively to only one resource, and that continued input from various resources may succeed in producing eventual changes in thought and behaviour. The following statement by one participant indicates that this negative experience was seen in the context of the relationship with a specific social worker and not generalised to all social workers: *"So ek soek 'n ander een."*

The following sub-theme, however, shows that some of the previous experiences were positive, and conducive to ongoing efforts to assist the participants in their efforts to recover from chemical addiction.

## Sub-theme 2: Chemically addicted adolescents reported positive previous experiences with social workers

Following the negative reports on contact with social workers, the participants also indicated some positive experiences. Consistent with the latter statement in the previous sub-theme, as well as the literature regarding the value of multiple resources, a participant reported previous negative experiences which were addressed by the participant himself: *“Toe gaan ek elke slag terug en toe is ek nou bly want toe kry ek een wat my baie gehelp het.”*

In addition, the participants illuminated the value of motivation as follows:

*“Ek kon vir haar sê wanneer ek reg was om ‘rehab’ toe te wil gaan, maar sy’t net aangehou om my te ‘motivate’ tot ek reg was.”*

*“Sy het my aan die hand gevat en my nie gedruk nie.”*

Motivation can be described as the “reason behind our thoughts, actions and feelings” (Gouws et al., 2000:59). The level of motivation to participate in the aftercare process and ongoing recovery can be viewed as extrinsic versus intrinsic, as described in the table below:

**Table 3.4:** Extrinsic versus intrinsic levels of motivation (Gouws et al., 2000:61; Gordon, 2003:18; Bezuidenhout & Joubert, 2003:165-167)

Extrinsic levels of motivation	Intrinsic levels of motivation
<ul style="list-style-type: none"> <li>• Doubt own abilities</li> <li>• No desire to learn or do more than is needed</li> <li>• Pessimistic way of thinking</li> <li>• Mainly focused on short-term goals</li> <li>• Rely on others</li> <li>• Motivated by social approval</li> </ul>	<ul style="list-style-type: none"> <li>• Need to enrich self</li> <li>• Perseverance and practice</li> <li>• Interested in tasks</li> <li>• Curious</li> <li>• Want to achieve success</li> <li>• Positive regarding learning through mistakes</li> <li>• Willing to make an effort</li> </ul>

Participants reported support and care from their social workers, and indicated that this relationship was conducive to aftercare, as they were looking forward to returning to the services following treatment.

*“Ek dink sy wag vir my en sy is trots op my. Ek ‘like’ dit dat ek haar weer gaan sien.”*

*“My ‘social worker’ het my gehelp om hier te kom.”*

*“Die een is ‘nice’ en sy sal my kan help”.*

*“Ek hou van die maatskaplike werker sien. Sy kan my baie help met probleme.”*

*“Ek dink die ‘social worker’ sal my sien as ek by die huis kom.”*

In line with the statements above, Juhnke and Hagedorn (2006:15) note that some social workers have a specific interest in and affinity to the addiction field. This attitude reflects in the way they respond to clients. Building on this, Taleff (2006:130) postulates that clients’ responses to interventions are often influenced by the use of, or lack of, ethical considerations such as respect and self-determination, as well as attentive listening.

This theme provides insight into the impact of Social Work values, and of clarification to the clients of the social worker’s role and motives. The lack of this explanation resulted in a lack of trust in the professional relationship. On the other hand, the use of Social Work values and the explanation of the social worker’s role and motives resulted in positive relationships between the social workers and their clients. The specific advantage is that clarification impacted on the relapsed CAA’s faith that they could deal with their problems, leading to intrinsic levels of motivation.

### **Theme 1: Chemically addicted adolescents have specific expectations of social workers rendering aftercare services**

The literature studied by the researcher mainly focuses on theoretical approaches and methods to deliver services to CAAs (e.g. Fisher & Harrison, 2005; Juhnke & Hagedorn, 2006; Lessa & Scanlon, 2006). Regarding social services delivered to CAAs, Boyden and Ennew (as quoted in Desai & Potter, 2006:52) stress the importance of a specific needs-assessment with the adolescent client-system before planning Social Work intervention. Regarding the CAAs who participated in this study, this statement relates to the need to assess the specific challenges associated with methamphetamine addiction, the environmental influences typical of the Western Cape (see Chapter 1, p. 2), and the normal challenges of adolescence.



Juhnke and Hagedorn (2006:68-70) note that social workers dealing with chemical addiction should be willing to learn about addiction, in order to be able to build a relationship with the chemically addicted client. In addition, Taleff (2006:15) proposes that social workers working with chemical addiction should be skilled in the art of critical thinking, meaning that all the related factors pertaining to a client's circumstances should be evaluated before a conclusion is made. Consistent with the abovementioned statement by Boyden and Ennew (as quoted in Desai & Potter, 2006:52), Taleff (2006:15) warns that the client must be heard, leading to a proper assessment, assisting the social worker not to base conclusions only on theoretical knowledge or personal experiences, but on the client-system's unique circumstances.

This theme was divided in the following sub-themes:

- Chemically addicted adolescents expressed the need and have the expectation for a personal relationship with social workers who render aftercare services to them.
  - Category: Chemically addicted adolescents' expectations about the relationship qualities to be demonstrated by social workers rendering aftercare services to this client-system
- Chemically addicted adolescents expect social workers to be knowledgeable about addiction and recovery from addiction.
- Chemically addicted adolescents requested regular contact with and the availability of social workers during aftercare.

In the next section of this discussion these sub-themes and category will be presented.

**Sub-theme 1.1: Chemically addicted adolescents expressed the need and have the expectation for a personal relationship with social workers who render aftercare services to them**

The following utterances from participants point to the need for a relationship with the social worker rendering aftercare services to them and such a

relationship must be characterised by: caring for the adolescents; making an effort to get to know them; spending time with them; listening to them; trying to understand them; believing in them; and motivating them:

*“Ek ken haar nie eintlik nie. Ek wil haar ken.”*

*“Sy moet vir my lief wees.”*

*“Sy moet omgee vir my.”*

*“Ek wil nie teruggaan na haar [referring to his previous social worker] toe nie. Ek soek een wat omgee.”*

*“Sy moet tyd gee om my te sien en vir my te luister.”*

*“The social worker has to understand me and where I come from and also what kind of person I am.”*

*“Ek sal daarvan hou as die ‘social worker’ vir my wil leer ken en my wil verstaan.”*

*“I would like one who motivates me every day and who wants me to be sober.”*

*“She must check up on me or give me a call like she really cares.”*

*“At all times she must make me feel worthwhile and comfortable around her.”*

*“She must make me feel like I talk to my mother, like there is a bond between us.”*

*“En dit sal ‘nice’ wees as sy kan lief wees vir my en my nie wil afdruk nie.”*

*“She must look forward to see me and be happy when I do well.”*

*“Ek wil ook sien sy stel regtig belang in my en wil my regtig help.”*

In confirmation of the articulated need for a relationship between CAAs and the social workers rendering aftercare services to them, Powis (in Becker, 2005:168) stresses that a caring and trusting relationship between social workers and these clients forms the foundation of intervention. Ganzer and Ornstein (2008:155) agree, and note that the relationship between the social worker and the chemically addicted person is instrumental in the recovery process. The social worker must therefore be able to facilitate a trust relationship. Relating this aspect to the initial stage of service delivery, Hepworth et al. (2006:182) describe the development of a professional social

worker-client relationship as follows: During the initial contact the social worker's aim is to establish a relationship (for the purpose of service rendering to the client) with the client. At this stage the social worker is exploring the client's needs in order to determine the relationship amongst the different aspects contributing to the problem scenario. The nature of the evolving relationship between the client and the social worker is influenced and informed by the client's clear understanding of the reason for intervention, together with a feeling that "I am being heard". In addition, experiencing a sense of being cared for is a prerequisite for and the result of a proper exploration and assessment. Grobler, Schenck and Du Toit (2005:200-210) assert that using immediacy (i.e. focusing on the here and now) assists the social worker to build a positive relationship with clients. The purpose of this skill is to develop trust and to build the relationship, and the focus is on the client's frame of reference. The indication of a lack of immediacy during assessment and consequential lack of trust in the professional relationship will be disadvantageous in that the CAA will not be clear about and/or understand the purpose of the intervention process, and therefore might not be prepared to avail him/herself to accept the treatment.

This expectation of, and need for, having a personal relationship (referred to in the discussion above) stems from the previous relationship experiences the participants have had with social workers. The following utterances paint a word picture of these relationship experiences:

*"Sy weet nie waarvan sy praat nie, want sy stuur jou net weg en vergeet van jou."*

*"She pretends to care, but she is just doing it for the pay."*

*"When I get there she says: 'where were we?' She cannot even remember me."*

*"My social worker never knew who I was. Every time she says: 'where were we', like she knows nothing."*

*"She always had to look through her papers to know who I am. So I don't trust that one."*

*"Sy luister net vir my ouers en sê vat die en daai weg, 'like' al my 'fun', maar sy ken my nie eens nie."*

*“Daai vrou het net gekom en gesê sy wil my help. Toe dink ek ‘like’ sy ken my nie, hoe wil sy nou weet.”*

*“When I went there, she filled in my form and said, ‘no there is no place for you now’. And then she just came back and said there is a rehab for me and that is all that I saw.”*

*“Die maatskaplike werker wat my gestuur het het my nie eens geken nie.”*

These utterances must also be read in conjunction with the unique theme presented at the beginning of this section, pointing to participants’ previous negative experiences relating to social workers’ service delivery to them.

In their narratives the participants frequently wrote about the relationship qualities the social worker must demonstrate when engaging with them. In the next section of this chapter these aspects will be presented.

**Category: Chemically addicted adolescents’ expectations about the relationship qualities to be demonstrated by social workers rendering aftercare services to this client-system**

In the previous sub-theme, the participants expressed a need for an open, trusting personal relationship with their social workers during aftercare service delivery. In this category, information is given about the relationship qualities that must be demonstrated by social workers when engaging with the CAA while rendering aftercare services.

The participants reported that in order for them to stop criminal behaviour and dishonesty, as hindrances on the road to recovery, they need a relationship with the social worker in which **trust** is demonstrated. They referred to this in the extracts that follow.

*“That one [referring to the social worker providing aftercare services] must be trusted. If I cannot trust I will just lie and that is not good if I want to stay sober.”*

*“Ek moet haar kan ‘trust’. As ek wil steel en ‘drugs’ gebruik gaan ek dan na die ‘social worker’ vir help.”*

*“En ek wil openlik met hulle kan wees en nie hoof te lieg en te ‘cover’ nie.”*

*“Sy moet my help wanneer ek sukkel, maar dan moet daar ‘trust’ wees.”*

*“Sy moet so lief wees vir my dat sy ‘getrust’ kan word en dat sy my nie sal los nie.”*

*“I want her to know that I want to be sober and that I need her help.”*

*“Sy moet weet wat die beste vir my is.”*

The participants also expressed the need, and have the expectation, that social workers who render aftercare services should be **professionals that they can confide** in. The following utterances underscore this:

*“Sy moenie praat wanneer ek vir haar belangrike dinge vertel nie.”*

*“Sy moet betroubaar wees met die goete wat ek met haar deel.”*

Following on the abovementioned, **openness** was another relationship quality identified by the participants as they need social workers to engage in open communication with them. The following storyline attests to this:

*“She keeps on writing and I don’t know what.”*

*“Ek lieg vir haar en dan skryf sy net, sy kyk nie eens op nie. Ek weet nie wat sy skryf nie.”*

*“Maar sy moet ook vir my sê as ek iets verkeerd doen en my help om sober te bly.”*

Another relationship quality to be demonstrated by the social worker in the relationship with the CAA is that the former must have a **genuine interest in and concern for the adolescent**. This is deduced from the following utterances by the participants:

*“She is full of clever stuff, but she has never been to my house.”*

*“Ek wil haar ‘trust’, so sy moet my wil verstaan en regtig wil hoor wat my storie is.”*

*“She should encourage me and feel my point.”*

*“I want to know what is in my file and she must discuss it with me and not just with my parents.”*

*“She must learn about my life so she can understand me.”*

*“She must understand my thoughts and motivate me to stay sober.”*

*“I want her to know that I want to be sober and that I need her help.”*

*“Om my lewe te verander ten spyte van die dinge wat ek in die verlede gedoen het. Sy moet glo ek kan en my help.”*

*“She must not tell me I am a druggy and I will never change.”*

*“She must be kind to me. And love me and she must have hope for me.”*

*“En vir my luister en ons moet wees of ons mekaar lankal ken.”*

Personal interest is experienced when CAAs are accepted as human beings with the potential to change and be reintegrated back into their families and communities (Department of Social Development Western Cape, 2008:14-15). Latching on to the issue of demonstrating interest in and a concern for the client-system is the fact that in providing aftercare services to the adolescent, his/her needs, and not those of the social worker, must be the focus of attention. One participant articulated it as follows: *“She must not tell me about her problems. She must work on my problems. That is why she is there.”*

The participants referred to **demonstrating passion for their work** as another relationship quality that must be displayed by the social workers when providing aftercare to these young people. In this regard they said the following:

*“Sy moet ‘n passie vir haar werk het.”*

*“Dit moet darem lyk of sy van mense hou en lief is vir haar werk en die ‘addicts’.”*

*“Ek ‘like’ dit as die ‘social worker’ vriendelik en ‘enthusiastic’ is.”*

*“Sy moet vir my moed gee wanneer ek moeg raak vir die gesukkel.”*

*“Sy moet ‘n goeie lewe leef en daai pad wat sy loop vir my wys.”*

The latter statement also point to the participant’s need and expectation that the social worker must be an exemplary **role model**.

In echoing some of the abovementioned statements made by the participants, Sheafor and Horejsi (2006:1) are of the view that the social worker must instil hopefulness in the client-system by showing faith in the person and process, through encouragement and a commitment to service delivery. The social worker must infuse energy into the client-systems by encouraging optimistic positive attitudes and actions.

Another expectation in relation to the relationship qualities of social workers in rendering aftercare services is that these professionals must be **objective**. In the supporting participants' statements below, this objectivity can be seen as displaying a **non-judgemental attitude** (Matrix Institute on Addiction, 2008b:1):

*“Sy moet nie parte vat nie.”*

*“Sy moet al kant van ‘n storie luister.”*

*“Sy moet nie preek nie.”*

Ganzer and Ornstein (2008:155) suggest that an objective attitude prevents judgement, which will enhance the trust in the relationship between the social worker and the client. Grobler et al. (2005:10-11, 200-210) note that should the social worker disagree, judge, prescribe or criticise, this can destroy the relationship.

In the above discussion, the participants' need for a personal relationship with the social workers providing aftercare services to them and the relationship qualities that they felt must be demonstrated in these helping relationships were highlighted. Apart from expressing the need for, and the expectation to have, a relationship with the social workers rendering aftercare services, characterised by trust, openness, objectivity, and a sincere interest in and concern for the client, participants also held the expectation that these social workers must be knowledgeable about addiction and the recovery from addiction. This expectation will be presented as the next sub-theme.

### **Sub-theme 1.2: Chemically addicted adolescents expect social workers to be knowledgeable about addiction and recovery from addiction**

The participants expected **social workers to be knowledgeable and skilled in the field of chemical addiction**. The following statements underscore this expectation:

*“Ek glo vas dat as ‘social workers’ verstaan van verslawing en wat verslaafdes deurmaak, dan sal hulle ‘n verskil in my omgewing kan maak.”*

*“En ook ‘addiction’ verstaan en nie net maak of sy weet nie.”*

*“But she must know of addition and how it works.”*

*“Sy moet ook verstaan wat dit beteken om ‘n verslaafde te wees.”*

Fisher and Harrison (2005:4) concur that it would be unreasonable to expect that all social workers should have the same knowledge and skills regarding chemical addiction as addiction counsellors. However, all social workers will at some stage encounter problems and needs associated with chemical addiction. These authors warn that without basic skills of understanding addiction and recovery, assessing chemical addiction, and planning interventions or referring clients to relevant resources, social workers will fall in the trap of making decisions that are not based on a sound knowledge base. Apart from knowledge about chemical addiction, the participants also reported a need that **social workers should have had hands-on experience in the field of addiction**. The following utterances testify to this:

*“They just learn a lot of stuff from a book, but they have never lived where I lived and they are not addicts.”*

*“She can help me for example to know what I am going through.”*

*“Sy weet niks van die goete nie.”*

The value of knowledge and experience is expressed by the following remark by a participant, who also indicated that it leads to faith in the professional relationship: *“Dis nodig dat sy ervaring het, soos myne daar buite. Sy weet van.”*



Juhnke and Hagedorn (2006:61) are of the opinion that knowledge about chemical addiction and the recovery from it leads to an understanding of how chemical addiction develops. This knowledge should form the foundation of the investigation into the unique circumstances of each client. These authors explain that the combination of knowledge and an understanding of the unique needs of the client should underlie the chosen methods, approaches and techniques that will be used during intervention. They note that knowledge and understanding also contribute to the professional relationship as they demonstrate that the social worker truly understands the situation.

Regarding the recovery process, the participants specifically focussed on the value of **knowledge about and experience in relation to the 12-Steps Programme<sup>7</sup> of Narcotics Anonymous (NA)** to which they were introduced at the treatment centres.

*“Sy moenie net weet van 12 Stappe nie. Sy moet weet wat dit beteken en hoe mens dit doen, want sy moet my help om dit aan te hou doen.”*

*“She must know how the 12-Steps work and how to stay clean.”*

*“She must know all about the 12-Steps and help me to do it right.”*

*“She must be someone who knows what she is talking about and must know the 12-Steps to help me do it.”*

The importance of linking of services is also highlighted in this sub-theme. The participants expressed a need that **aftercare services should be consistent with their treatment programmes**. The need to continue with services congruent with the treatment programme during aftercare becomes apparent when it is considered that the participants' in-patient treatment programmes were only four to eight weeks long. The following statements represent the participants' views in this regard:

*“Sy moet vir my vra wat ek in die ‘rehab’ geleer het.”*

*“She must know about the stuff I learned in treatment to help me to carry on.”*

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<sup>7</sup> The 12-Steps are the core of the NA programme. The focus areas are: surrender; forgiveness; humility; limitations; and service to others. These steps assist chemically addicted persons to focus on all the issues that need to be addressed in recovery, and are thus not limited to chemical addiction only (Fisher & Harrison, 2005:177-178).

*“So as hulle verstaan dan weet hulle beter wat ons nodig het en van hoe ons die ‘rehab’ se goete wil aanhou.”*

*“She must know about the stuff we learn here, because it helps and she must help me to go on trying.”*

The importance of the link between the in-patient treatment and aftercare programmes is discussed by Florentine and Hillhouse (2000:73), who note that the nature of chemical addiction is such that the length of treatment should be three months, in order to ensure that new behaviour is internalised. Therefore, when an in-patient treatment programme is shorter than the prescribed time, aftercare should be closely linked to the treatment programme.

Concluding this sub-theme, Taleff (2006:2) warns that well-meaning actions taken by social workers could be harmful when a sound knowledge base combined with some experience does not underlie these decisions and actions. The participants identified a need for knowledge regarding addiction as well as the 12-Steps. They described the value of experience, and related this to the need to link aftercare services with the treatment programmes attended by the addicted adolescents.

The next sub-theme will present the participants' expectation to have regular contact with their social worker during aftercare, as well as being available to the client-system.

### **Sub-theme 1.3: Chemically addicted adolescents requested regular contact with and availability of social workers during aftercare**

Some of the negative encounters experienced by the participants were due to the fact that social workers were not available to them during previous treatment episodes (as discussed under the unique theme above). This is confirmed by a participant saying: *“Ek het gaan vra dat sy my help, toe sê sy net: ‘nee sy kan nie nou nie’.”*

In view of this, the **participants requested, and had the expectation, that social workers should be available to them during the rendering of aftercare services.** The following utterances point to this:

*“She must be there when I need help in a difficult situation.”*

*“She must come to see me or phone me. And when I need her I can phone her.”*

This expectation that social workers should be available and accessible is implied in the Draft Systems Model for Prevention and Aftercare of Chemical Addiction (Department of Social Development Western Cape, 2008:14-15) which clearly states that social workers should strive to render effective, efficient, relevant, prompt and sustainable reintegration and aftercare services. Reintegration and aftercare services should furthermore be made available and accessible to all clients without any preference or any discriminatory borders. This recommendation is in line with the Constitution of the Republic of South Africa (1996:13), which states that South African children have a right to health care and social services. The abovementioned recommendations confirm Hepworth et al.’s (2006:54-60) viewpoint that “all human beings deserve access to resources”, and presuppose the availability and accessibility of services. These authors believe that given appropriate resources, all humans are capable of growth and change.

The availability of social workers was also referred to in terms of the participants having **regular contact with these professionals while they were in the aftercare phase of treatment.** The following statements bear witness to the participants’ need for regular contact with their social workers:

*“Ek sal definitief die ‘social worker’ wil baie sien.”*

*“She must contact me and say how are you and are you ok without the drugs.”*

*“Ek wil nie ‘n periode verhouding met haar hê en dan is dit weer weg nie.”*

*“I need to see her lots of times, because I will need help.”*

However, some of the statements relating to the availability of social workers were unrealistic. The following statements show that they expected the social workers to be available whenever needed, indicating a lack of insight regarding boundaries in the professional relationship:

*“Sy moet beskikbaar wees 24/7.”*

*“Ek wil hê dat sy daaglik ‘opcheck’ op my en vir my sê hoe trots sy is op my.”*

*“Sy moet my elke dag phone.”*

*“I need to see her more than once a month. I would like to see her every day, so I don’t feel lonely.”*

*“Dan wil ek haar enige tyd kan bel om te gesels.”*

In confirmation of the articulated need for regular contact, Arterburn and Burns (2007:13) suggest that it needs to be considered that chemical substances make adolescents feel good. When they are unable to hope for recovery, no support is provided and they are isolated, returning to chemical substances is viewed as the only way to feel better. Ganzer and Ornstein (2008:162) concur that the challenge is to define the line between being reliable and available on the one hand, and being assertive to ensure that the client does not manipulate the worker and abuse the relationship on the other hand. These authors emphasise the need for networks to relieve social workers from being solely responsible for the support of CAAs following treatment.

Through their narratives the participants gave clear indications of the areas in which they would like to be assisted by the social workers rendering aftercare services to them. These aspects will be presented in the next section of this report.

## **Theme 2: Aspects chemically addicted adolescents would like to be assisted with during aftercare**

In their narratives the participants referred to various aspects that they would like to be assisted with in the aftercare phase of treatment to prevent them from relapsing and to help them to stay on the road of recovery.

Writing about relapsing, Marlatt and Gordon (1985:46) note that a relapse does not occur once the chemical substance is consumed. It starts when the CAA fails to adhere to his/her recovery plan. Although the relapse starts at this point, it is important to consider that intervention can still prevent the intake of the chemical substance. Following on in- or out-patient treatment, aftercare (as a phase of treatment) is imperative to address the factors that could lead to a relapse. Arterburn and Burns (2007:179) point out that the following indicators could signal the beginning of a relapse: 1) harmful relationships with deviant peers, 2) dishonesty, 3) critical spirit (complaining and feeling dissatisfied), 4) self-centredness, 5) isolation, 6) low frustration and tolerance levels, 7) anxiety, 8) defiance (irritable and closed to accepting advice), 9) grandiosity (overly self-assured), and 10) depression. More indicators fuelling the possibility of a relapse are provided by Malhotra et al. (2007:6), namely: 1) stress, 2) painful emotions, 3) positive emotions, 4) interpersonal conflict, 5) the inability to deal with social pressure, 6) the use of other substances, and 7) the presence of chemical substance-related cues.

Adolescence is a period of transition into adulthood when important life decisions must be made. It is the time when identity and the personal value system are integrated. This process is influenced by personal choices and environmental demands (Louw et al., 2001:338; Meyer, in Wait, Meyer & Loxton, 2005:165). Gouws et al. (2000:5) explain that the lack of development in one domain influences the development of the other domains, thus affecting the adolescent's general development. Gerwe (2000:415) postulates that recent neuro-scientific studies into the early developmental process indicate that there is increased evidence of the enormous influence of this period on later developmental processes. Therefore, adolescents' chemical

substance abuse interrupts their general development, and impacts on all the life tasks that they have to master. The fact that these life tasks have not been mastered therefore makes efforts to recover from the addiction more difficult.

After these introductory remarks, the aspects the participants indicated that they would like to be assisted with during the aftercare phase of treatment will now be presented and introduced.

One of the main aspects that the participants needed assistance with in aftercare relates to intra- and interpersonal skills in dealing with challenges they face, and demands from the environment. The following remark made by one of the participants refers to the challenges faced by CAAs in aftercare:

*“The things I struggle with are opening up, swearing a lot, making new friends and enjoying me without drugs.”*

In view of the utterances from the participants, specially relating to “what” they would like to be assisted with during aftercare, **skills development** seems to be of paramount importance during aftercare interventions to CAAs. Falkowski (2003:46) and Bezuidenhout (2008:133-135) are of the view that relapses can be prevented through addressing the lack of poorly developed coping skills during aftercare.

The participants articulated the need for skills on how to change the old habits relating to their addiction, break defence mechanisms, deal with old friends and make new ones, act assertively in interpersonal contexts, manage anger and stress, solve problems, make decisions, deal with emotions, budget finances, deal with cravings and temptations, and develop a realistic self-image.

Furthermore, they want social workers to focus on the following during aftercare intervention: helping them with matters relating to spirituality, the implementation of the 12-Steps, finding employment and returning to school, rebuilding their relationships with their parents and reintegrating with their families, and becoming integrated in their communities. The abovementioned

identified focal areas of aftercare intervention will now be introduced and discussed one after the other:

### **Sub-theme 2.1: Participants' need for assistance and skills regarding how to change the old habits relating to their addiction**

The **need for assistance and skills to change the (still challenging) old habits relating to the addiction** became clear from the following utterances from the participants:

*“En ek wil die tronk vermy, so ek moetie slegte goeters doen nie [referring to robbery and stealing] en sy moet vir my help om reg te lewe.”*

*“En my gedurig herinner aan die verkeerde dinge van die verlede.”*

*“She must help me to stop lying and stealing and swearing.”*

*“I am done with the drugs and no more house breaking.”*

*“Om op te hou steel en mense roof.”*

*“Ek gaan ook sukkel om regte goed te doen in plaas van verkeerde goed [referring to chemical substance-related activities].”*

*“Ek gaan sukkel om op te hou om van my medemens te steel. Inbreek.”*

The participants' need for skills to change the old habits relating to their addiction illustrates the view of Powis (in Becker, 2005:169) that in dealing with old behaviour that maintains addiction, addicts need to be assisted in developing coping skills and strategies that will create new behaviours and make lifestyle changes. Lessa and Scanlon (2006:287) link coping skills with self-efficacy, and note that this is a cognitive process dealing with perceptions regarding competencies. The CAA must be assisted to become “ready, willing and able”, which would enhance self-efficacy, and decrease relapse potential. In support of the abovementioned arguments, a study conducted by Hyde, Hankins, Deale and Marteau (2008:613) illuminates the positive impact of self-efficacy on behaviour change. The statements provided above point to a lack of self-efficacy and resilience. Replacing old habits with new ones would assist them to become more resilient. Resilience provides hope and leads to

the capacity to continue further growth and development, despite high risks and adversity. It relates to the ability to cope, using one's assets, awareness, resources, skills and ownership to deal with problems in order to flourish (Saleeby, 2006:198; Ebersöhn & Eloff, 2006:4-5).

Further aspects to attend to when dealing with former behaviour that maintained the addiction, according to Powis (in Becker, 2005:169-180) include: the exploration of areas that may block change and recovery, such as shame, low self-esteem and unresolved emotions; the identification of high-risk situations; developing coping skills and strategies to deal with cravings; enacting new behaviours; and making lifestyle changes.

Connected to being assisted by social workers to develop skills to change old habits relating to the addiction, is a need for assistance and skills to break down defence mechanisms. This aspect will be addressed in the next sub-theme.

### **Sub-theme 2.2: Participants need assistance and skills regarding how to break down defence mechanisms**

De Jager and Truter (in Becker, 2005:125) explain that defence mechanisms are used to “find shelter” from real-life challenges. Defence mechanisms are therefore often mistaken for resistance.

The participants mentioned “lying” and “covering up” as defence mechanisms that should be addressed in aftercare, as they were used to maintain the behaviour referred to in the previous sub-theme. The following storylines clearly refer to lying and covering up as defence mechanisms, and the participants' need for assistance to deal with this:

*“En ek wil openlik met hulle kan wees en nie hoef te lieg en te cover nie.”*

*“If I cannot trust I will just lie and that is not good if I want to stay sober.”*



The researcher came across numerous discussions about the use of defence mechanisms among chemically addicted persons. Denial is often interpreted as lying, and is used when the addict refuses to admit the addiction or the consequences thereof. It also implies that it is a refusal to accept help, and leads to the use of other defence mechanisms such as minimising and blaming. Denial causes tension and stress (Grobler et al., 2005:75-76; Caroufek, 2007:4-6). Blaming is also often interpreted as lying, and is an attempt to find other explanations for destructive chemical substance-related actions, thereby covering up the impact of the addiction (Powis, in Becker, 2005:172).

A defence mechanism related to covering up is projection, which is closely related to blaming. It takes place when the addict projects the reason for his/her situation and keeps others responsible for the problem (Sheafor & Horejsi, 2006:273). Minimising (also a defence mechanism for covering up), on the other hand, is used when the addict experiences shame and guilt because of the consequences of the addiction. In order to deal with these painful feelings, the addict chooses to minimise the contents of a situation (Perkinson, 2008:98-107). Another form of covering up and explaining the addiction or related problems is rationalising. In order to make sense of their behaviour, addicts attempt to provide reasons for their actions. They find external reasons for their addiction in order to avoid the responsibility of ownership relating to the consequences of their addiction (Perkinson, 2008:98-107).

Regarding the impact of defence mechanisms on the recovery potential, Gordon (2003:18) warns that defence mechanisms impact negatively on the level of motivation to enter treatment, or to commit to aftercare intervention.

### **Sub-theme 2.3: Participants' need for assistance and skills regarding how to deal with old friends and make new ones**

The importance of association with peers during adolescence should not be underestimated. According to Gouws et al., (2000:76-77) the peer group fulfils

the following functions during the adolescent phase: It helps with the emancipation from parents; it assists with the search for an individual identity outside the family; it helps the adolescent to obtain social acceptance; it provides a social support network; it serves as a source of reference and feedback, and provides opportunities for recreation.

According to the United Nations (2003:4), family and peers are the most important contributors to adolescent chemical use and abuse, and by implication to relapses. Falkowski (2003:46) identifies poor social skills and affiliation with chemical substance-using peers as factors that maintain addiction and cause relapses to occur. In confirmation of the abovementioned views, one participant said: *“En hoe kan ek my vriende wat nog ‘drug’ help, want as hulle ‘drug’ dan kan ek die goete los nie.”*

In their narratives the **participants requested assistance and identified a need for skills that would enable them to deal with chemical substance-using peers.**

*“Ek weet nie wat ek gaan maak met die vriende wat ‘drugs’ gebruik nie.”*

*“Hulle sal aanmekaar na my huis toe kom.”*

*“Ek gaan gedwing wees om vir hulle te sien.”*

*“En hulle sal my aanmekaar dwing om ‘drugs’ te gebruik.”*

*“Ek wil vra dat sy [referring to the social worker providing aftercare] my help want ek gaan sukkel met vriende.”*

One participant wants advice on *“wat ek met die ou vriende moet maak. As hulle tot by my kom en verkeerde dinge wys.”*

He explained the reason behind the need for advice as follows: *“Ek is bang hulle gaan my vra om te rook. Want dit maak laat ek sommer lus kry vir rook.”*

Peer pressure can be direct or indirect. Direct pressure occurs when peers expose the CAA in recovery to chemical substances, and use verbal and non-verbal communication to bring the message across that the adolescent will only be accepted in the peer group if he/she uses the chemical substance.

Alternatively, indirect pressure relates to environmental cues, such as paraphernalia, language and music which are associated with the use of chemical substances (Elliot-Wright, 2004: 31).

Consistent with their awareness of the need for assistance and skills on how to deal with chemical substance-using peers, the participants admitted to not knowing how to deal with this issue. They related contact with these peers to “temptations”, linking them to relapses. The following storylines attest to this:

*“Ek moet ook leer hoe om op ‘n mooi manier met ou vriende te ‘deal’.”*

*“The things bothering me in my community are my old friends and the temptations.”*

*“Sy [referring to the social worker] kan my help om te weet wat ek moet maak as my vriende vir my besluite wil kom maak.”*

Apart from assistance and skills on how to deal with former friends, the following statements illustrate awareness of the necessity of making new friends, as well as the lack of skills on how to establish and maintain new friendships.

*“O ja, en ek het hulp nodig dat sy my help om sober vriende te kry.”*

*“Ek wil hê my ‘social worker’ moet my weg hou van my vriende af en nuwe vriende kry.”*

*“And help with choices to make new friends that can help me.”*

*“Sy moet my help om ‘n ander vriendekring te kry as ek huis toe gaan.”*

*“And she must show me how to make new friends.”*

*“Ek soek iemand wat my kan help hoe om met mense te praat en nuwe vriende te maak.”*

*“Die maatskaplike werker moet my leer hoe en wanneer om mense te vertrou.”*

Still on this topic of establishing new friendships, the participants (through the following statements) expressed the need for assistance and skills in how to establish relationships of a romantic nature, and how to be respectful and loving in relationships:

*“Ek wil ook by die maatskaplike werker hoor hoe om ‘n meisie op ‘n mooi manier te benader.”*

*“En sy moet my leer om respek en liefde te toon.”*

*“Hoe om net een meisie te hê.”*

This sub-theme has focused on CAAs’ need for assistance and skills to deal with old relationships and establish new ones. Additionally, the participants requested assistance and expressed a need for skills on how to act assertively in an interpersonal context, and how to manage anger and stress. In the following sub-theme these aspects will become the focus of discussion.

#### **Sub-theme 2.4: Participants’ need for assistance and skills regarding how to act assertively in an interpersonal context, and how to manage anger and stress**

Assertiveness is a valuable skill to enable the CAA in recovery to deal with temptations from friends (Jarvis et al., 2005:104). The participants made specific references that indicated their **need for assistance to develop assertiveness skills**:

*“Ek moet leer om ‘nee’ te sê vir my vriende.”*

*“Ek weet ek gaan weer tik [referring to methamphetamine] as ek nie wegbly nie en sy [referring to the social worker] moet my help wegbly.”*

*“En ek sukkel as mense my wil laat verkeerde dinge doen. Sy [referring to the social worker] moet my help.”*

*“En help met ‘drugs’-probleme as my vriende my dwing om saam te rook.”*

*“Ek weet een of ander tyd sal hulle vir my ‘Bocky’ [referring to methamphetamine] in my hande gee.”*

*“Ek is nie so sterk om vir hulle te sê ek wil ophou rook al wil ek dit ophou rook.”*

Four participants verbalised as follows how they planned to act assertively:

*“Ek gaan sukkel om te kan nee sê, maar ek dink ek is sterk. “*

*“As hulle my vra hoekom wil ek nie rook nie dan gaan ek moet vir hulle sê: ‘dis want ek wil regkom’.* “

*“As hulle my vra om te rook dan sê ek: ‘nee’.”*

*“Ek gaan my ander vriende kry weg van by die ‘drugs’ af.”*

Page and Page (2003:101-112) and Fuller (2007:77) concur that adolescent stress leads to a feeling of helplessness, and has a lot to do with a lack of assertiveness regarding social and peer pressure. The following statements illustrate the need for assistance to manage stress:

*“I also want to know what to do when I stress.”*

*“Ek hou nie daarvan as iemand my sê ek is gerook en ek weet vir feit ek is nie. Dan voel ek ek raak van my trollie af.”*

*“Die probleme wat ek het is dat ek stres en wil baklei”*

Page and Page (2003:280) note that the inability to deal with stress leads to feelings and expressions of anger and frustration. The authors advise that CAAs should learn that anger is not an inappropriate feeling, but that it is their responsibility to manage anger. The participants were able to identify **the inability to deal with anger and requested aftercare assistance** with this issue. The following quotations from the narratives speak of this:

*“And I need to stop fighting.”*

*“I must also learn to handle my anger and not be ugly with other people.*

*“She [referring to the social worker] must help me not to be rude to people and not to hate them.”*

*“En ek wil graag ophou vloek en so gou kwaad raak. As sy [referring to the social worker] my kan help sal ek bly wees.”*

*“She [referring to the social worker] must help me with my anger problem. I fight a lot.”*

Problem-solving and decision-making skills were identified as tools that could contribute to their ability to deal with stress and anger, and to assist them to become assertive and resilient. This will be touched on in the following section.

### **Sub-theme 2.5: Participants' need for assistance and skills regarding how to solve problems and make decisions**

The following statements highlight a **need to discuss problems** other than their addictions, and the **need for problem-solving skills** that might assist them with managing their stress and anger assertively:

*"She [referring to the social worker] must help me with my problems."*

*"And she [referring to the social worker] must not just talk of addiction, but also about my other problems."*

*"Ek wil kan gaan praat as ek 'n groot probleem het en nie weet van nie. Dan moet die 'social worker' my leer van hoe ek moet maak."*

*"Ek wil hê dat as ek 'n probleem het moet ek na haar toe kan gaan en haar vra om my te wys hoe om te maak."*

Page and Page (2003: 80-82) point to the fact that constructive problem-solving and decision-making skills can assist the CAA to become assertive and resilient, and therefore able to deal with challenges in the recovery process. The following statements refer to this need:

*"She [referring to the social worker] must tell me when I do a good thing and when I do a bad thing."*

*"En wat ek met die ou vriende moet maak. As hulle tot by my kom en verkeerde dinge wys."*

*"She [referring to the social worker] must tell me more about drugs and what the bad things about drugs are."*

The importance of the development of problem-solving and decision-making skills is also discussed by Louw and Louw (2007:307), who note that the impact of chemical substances on the CAA leads to the inability to comprehend the long-term consequences of choices that he/she will make. Gouws et al. (2000:124-127) explain that the ability to make positive decisions as a solution to the problem becomes the goal to be attained. The adolescents must be equipped to find knowledge about the problem, before a solution is found and a decision made.

Another aspect to address through aftercare intervention requested by the participants was assistance with and skills for dealing with emotions.

### **Sub-theme 2.6: Participants' need for assistance and skills regarding how to deal with emotions**

The following statement illustrates the participants' need to address emotions during aftercare: *"It will help me to share what I feel."*

Adolescence is characterised by mood swings, which can be attributed to hormonal changes as well as developmental stress, considering the transitions that need to be made during this life stage (Louw & Louw, 2007:319). Gouws et al. (2000:98-100) state that emotions typical of adolescence include fear, worry, anxiety, anger, and jealousy, and they see emotions and thoughts as being interrelated. Elaborating on this idea, Neuland (2006:37) postulates that emotions influence the way CAAs think, and alter their perceptions of themselves and the world they live in. Gouws et al. (2000:35; 63) emphasise the point that emotional support of CAAs is essential for recovery, as emotions influence beliefs, and beliefs influence actions. These authors relate emotional well-being with mental health, including positive thinking that leads to hope and solution-orientated attitudes.

**Fear** was identified as an emotion that a participant needed assistance with. *"Ek is ook bang om huis toe te gaan, want ek weet ek gaan doodgemaak word."*

Other participants expressed feelings of **guilt** as a result of their addiction and the problems caused as a result of the addiction. *"Ek voel sleg oor al die slegte dinge wat gedoen was."*

Expressing a wish to deal with the feeling of guilt, a participant commented: *"I wish my family can allow me to give them the money."*

The following utterance by a participant provides a written picture of the impact of the inability to deal with emotions: *“Dan voel ek ek raak van my trolle af.”*

Mans (2000:10) describes the reasons for chemical substance use, abuse and relapse, and indicates that chemical substances provide the adolescent with an opportunity to escape from painful emotions. Dealing with emotions therefore plays an active part in relapse prevention that should be addressed in aftercare. Page and Page (2003:53-59) suggest that the following aspects be included in aftercare services: the identification of own emotions and other people’s emotions; impulse control and delayed gratification, and the ability to calm themselves.

### **Sub-theme 2.7: Participants’ need for assistance and skills with budgeting**

Participants reported a **need to be taught how to learn how to budget their finances**. The following storylines bear witness to this:

*“If I get a job, then I wish she can help me with the money.”*

*“En ek gaan my geld spaar en vir my ma sê sy moet vir my iets koop.”*

*“Dan hou ek my geld vir die skool.”*

The literature confirms that budgeting and financial planning should form part of the key areas to be addressed in relapse prevention (United Nations, 2003:24-25; Fisher & Harrison, 2005:162-169; Ebersöhn & Eloff, 2006:59-60). The need to develop financial-planning skills is based on two reasons. Firstly CAAs and their families have suffered financial losses because of their addiction, which results in feelings of guilt and a need to repair this damage (as described in the previous sub-theme). Secondly, these young people were previously focused on securing funds for the chemical substances. Therefore, the ability to plan financially was not developed and could lead to stress (Fisher & Harrison, 2005:162-169).



**Sub-theme 2.8: Participants' need for assistance with regard to planning an after-treatment recovery plan that will prevent relapses, maintain sobriety, and teach how to manage their time**

Velasquez, Maurer, Crouch and DiClemente (2001:181) state that addicted adolescents have not learned how to spend time effectively, and view the management of time as essential. In agreement, Fisher and Harrison (2005:162-169) advise that in recovery, these youngsters should learn to divide their time between work/school, rest and socialisation as part of relapse prevention. The following remark by a participant highlights the need for assistance to be able to develop a new lifestyle: *“Sy moet my ook help in pas by my sober lewe.”*

In order to do so, the participants' utterances below refer to **the need for assistance to develop a recovery plan**. Not only do the storylines point to the need for a plan to occupy time effectively, but also to the need for help in practising their new behaviour and avoiding contact with temptations:

*“She [referring to the social worker] must help to stay busy.”*

*“She [referring to the social worker] must tell me how to enjoy life drug free.”*

*“Sy [referring to the social worker] moet my help met 'n plan om te keer dat ek weer sulke mal goed doen.”*

*“Ek wil hê sy [referring to the social worker] moet my help om met my lewe te kan werk.”*

*“I want to learn to keep busy. I am looking for a job.”*

*“I need a social worker for aftercare to help me to go on with this sober life.”*

*“Want ek moet my besig hou.”*

*“As ek uit die skool uit kom sal ek werk om besig te kan wees.”*

Related to the previous discussion, Velasquez et al. (2001:177-181) suggest that, by replacing tempting activities with healthy substance-free ones, CAAs will learn to enjoy life again, thereby reinforcing their efforts to remain sober. In addition, a change of lifestyle means that a more productive lifestyle (e.g.

taking up a hobby or engaging in sport activities) should be adopted to ensure improved quality of life (Mans, 2000:10; Malhotra et al., 2007:1). Two of the participants referred to the value of hobbies and sports in order to fill time, and in so doing prevent relapses and maintain sobriety:

*“To work out a plan and to get a hobby. Example: sport.”*

*“Ek begeer regtig ‘n fiets. Dan sal ek elke dag net oefeninge doen.”*

Velleman (2001:110) concurs that a “relapse plan” is an essential component of aftercare, but cautions that the discussion of the possibility of a relapse and the subsequent development of a relapse plan to be able to deal with it must not be seen as “permitting” the adolescent to relapse. In support of this viewpoint, Keegan and Moss (2008:100) note that many addicts suffer from multiple relapses, as they need to commit not only to treatment, but also to recovery. They have to accept the continued danger of relapsing and cravings as a reality of their daily lives.

A part of this relapse plan is to assist them to deal with cravings and temptations. These aspects will be discussed below.

### **Sub-theme 2.9: Participants’ need for assistance and skills regarding how to deal with cravings and temptations**

According to Gwinell and Adamec (2006:78), “cravings refer to the intense and often overpowering desire to use chemical substances.” Connors et al. (2001:199) define cravings as “internal and external stimuli associated with drug withdrawal”, while Stoppard (2000:7) asserts that one of the contributing factors to adolescent substance abuse is the feeling of pleasure that the substance creates. Dimoff (2007:2) states that when CAAs experience stress, they will long for the feeling of pleasure that they experienced during chemical substance use, and therefore relapse potential is increased. Connors et al. (2001:199) explain that a relapse occurs as the addicted person is seeking to relieve physical and emotional cravings.

Cravings become accentuated during high-risk situations such as conflict, painful emotions and stress (Malhotra et al., 2007:8). A further explanation is provided by Grieve, Van Deventer and Mojapelo-Batka (2005:176-177), who refer to optimal arousal and cognition as key aspects in motivation of behaviour. These authors concur that arousal becomes a motivational force in order to maintain homeostasis, but also to actively seek stimulation to maintain levels of arousal. Cravings therefore impact on CAAs' reasoning, which is influenced by the motivational force of their attempts to maintain the levels of arousal previously provided by their chemical substances of choice.

Falkowski (2003:51) asserts that intense cravings for the "good feeling" provided by the chemical substance are ongoing. The youngsters therefore need coping skills and a sense of purpose to withstand these cravings. In support of this, Brummer (2006:15) refers to the Matrix Model, which focuses on teaching chemically addicted persons skills to deal with cravings as part of relapse prevention, rather than protecting them by locking them up during cravings. Elaborating further on the abovementioned, Lennard-Brown, (2004b:49) suggests that assisting the CAA to identify and resist triggers that cause cravings should be an aspect to address during aftercare intervention. According to the Matrix Institute on Addiction (2008b:1-2), a trigger can be described as a stimulus, which can include people, things, places, times of day and emotional states, which have been repeatedly associated with the preparation for and/or anticipation of the use of chemical substances. Triggers and cravings lead to irrational behaviour and thoughts.

The participants specifically requested **assistance from social workers about how to deal with cravings** when they remarked:

*"As ek weer lus raak vir 'drugs' wil ek enige tyd na die 'social worker' toe gaan en weet sy sal my help."*

*"The social worker should be someone I could call when I have cravings or on the edge of relapsing."*

*"She must help me to deal with these cravings."*

*"En oor hoe om te 'deal' met die lus vir 'drugs'."*

*“Daai is dinge wat ek moet help kry, want dit maak laat ek sommer lus kry vir rook. Dan weet ek ek is gerook.”*

Showing an awareness of the impact of cravings on relapse potential, the following statements express concern that the recovery from chemical addiction will not be achieved easily:

*“Ek gaan sukkel om die ‘drugs’ te los.”*

*“Ek gaan ook sukkel om sonder dwelms te kan wees.”*

The majority of the participants in this study were addicted to methamphetamine, which is classified as a nervous system stimulant (Mans, 2000:7-8). Tolerance for central nervous system stimulants develops rapidly, and is characterised by intense craving for the chemical substance during withdrawal (World Health Organisation, 2004:19). Physical addiction is also related to tolerance. Tolerance and physical addiction develop as “the nerve cells chemically and structurally counteract the drug’s psychoactive effects”. These chemical changes result in the individual becoming obsessed with obtaining the chemical substance “for a sense of well-being”. The physical addiction and tolerance leave the chemically addicted person with cravings for the chemical substance, and these cravings direct his/her behaviour (Gooney, 2002:37). Based on this observation, the need of the participants for assistance during aftercare treatment on how to deal with cravings must be seriously considered.

Additionally, Velasquez et al. (2001:177) suggest that self-worth plays a role in the management of cravings. The authors support this suggestion by referring to studies that have shown that people with a sense of self-worth can withstand cravings better. This reference to “self-worth” relates to self-image, and the participants also articulated a need for assistance in this regard. This aspect will be presented next.

### **Sub-theme 2.10: Participants' need for assistance and skills regarding how to develop a realistic self-image**

Page and Page (2003:34-39) note that identity is related to self-image. The authors explain that self-image (or the portrait which one has of oneself) is determined by self-esteem (or the estimate one places on oneself). Meyer (in Wait et al., 2005:166) refers to Erikson, who postulated that adolescents need to identify a career, become aware of their intellectual ability, develop sexuality and different relationships, and become aware of religious needs and beliefs, as well as identifying hobbies and sports. The ability to attend to all these aspects contributes to the development of a healthy self-image. Agreeing with this line of thought, Bezuidenhout (2008:133-135) notes that self-image impacts on one's self-confidence and decision-making abilities. A realistic self-image is characterised by a sense of competence, worthiness and belonging. On the other hand, according to this author, a negative self-image may result in chemical substance addiction and juvenile delinquency.

Components of the self-image are the "ideal self" and the "Pygmalion self". The ideal self refers to what a person wants to be in terms of appearance, abilities, skills and morals, and is determined by interactions. The Pygmalion self refers to the powerful influence of the expectations from others, leading to "I am who you think I am" (Page & Page, 2003:34-39; Bezuidenhout, 2008:133-135). Louw and Louw (2007:315) distinguish between the following aspects regarding the development of a self-image in adolescence:

- The actual self: this refers to the adolescent's actual perception of him- or herself
- The false self: this refers to the way the adolescent acts in the presence of others, thereby influencing the way he/she is being perceived
- The ideal self: this resembles the characteristics he/she would prefer to have
- The feared self: relates to the characteristics he/she does not want to have

The authors concur that chemical addiction often results in behaviour that is in line with the feared self. Therefore the feared self becomes the actual self, which limits self-worth.

The need to develop an identity was illustrated by the following statement made by a participant: *“Ek is onseker van myself.”*

In order to develop a realistic self-image, one needs to get to know oneself in terms of one's characteristics, strengths and weaknesses (Alpaslan, 1997:37). In the following statements made by two of the participants, this need for self-knowledge is expressed:

*“I want to know my good things. She must help me figure out what I am good at.”*

*“Ek wil graag hê sy moet my goeie punte ook kan sien en nie net die swakkes nie”.*

In confirmation of the utterances above, Page and Page (2003:45-49) postulate that the self-image is enhanced through the development of a sense of self-worth. The authors suggest that external self-worth is often determined by labels, and therefore by conditional self-worth. Internal self-worth, on the other hand, is an unconditional value of the self, which can be determined by a strong self-image or self-esteem. Relating to self-worth, participants made the following comments that indicate a need to feel worthy:

*“Om myself en ander te vergewe vir al die slegte dinge wat gedoen was.”*

*“Ek kan ook saam met hulle werk dat hulle kan verstaan hoe dit voel om verslaaf te wees [i.e. making a contribution].”*

Concluding this sub-theme, it is noted that the process of acquiring a realistic self-image is ignited through self-awareness, which is an essential component of mental health (Hepworth et al., 2006:521).

### **Sub-theme 2.11: Participants' need for assistance in relation to their spirituality**

Gouws et al. (2000:118) assert that spirituality gives the adolescent hope and confidence. Van Niekerk and Prins (2001:73) elaborate on this view, noting that spirituality has a valuable impact on self-efficacy, as hope derived from spiritual well-being increases the belief that they “can do it” (in this case remain sober). In agreement with these viewpoints, Lessa and Scanlon (2006:14) postulate that spirituality relates to a sense of self that provides a chemically addicted person with a purpose, a belief in the potential to change and grow, and affecting the way the person perceives the world. It is a continuous process that assists in making changes. The following remarks point to the fact that participants feel a **need for assistance in relation to their spirituality**:

*“En ek moet aan die man van Bo ook werk.”*

*“Ek gaan sukkel om godsdienst by te woon.”*

Lessa and Scanlon (2006:220) state that spiritual well-being assists CAAs in dealing with emotions. It contributes to forgiveness, which leads to acceptance, letting go, and moving on. Webb, Robinson, Brower and Zucker (2006:55) view forgiveness (as part of spirituality) as a highly relevant issue to address when assisting CAAs in recovery. The authors postulate that religion and spirituality play vital roles in physical and mental health, and are related to the potential to recover from addiction. The authors continue to draw a link between spiritual health, forgiveness and recovery (cf. Worthington, Sandage & Berry, in McCullough, Pargament & Thoresen, 2000:228). Touching on spirituality and forgiveness seems to be appropriate during aftercare interventions to CAAs, especially in view of the need in this regard as articulated by one participant: *“Om myself en ander te vergewe vir al die slegte dinge wat gedoen was.”*

### **Sub-theme 2.12: Participants' need for assistance regarding implementation of the NA's 12-Steps Programme**

The NA 12-Steps Programme is a way of life for its members, and is spiritual in nature (Fisher & Harrison, 2005:175-185). NA as a support group provides social support as well as access to the 12-Steps Programme that addresses cognitive, behavioural and spiritual needs of chemically addicted persons (Ritsher, McKellar, Finney, Otilingam & Moos, 2002:711; Majer, Jason, North, Ferrari, Porter, Olsen, Davis, Aarse & Molloy, 2008:146). Barrett and Ollendick (2004:337) advise that the 12-Steps Programme can effectively address relapse prevention.

The following remarks accentuate the need for assistance in this regard:

*"I mean, I want to continue with the 12-Steps but I need someone to help me."*

*"En ek moet met die 12 Stappe aan my self ook nog werk."*

*"Dis deel van die 12 Stappe en sy [referring to the social worker] moet help."*

*"Want ek moet leer hoe om aan te hou met gesond word."*

Apart from the abovementioned aspect to be attended to during aftercare intervention, the participants reported that they needed assistance to be able to continue with their education, or to find employment. This will be discussed in the next section of this chapter.

### **Sub-theme 2.13: Participants' need for assistance with finding employment and/or returning to school**

Sussman and Ames (2001:105) point out that one of the symptoms of adolescent chemical substance abuse is a drop in school performance and attendance, as well as a high drop-out rate. The authors therefore conclude that following treatment, these young people need assistance with catching up on school work, as well as assistance regarding study techniques from teachers. Falkowski (2003:46) and Bezuidenhout (2008:133-135) identify



failure in school performance as well as school pressure as areas that should be addressed in order to prevent relapses from occurring. The following statements are representative of the participants' expressed **need to be supported to be able to return to school**:

*"She [referring to the social worker] must help me to get back in school."*

*"Ek wil help hê want ek moet terug gaan skool toe en sy [referring to the social worker] moet help, want ek weet nie gaan hulle my vat nie."*

*"En help om weer terug skool toe te gaan."*

*"Ek gaan sit met werksprobleme as my skoolloopbaan nie voltooi is nie."*

*"Ek sal bly wees as sy [referring to the social worker] my kan help om terug te gaan skool toe of om 'n werk te kry."*

Focusing on employment on the other hand, Meyer (in Wait et al., 2005:176) asserts that adolescents have to be assisted to make career choices based on realistic perceptions of their abilities, interests, ideals, and the requirements of the options they consider. The participants indicated that they wanted to be employed, but that they **need vocational guidance**:

*"I am looking for a job."*

*"Sy [referring to the social worker] moet my 'n werk gee."*

*"En sy [referring to the social worker] moet my leer van hoe om 'n werk te kan kry."*

*"Ek moet help kry om 'n werk te kan kry."*

From the narratives of the participants, the need for assistance to rebuild relationships with their parents and to be integrated with their families became apparent. The focus of discussion will now centre on this aspect.

#### **Sub-theme 2:14: Participants' need for assistance to help rebuild their relationships with their parents and to be reintegrated into their families**

Gruber and Taylor (in Straussner & Fewell, 2006:3) are of the opinion that the family should be viewed as an integral part of aftercare services, considering

the facts that the addiction occurred in the family; that the family could have participated in and perpetuated the addiction; that the addiction harmed the family; and that the family is an important potential treatment and recovery resource.

Also focusing on the value of family involvement in aftercare, Gouws et al. (2000:5) point out that the successful achievement of the participants' adolescent development tasks were restricted and damaged by the impact of their addictions. The authors therefore argue that the family must become aware of this damage, and assist the adolescent to restore the damage as far as possible. In addition, Gouws et al. (2000:68) postulate that parental interest and an attempt to understand and accept the adolescent, to approve and trust him/her, the creation and maintenance of a happy home environment, and fair discipline and guidance are important characteristics needed for families to be able to provide this vital assistance.

The need for Social Work assistance in this regard during aftercare became clear as the participants (in the storylines below) expressed concern about the amount of support they would receive when they went home, and would like assistance in this regard:

*“En my ouers sal my nie ondersteun nie.”*

*“Onseker van die ondersteuning by die huis.”*

*“En ook as ek ‘n probleem het saam met my ouer.”*

*“Ek is onseker. Ek wil hê sy [referring to the social worker] moet my help dat my ouers my sal ondersteun.”*

The **participants need assistance from the social workers to restore parent-child relationships and bonds**. The following storylines refer to this:

*“As sy [referring to the social worker] weer kom gaan ek haar vra om my te help om ‘n beter verhouding met my biologiese pa te kan hê.”*

*“Ek wil regkom met my pa. Ek kan naweke saam met hom werk.”*

*“Om oor die weg te kom met my ouers.”*

Addiction in the family leads to lower levels of family cohesion, expressiveness, problem-solving skills and recreational orientation, while it leads to higher levels of conflict (Sussman & Ames, 2001:107-108). Brandt and Delpont (2005:165) report that the lack of trust in families leads to a perception of “my parents do not trust me anyway”. These viewpoints were also expressed by the participants, and they asked for help to restore the trust between them and their parents.

*“I would love for her to help me build the trust again with my family.”*

*“I will work hard to show them I have changed. [i.e. to win back their trust and gain their approval]”*

*“Ek wil graag hê sy en my ouers moet my verstaan en aanvaar vir wie ek is.”*

*“En ook help want al wat ... my moeder vir my sê: ‘jy is al weer gerook.’ Dan wil ek glad nie eens gerook het nie.”*

*“En my ouers gaan ook dink dat ek nog nie klaar is met die dinge nie.”*

*“My ouers gaan nog altyd my beskuldig van dinge wat ek nie gedoen het nie.”*

One participant requested practical support from his family: *“Ek wil NA toe gaan en ‘12-Steps’ doen. My ma sal my daarmee [moet] ondersteun.”*

Another participant asked for the social worker to be of assistance with rebuilding relationships with the parents and reintegration in the family: *“Sy moet my huislewe ken en al daai probleme verstaan.”*

Considering the literature, Pires and Jenkin (2007:170-171) note that adolescence is the phase in the human life-cycle where an individual starts to spend more time with his/her peers, while the peer influence also increases. Building on this fact, Fuller (2007:76) explains that the adolescent begins to function more distinctly in two worlds: 1) the world involving peers and 2) the world involving the family, and experiences stress as he/she has to attempt to fit into both these worlds. For this reason the adolescent still needs the input and structure of his/her family and needs to strive for a balance between time spent with peers and time spent with the family.

Although participants in the abovementioned utterances expressed the need to rebuild their relationships with their parents and longed for reintegration with their families, the latter can be threatened by a number of issues which can permit relapses to occur. The literature refers to the following in this regard: poor family relationships in the home environment; parental use or abuse of chemical substances; ineffective parenting with reference to unclear parental expectations; dysfunctional discipline; absence of parental limit-setting and consequences of behavioural problems; poor parent-child communication; a lack of parental warmth and trust; a lack of parental involvement; and parents being poor role models (Dodgen & Shea, 2000:39; Gouws et al., 2000:106; Fraser, 2002:122; Dimoff, 2007:2; Falkowski, 2003:46).

The need to restore communication and to address the need for conflict management skills with their parents in order to become part of the family again was reported as follows:

*“She must help me to talk to my parents.”*

*“En saam met my ouers baie baklei en stress.”*

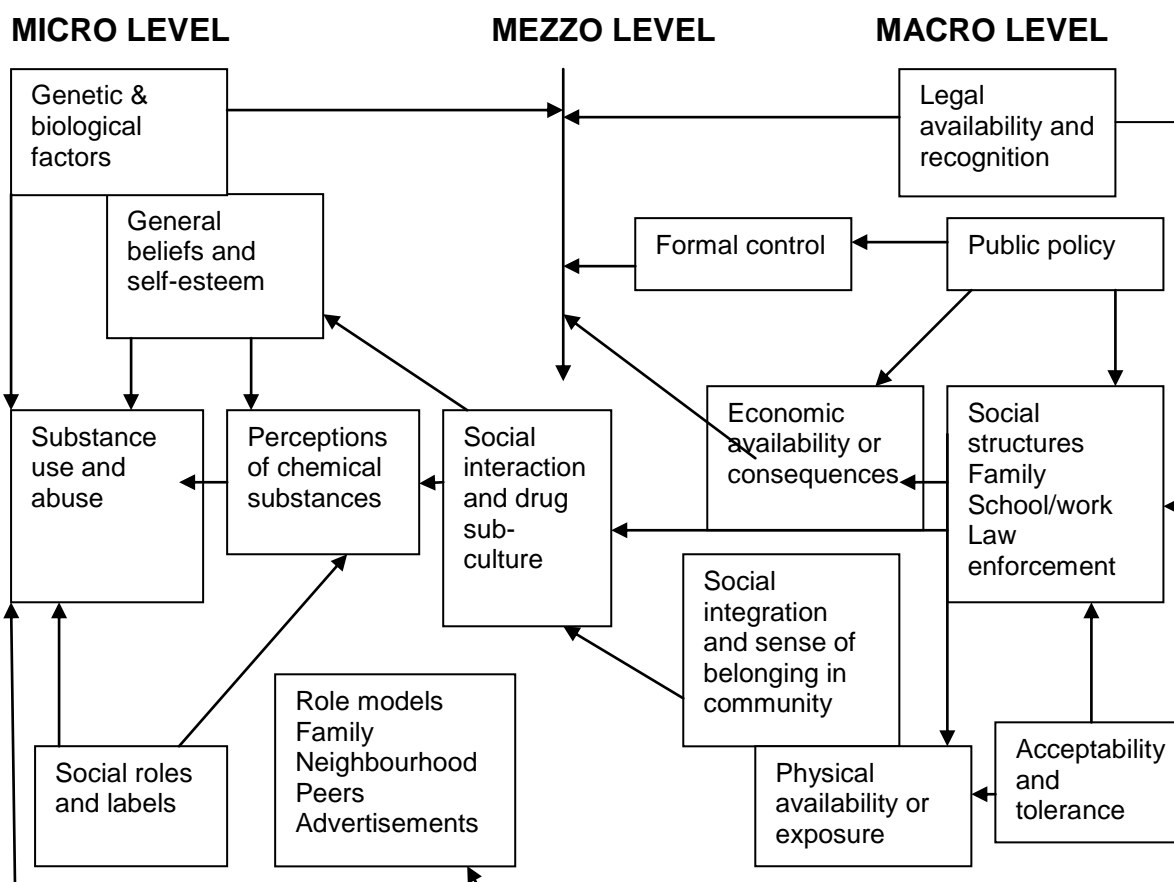
The participants reported a concern regarding abuse of chemical substances by family members that could threaten their recovery processes, as well as the successful reintegration in the family:

*“Ek soek help met huisprobleme. My pa verbruik ook ‘drugs’.”*

*“My broertjie wat 13 jaar oud is rook ook nou dagga.”*

In summary: the data obtained from the participants revealed that chemical substance abuse has an impact on an intrapersonal (micro), an interpersonal (mezzo) and an environmental (macro) level. These levels are all relevant in the increase or decrease in relapse potential following treatment. The discussions thus far have introduced the intrapersonal and interpersonal levels of impact, while the discussion to follow will focus on the environmental level of impact. Figure 3.3 provides an illustration of the levels of impact.

**Figure 3.3:** Micro-, mezzo- and macro-level impact on the prevalence of chemical substance abuse (as adopted from Brandt & Delpont, 2005:173)



Apart from a need for assistance from social workers to rebuild their relationships with their parents and to be reintegrated into their families, the participants also expressed the need for assistance with being integrated into their communities.

### **Sub-theme 2.15: Participants' need for assistance in becoming integrated into their communities**

Previous relapse experiences impacts on CAAs' self-efficacy and the perception that they are accepted only by former chemical substance-using friends. Both Mans (2000:10) and Dimoff (2007:2) argue that addicted adolescents' continued search for emotional release and acceptance by society, as well as a lack of coping skills, impact negatively on their reintegration into society. In order to change these perceptions, the Draft Systems Model for Prevention and Aftercare (Department of Social

Development Western Cape, 2008:14-15) advises that social workers form partnerships with community organisations and institutions to ensure that aftercare services lead to acceptance and support from multiple sources.

Regarding multiple sources, Fuller (2007:109) concurs that adolescents need to develop a sense of belonging, which could be obtained from the family, school, peers and the community. Focusing on the community, Falkowski (2003:46) notes that strong bonds with social institutions could contribute to aftercare services and prevent relapses from occurring. In support of this, Malhotra et al. (2007:4) propose a multi-systemic approach when planning aftercare services to CAAs. De Wet (2004) identifies the following social support systems that could be utilised: caregivers such as teachers; peer association at schools and churches; institutions such as the churches, schools, and social welfare organisations; and citizen associations such as sport clubs and cultural organisations.

With regard to **reintegration into the community**, the participants stated that they **need social workers to help them** in this regard, but those social workers should know their communities and the challenges they face community-wise. The following storylines point to this:

*“The social worker must give me tips of how to cope in my community and motivate me to stay sober.”*

*“Die een moet my ook verstaan en ook hoe my gemeenskap werk.”*

*“She must know my community. She must go with me to my community so she can see what I deal with.”*

*“It will help her to understand my side. The community is difficult.”*

In addition to understanding the challenges in the community, a participant also requested that **social workers must be aware of support systems in their communities**. *“Maar dan moet sy die gemeenskap ook ken sodat sy kan weet waar ek goeie vriende kan kry.”*

The participants also expressed a **need for social workers to link them up with support groups and Narcotics Anonymous:**

*“Ek wil NA toe gaan en 12-Steps doen.”*

*“And she [referring to the social worker] must take me to NA meetings.”*

*“Sy [referring to the social worker] moet ook help met maniere hoe ek by NA kan uitkom.”*

*“Om by ondersteuningsgroepe te kan uitkom.”*

NA is a self-help group with the desire to stop using chemical substances as the only requirement. It is also characterised by anonymity of its members, and the sponsor-system, where members act as guides and support networks to one another. The literature indicates the following advantages regarding self-help groups such as NA:

- Self-help groups provide CAAs with role models to assist them in forming new beliefs regarding substance abuse (Brandt & Delpont, 2005:168).
- Self-help groups assist CAAs to form new, healthy interpersonal relationships and to learn to function in the community (Focus Adolescent Services, 2006:6).
- Self-help groups for the family, such as AL-ANON, NARANON and Tough Love ensure that the family members understand the addiction, as well as the recovery process, and that they receive support regarding their own experiences of the addiction in the family (Mental Health Touches, 2006:6).
- These groups provide CAAs with the opportunity to interact socially, and lead to independent social interactions (Barr & Parrett, 2001:26).
- Self-help groups enhance the feeling of belonging and the ability to adjust norms in a positive way, thus addressing the developmental tasks of adolescence (McWhirter et al., 2004:126-127).
- Self-help groups have the value of interaction with others “who know what it feels like” (McLeod, 2003:449).

In the previous sub-theme, mention was made of the mistrust between the participants and their parents resulting from the chemical substance abuse

(see Sub-theme 3.14). From the accounts below, the mistrust of the participants from the side of the community became apparent. **Assistance to establish the trust between the participants and their respective communities** becomes an identified focal point to be addressed by the social worker during the aftercare interventions.

*“I will appreciate the acceptance and trust in the community.”*

*“I will need help there because I know it will be difficult for some of them to see that I am a new person.”*

Brendtro, Brokenleg and Von Bockern (2002:7) postulate that a lack of acceptance by the community is associated with labelling which can alienate adolescents, putting them at risk and therefore contributing to relapsing.

Reflecting on the fact that chemical substances are readily available, with specific reference to methamphetamine in the Western Cape (Van Niekerk & Prins, 2001:38; Caelers, 2005:1; Dimoff, 2007:2), the participants reported that this situation was experienced as a stressful aspect in their recovery process and that they would like assistance in this regard. Availability of chemical substances, as well as the tolerance of chemical substance-use in the community pose a risk to CAAs following treatment (Falkowski, 2003:46; Bezuidenhout, 2008:133-135). The following quotations make reference to this:

*“Daar waar ek woon is daar orals ‘drugs’.”*

*“Om die slegte dinge soos ‘drugs’ in my omgewing te ignoreer sodat ek ‘n skoon lewe kan bly lei.”*

*“Ek gaan sukkel met al die ‘drugs’ in die samelewing.”*

*“Ek het help nodig in die gebied waar ek woon.”*

*“Almal gebruik nog die ‘drugs’.”*

In addition, the reality of the link between chemical substance addiction and gangs in the Western Cape (Ganga, 2007), was confirmed by the participants through the following statements:

*“Ek is ook bang om in die wrede wêreld te wees en bang vir verdere dwelms.”*



*“What does she know about gangs and the numbers?”*

*“Ek is ook bang om huis toe te gaan, want ek weet ek gaan doodgemaak word.”*

Addressing this concern, a participant requested social workers to become involved in his community as part of aftercare services. He stated: *“Ek sal dit baie like as sy [referring to the social worker] active is en optogte teen die dwelms daar by ons reël. Dan sal ek sien sy gee regtig om en wil ons gemeenskap help.”*

Griewe et al. (2005:177) note that apart from personally valued motives for behaviour, socially valued incentives can also “push people towards goals”. The motivation to continue sobriety is therefore influenced by whether chemical substances are available and tolerated or not. Fraser (2002:121) and Terblanche and Venter (1999:167) agree that tolerance for chemical-substance use in the community, availability thereof and high crime rates put the CAA at risk.

Another risk related to the availability of chemical substances in the community, combined with the adolescents’ need to associate with peers, is the exposure to social places where chemical substances are available, known as “wet places”. Fisher and Harrison (2005:158) postulate that chemically addicted persons in recovery should avoid “wet places” in order to prevent relapses. Participants expressed the need for social workers to assist in this regard, and become knowledgeable about where these “wet places” are:

*“She must help me to deal with the old friends and the wet places.”*

*“I must also learn how to know the wet places in my community.”*

This sentiment is supported by Malhotra et al. (2007:2), who stress the importance of separation from the drug-using sub-culture, in order to maintain sobriety.

The findings regarding addicted adolescents' needs pertaining to aftercare services by social workers focused on the adolescents' own needs, their expectations regarding social workers, and needs related to their families and their communities. Upon the conclusion of the analysis and description of the data in this chapter, the researcher compared and verified the findings of previous studies in this field with the data obtained in this study. This will be discussed in the next section of this chapter.

### **3.4 Verification with previous studies**

The researcher considered the findings of two recent South African studies related to aftercare needs of CAAs, in order to complete the verification of data with the literature. A study conducted in Pretoria among CAAs during 2003 revealed the following aftercare needs consistent with the findings of this study (Van den Berg, 2003: 156-196): CAAs need 1) assistance to return to school following treatment, 2) to be accepted back into society following treatment, 3) assistance to deal with temptations following treatment, 4) to unlearn the use of defence mechanisms that previously maintained addictive behaviour, 5) to deal with emotions, specifically anger, during aftercare, and 6) to develop conflict management and assertiveness skills during aftercare. This study by Van den Berg (2003: 156-196) highlights three areas that were not mentioned by the participants in this study. The first two areas that were identified as needs were the development of a new life and relapse prevention programmes. However, this is similar to the need to develop a recovery plan and time-management skills identified as aftercare needs in this study. Developing healthy eating habits was the third aspect that was identified during Van den Berg's study (Van den Berg, 2003: 156-196).

Focusing on the Western Cape, the researcher also considered the findings related to her previous research regarding the relapse experiences of CAAs following treatment conducted during 2007 (Van der Westhuizen 2007:61-129). Findings related to aftercare needs and consistent with the findings in this study are as follows: 1) The participants experienced social, parental and emotional problems that led to relapse, and needed to be addressed during

aftercare services. 2) Assistance with reasoning was needed, as this impacted on self-efficacy, motivation to change and the ability to deal with problems. 3) Adolescents and their parents needed support and guidance to change lifestyles after treatment. 4) The development of life skills as part of aftercare was an important element in the ability to change lifestyles. 5) The participants identified time-management and the ability to deal with cravings as important life skills to master as part of relapse prevention. 6) The availability and acceptability of chemical substances in the communities were seen as precipitating factors in relapse and were identified as areas to be addressed during aftercare. 7) To develop a sense of purpose would be valuable and would contribute to the enhancement of self-efficacy. An additional aspect to be addressed during aftercare that was not identified in this study was the fact that abstinence plays an important role in relapse prevention.

### **3.5 Conclusion**

This study aimed to obtain an understanding of the aftercare needs of CAAs regarding Social Work services. In order to achieve the goal and objectives of this research study, as described in Chapters 1 and 2, data was collected among 31 chemically addicted adolescents in the Western Cape, who relapsed after in-patient treatment, and went back to in-patient treatment centres. The needs were recorded by means of written narratives. Following data analysis, the data was divided into themes and sub-themes, verified with the relevant literature and previous studies, and discussed in depth in this chapter.

The data resulted in **one unique theme**, namely: chemically addicted adolescents' previous experiences with social workers. The researcher, independent coder and promoters elected to include this topic as a unique theme, as it introduced their aftercare needs by means of a discussion of both positive and negative previous experiences when receiving aftercare services from social workers. The **two main themes** were: chemically addicted adolescents have specific expectations from social workers rendering

aftercare services, and aspects chemically addicted adolescents would like to be assisted with during aftercare.

The specific expectations from social workers rendering aftercare services emphasised the following aspects:

- Chemically addicted adolescents expressed the need for regular contact with their social workers.
- The participants identified the following specific characteristics that they were looking for in social workers who rendered aftercare services: trustworthiness, non-judgemental attitudes, open and honest communication, passion for their work, and genuine personal interest.
- The abovementioned characteristics should lead to a personal relationship with social workers who believe in them, who are accessible, and whom they can trust.

Aspects to be addressed during aftercare as identified by the participants were:

- The participants identified skills to assist them in their efforts to recover from chemical addiction. These skills are:
  - changing the former habits relating to their addiction,
  - breaking defence mechanisms,
  - dealing with old friends and making new ones,
  - acting assertively in interpersonal contexts,
  - managing anger and stress,
  - solving problems,
  - making decisions,
  - dealing with emotions,
  - budgeting,
  - dealing with cravings and temptations,
  - developing a realistic self-image.
- In addition to the skills mentioned above, the participants requested assistance with:
  - matters relating to spirituality,
  - the implementation of the 12-Steps ,

- finding employment and returning to school,
- rebuilding their relationships with their parents and reintegrating with their families,
- becoming integrated in their communities.

Previous studies in this area also indicated that healthy eating habits and the importance of abstinence should be included in aftercare services.

Triangulation of sources of data (Weyers et al., 2008:207-210) was employed in order to ensure that this research results in user-friendly guidelines. The findings described in this chapter were therefore supplemented with findings obtained from the exploration of social workers' perceptions and experiences regarding current aftercare services. These findings will be discussed in Chapter 4.

## CHAPTER 4

### DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL: SOCIAL WORKERS' PERCEPTIONS AND EXPERIENCES OF AFTERCARE SERVICES TO CHEMICALLY ADDICTED ADOLESCENTS

#### 4.1 Introduction

Treatment for chemical addiction often does not result in recovery. According to the Disease Model of Addiction, relapsing is a constant threat to ongoing recovery (Fisher & Harrison, 2005:37-52). In support of this viewpoint, Falkowski (2003:35) postulates that commitment to and participation in aftercare services are restricted by such things as stigmatisation, which prevents chemically addicted persons in recovery from publicly admitting that they are suffering from addiction, even when they have achieved a period of sobriety. It results in behaviour that is not conducive to their recovery, as they try to act as if their addiction is in the past, or never existed. Addressing the issue of relapse potential, Sussman and Ames (2001:102) concur that the cessation of chemical substance abuse and the maintenance of recovery are currently the focus areas in most treatment programmes. The authors therefore argue that practitioners and researchers are challenged to evaluate the effectiveness of these programmes and adjust them accordingly in an effort to prevent relapses from occurring following treatment.

A study conducted by Zhang, Gerstein and Friedman (2008:288-400) found that the lack of housing, unemployment, inadequate education (or lack of access to continue education following treatment), inability to deal with painful emotions, unaddressed family issues, a lack of finances, and legal issues (such as pending court cases related to chemical substance-related behaviour) were neglected in treatment programmes. The lack of focus on these areas resulted in a lack of commitment to the recovery process among the participants in their study. The need to deliver a holistic service (including aftercare as part of treatment) to address the addiction and co-occurring

problems and needs was therefore highlighted. However, the authors warn that the practitioner must be careful that the client does not avoid addressing the addiction by defocusing on these issues (cf. Fisher & Harrison, 2005:37).

In addition, Pienaar (2005:13) identifies the following barriers relating to services to persons suffering from chemical addiction: service providers who do not understand addiction and recovery; the lack of resources in the community; the negative attitudes of society towards addicts; and the nature of physical and psychological dependence, which leads to a desire to continue using chemical substances, which in turn leads to implementation and maintenance of defence mechanisms and a refusal to accept help.

Considering that the majority of the relapsed CAAs who participated in the present study identified methamphetamine as their chemical substance of choice, it is interesting that Shrem and Halkitis (2008:675-676) advise that treatment and specifically aftercare services be adapted to the specific needs of methamphetamine addiction. The authors identify areas that need specific attention when addressing methamphetamine addiction as being long-lasting withdrawal symptoms, depression, and exposure to environmental cues that lead to triggers for cravings. They suggest that the intervention methods to be considered could include the exploration of substance-free activities, meditation, and stress management.

Aftercare services to CAAs should therefore take their specific needs into consideration, and tailor-made interventions need to be planned. However, the real-life challenges experienced by social workers working in this specific field also need to be considered. To contribute to the development of practice guidelines aiding social workers in aftercare service rendering to CAAs, the researcher implemented triangulation of data sources (Weyers et al, 2008:207-210. The aftercare needs of CAAs (task objective 1, see p. 36 and Chapter 3) was explored and described, together with the perceptions and experiences of social workers regarding current aftercare services rendered to the aforementioned client-system (task objective 2, see p. 36), which will be the focus of this chapter.

A sample was procured of social workers meeting the following criteria for inclusion: 1) They were registered social workers who were employed by the Department of Social Development or NGOs, and 2) they provided aftercare services to chemically addicted adolescents in the Western Cape. Data was collected by means of qualitative interviewing in the form of focus group discussions and the utilisation of participant observation as a complementary qualitative data collection method. The protocol for data recording was the use of tape-recordings to record the verbal data, and field notes to obtain the non-verbal data. The verbal- and non-verbal data was transcribed directly after the focus group discussions. The researcher made use of the framework for data analysis for qualitative research by Tesch (in Creswell, 2003:192) to ensure a systematic manner of analysis. An independent coder assisted with data verification. In order to compare and contrast the findings of this study with existing theories and previous research reported in the relevant literature, the researcher made use of a literature control. It was used as a verification tool which enabled the researcher to verify the major themes with the relevant literature (Holloway & Wheeler, 2010:28).

The following section provides the demographic data of the social workers who participated in this study.

#### **4.2 Demographic data of social workers who participated in this study**

By way of introduction the biographical particulars of the Social Work sample group who participated in this study is presented in the table below.

**Table 4.1:** Demographic details of social workers who participated in this study

<b>Age group</b>			
21-28 years	29-35 years	36-49 years	50 years +
11	7	8	3
<b>Qualifications</b>			
Degree in Social Work		Post-graduate studies in Social Work	
27		2 (Masters)	
<b>Years experience in Social Work</b>			
1-5 years	6-10 years	11-19 years	20 years +
11	6	8	4



<b>Racial group</b>			
African	Coloured	Asian	White
5	16		8
<b>Language</b>			
English	Afrikaans	Xhosa	Sotho
7	19	2	1
<b>Gender</b>			
Male		Female	
3		26	

The discussion to follow will provide a foundation for the discussion of the findings of this study. Twenty-nine social workers participated in seven focus groups. Of the 29 social workers, six were from the Department of Social Work, eight from ACVV, four from the ABBA Network, and 11 from SANCA.

#### **4.2.1 Gender distribution**

Twenty-six of the Social Work participants were female, while only three were male.

#### **4.2.2 Age distribution**

The majority of the social workers were in the younger age category. Eleven social workers were between 21 and 28 years of age, while seven were between 29 and 35 years of age, eight between 36 and 49 years of age, and three were older than 50 years.

#### **4.2.3 Language distribution**

The language distribution of the Social Work participants was consistent with the language distribution of the relapsed CAAs who participated in this study (see p. 106). Nineteen social workers were Afrikaans-speaking, seven were English-speaking, two were Xhosa-speaking and one was Se-Sotho-speaking.

#### **4.2.4 Cultural distribution**

The cultural distribution of the Social Work participants was also mainly consistent with the cultural distribution of the adolescents who participated in this study (see p. 106). Sixteen social workers were from the Coloured community, eight from the White community, and five from the African community. None of the social workers were from the Asian community.

#### **4.2.5 Highest qualifications obtained**

Two social workers noted that they had completed their master's degrees in Social Work while the remainder of the sample group indicated that their highest educational qualification was one in basic Social Work.

#### **4.2.6 Years of experience in the practice field**

Consistent with the age distribution of the participants, 11 social workers had one to five years' experience as social workers, six had six to 10 years' experience, eight had 11 to 19 years' experience, and four had more than 20 years' experience.

In the context of the demographic data, the next section will consist of a discussion of the findings emanating from the data analysis process of the transcribed recordings of the focus group discussions, as well as the conclusions of the researcher and the independent coder.

### **4.3 Research findings relating to perceptions and experiences of social workers regarding aftercare services rendered to chemically addicted adolescents**

Both the researcher and the independent coder utilised the framework for qualitative data analysis as proposed by Tesch (in Creswell, 2009:186) in

order to analyse the data acquired from the seven focus group discussions conducted with the 29 social workers. After completing the analysis, the researcher, the independent coder and the study's promoters engaged in a discussion to jointly decide upon the themes and sub-themes that emerged from the processes of data collection and analysis. Table 4.2 below presents this information.

**Table 4.2:** Findings relating to social workers' perceptions and experiences regarding aftercare services to chemically addicted adolescents

<b>Themes</b>	<b>Sub-themes</b>
<b>Theme 1:</b> Social workers perceive aftercare to chemically addicted adolescents as essential for life-long recovery	
<b>Theme 2:</b> Social workers' perceptions and experiences of current aftercare services delivered to chemically addicted adolescents	<b>Sub-theme 2.1:</b> Although social workers saw aftercare as a "specialised field" of service delivery it was currently not the case in practice
	<b>Sub-theme 2.2:</b> Social workers' comments on the format and content of aftercare services in practice currently rendered to chemically addicted adolescents
<b>Theme 3:</b> Social workers expressed a need for further knowledge relating to aftercare services to chemically addicted adolescents	
<b>Theme 4:</b> Obstacles experienced by social workers in the rendering of aftercare services to chemically addicted adolescents	<b>Sub-theme 4.1:</b> A skills deficiency owing to a lack of training/uncertainty about the nature of training to equip community resources to render effective aftercare service
	<b>Sub-theme 4.2:</b> The lack of contact between and alignment of programmes offered at treatment centres with aftercare service initiatives
	<b>Sub-theme 4.3:</b> Lack of transport, inaccessibility, lack of knowledge about aftercare services and employment-related challenges
	<b>Sub-theme 4.4:</b> A high drop-out rate amongst chemically addicted adolescents and lack of commitment to aftercare services
	<b>Sub-theme 4.5:</b> Difficulties experienced by chemically addicted adolescents in internalising new behaviour
	<b>Sub-theme 4.6:</b> The lack of time to render aftercare services due to a lack of manpower and funds
	<b>Sub-theme 4.7:</b> Social workers expressed frustration when there is a lack of resources
<b>Theme 5:</b> Social workers' views of the role of the family in aftercare to chemically addicted adolescents	<b>Sub-theme 5.1:</b> Families lack insight into the recovery process
	<b>Sub-theme 5.2:</b> Families need training and support to be able to support chemically addicted adolescents
	<b>Sub-theme 5.3:</b> The reintegration of the chemically addicted adolescent into the family

	<b>Sub-theme 5.4:</b> Family members must be supported to address their own problems that impact on recovery potential of chemically addicted adolescents
<b>Theme 6:</b> Social workers' suggestions with reference to the development of practice guidelines for rendering aftercare services to chemically addicted adolescents	<b>Sub-theme 6.1:</b> Practice guidelines for rendering aftercare services to chemically addicted adolescents should be standardised, and structured in a step-by-step format
	<b>Sub-theme 6.2:</b> Practice guidelines relating to aftercare services to chemically addicted adolescents should be visual, written in easy language, and should include practical and fun activities
	<b>Sub-theme 6.3:</b> Guidelines relating to the management, linking and networking of resources
	<b>Sub-theme 6.4:</b> Aftercare services should be provided through case work, group work and community work as primary methods of Social Work service delivery
	<b>Sub-theme 6.5:</b> Suggestions relating to the content to be included in guidelines for aftercare services to chemically addicted adolescents

#### **4.3.1 Thematic discussion of the perceptions and experiences of social workers regarding aftercare services to chemically addicted adolescents**

Under this sub-heading, the themes and related sub-themes will be presented one at a time. Each of the themes and sub-themes will be underscored by direct quotations made by the participants during the focus group discussions, and the research findings will be subjected to a literature control.

##### **Theme 1: Social workers perceive aftercare to chemically addicted adolescents as essential for life-long recovery**

All the social workers involved in aftercare services to the adolescents who participated in this study referred to **aftercare services as an essential component in the treatment of adolescent chemical addiction**. The following statements reflect this view:

*“Relapsing is a big problem. Like, when you look at how often clients relapse, then it’s quite clear that aftercare services are needed.”*

*“I think if you neglect it [referring to aftercare], all the other things we do become less successful.”*

*“Like, if we don’t help them to remain sober, what’s the point in helping them to get sober?”*

Continuing the previous item the following statements by participants stressed that **aftercare is essential, especially in view of obtaining life-long recovery from chemical addiction**:

*“Ja, essential, like.... because recovery is a lifelong process.”*

*“The moment they stop with the maintenance of the recovery they regress.”*

*“Yes, they will then go back to how they lived before they became sober because they are so used to it.”*

Keegan and Moss (2008:114) note that aftercare for adolescents suffering from chemical addiction is essential, and is viewed as the best predictor of successful recovery. The participants asserted that **aftercare treatment is crucial** and should **not** be seen as **optional when adolescent chemical addiction was being addressed**. In this regard they stated:

*“Regtig, dit [referring to aftercare services] moenie as opsioneel beskou word nie.”*

*“Dit [referring to aftercare treatment] is belangrik en dis deel van ‘n maatskaplike werker se werk. Dis nie of dit geïgnoreer kan word nie.”*

*“Ek sien nie baie suksesse met mense wat uit die sentrums kom nie... Miskien kan nasorg hiermee help.”*

*“Nasorg is seker die belangrikste deel.”*

*“Sien, in die sentrum is daar al hierdie ‘support’, maar dan kom hulle uit en skielik is daar niks.”*

*“Dit [referring to delivering aftercare services] is ‘n kritiese element van die hele rehabilitasieproses.”*

*“Die rehabilitasieproses is nie voltooi as nasorg nie plaasvind nie.”*

The social workers who participated in this study specifically referred to the fact that **a new lifestyle must be developed** after treatment, and that providing **aftercare services is crucial in this regard**. The participants stated the following in this regard:

*“It’s like this new lifestyle is strange. Aftercare must help them to get used to it.”*

*“It’s like this, if they don’t receive support to learn how to live well after they’ve been to treatment, the growing stops and then the recovery stops. And then relapsing becomes a real possibility.”*

*“I mean, going to a rehab does not mean you are cured. You must learn how to live like a sober person. That is why I think aftercare is essential.”*

Lessa and Scanlon (2006:275) note that the goal of aftercare is to prevent relapses. Relapse prevention should lead to the maintenance of cognitive and behavioural changes in order to sustain sobriety. The authors concur that the objectives are to prevent relapses by means of installing and utilising coping skills; preventing lapses (a slip) from escalating into relapses; and maintaining a balanced lifestyle. Supporting this argument, the Alberta Adolescent Recovery Centre in the United States (2007:2) highlights the following stages when dealing with adolescent chemical addiction: structured treatment; “habilitation” regarding appropriate life skills; and aftercare to support the adolescent when faced with the harsh realities once he/she leaves the safety of the treatment environment.

Debating the nature of aftercare services to CAAs, two social workers engaged in the following discussion:

*“Ek sien dit as noodsaaklik en ook as minder intensief.”*

*“Ek stem nie saam nie. Dis volgens my juis meer intensief. By nasorg moet die kliënt nou ‘commit’. Dis hier waar hulle leer om goed reg te doen.”*

*“Ja, maar dis meer verspreid, byvoorbeeld afspraak is nie weekliks nie, eerder elke tweede of derde week, maar vir ‘n langer tyd.”*

With regard to this discussion, Gouws et al. (2000:32) refer to the important developmental phase of adolescence, and note that the interruption of this development caused by chemical substance abuse should be considered when planning services. In line with this sentiment, Gorski (2001:2) warns that when the impaired development of the CAA is not addressed during and after treatment, the risk of relapsing increases. In further support, research points

to the fact that aftercare services to CAAs should be more intense than those of services to older persons suffering from chemical addiction. Adolescents need a longer treatment period because of the inherent developmental issues of adolescence (Alberta Adolescent Recovery Centre, 2007:1).

This theme highlights the participants' views regarding the value and nature of aftercare to CAAs. They described it as an essential part of treatment that should not be viewed as optional. The social workers acknowledged that recovery from chemical addiction is a life-long process. They linked the value of aftercare services with the development of new recovery lifestyles, and viewed this as essential to prevent relapses. In addition, they acknowledged that this service is different from prevention and treatment, and that it should be addressed in a different manner.

The following theme describes the social workers' perceptions and experiences relating to the aftercare services that they were rendering to CAAs at the time of this study.

## **Theme 2: Social workers' perceptions and experiences of current aftercare services delivered to chemically addicted adolescents**

The previous theme illuminated the fact that the participating social workers viewed aftercare to CAAs as essential to prevent relapses. This view is in line with Section 6 of the Prevention and Treatment of Drug Dependency Act of South Africa (1992), which states that chemically addicted persons should have access to professional aftercare services.

The data that emerged in relation to Theme 2 being presented in the discussion to follow were divided into two sub-themes: 1) although the social workers viewed aftercare as a "specialised field" of service delivery, it was currently not the case in practice; and 2) social workers' accounts of the format and content of aftercare services in practice rendered to CAAs.

**Sub-theme 2.1: Although social workers saw aftercare as a “specialised field” of service delivery it was currently not the case in practice**

The majority of the social worker participants (20 out of 29) reported that **aftercare services should be viewed as a specialised field in the Social Work profession**. The following two statements support the views that adolescent chemical addiction in the Western Cape (especially the addiction to methamphetamine) should be addressed as a matter of urgency and that it cannot be addressed as “yet another social problem” (cf. Caelers, 2005:1; Plúddeman et al., 2007:12):

*“It is [not] a focus area .... like an ‘add’-on or something.”*

*“Maar kom ons wees eerlik, die tik [referring to methamphetamine] probleem is ‘n sosiale krisis en dit word nie so hanteer nie.”*

The participants working at family welfare NGOs reported that they did not focus on addiction and specifically aftercare services *per se*, but rendering these services formed part of their caseloads. The following storylines testify to this:

*“Sien, al is ons fokus nie daarop nie [referring to addiction and rendering aftercare services as a field of specialisation], doen ons dit maar tog. As ons dit nie doen nie, doen ons nie ons werk nie. So, op die ou einde is dit altyd deel van gesinsorg. Ek ‘click’ dit nou eers [referring to the fact that aftercare services to chemically addicted client-systems form part of their reigm of service delivery], mens dink altyd dit hoort by SANCA.”*

*“Dit is belangrik en dis deel van ons werk, maar soms kyk jy nie na dit as nasorg nie.”*

*“Ja, ek dink dis half net deel van waaroor gesinsorg gaan. Jy kan nie anders dink nie.”*

*“Ons fokus op gesinsorg, en afhanklikheid moet aangespreek word as dit die gesin benadeel. So, in die geval van kinders moet ons betrokke wees, al is dit moeilik om samewerking te kry.”*



On the other hand, the following statements indicate that the participants felt that **aftercare was being neglected because it was not viewed as a specialised field and/or focus of attention during service delivery.**

*“En al doen ons ook nasorg is dit nie ‘n prioriteit nie. Hoe meer ons nou gesels hoe skuldiger voel ek.”*

*“Om eerlik te wees.....Dit moet ‘n prioriteit wees, maar dit is nie.”*

*“Also, we work with the most desperate people and then the ones who should be contacted for aftercare falls behind. I don’t like admitting this, but it happens. I guess....no, not just that. More like your priority is the one who sits in front of you. So the restriction is really that we need someone who focuses specifically in this area of addiction.”*

Not only do participants perceive aftercare to be neglected in practice, but one participant also mentioned the fact that **the irregularity of presenting aftercare services affected the quality of services.** She articulated it as follows: *“Ek bied ‘n nasorggroep aan, maar dis net een keer per maand, wat kontinuiteit benadeel.”*

The perception of one of the participants was that an out-patient programme was also part of an aftercare service. Another referred to the fact that out-patients formed part of aftercare groups, but that this could not be referred to as an aftercare group. The following storylines provide the detail:

*“I almost forgot: Our out-patient programme can also maybe serve as a sort of aftercare service.”*

*“Ons betrek ook buite pasiente [also referred to as day treatment, where patients remain in the community and participate in day treatment programmes (Alcohol and drug treatment referrals, 2009:7)] by die groep, so dis nie uitsluitlik ‘n nasorggroep nie.”*

Contrary to what is happening in practice as articulated by the participants in the above discussion, Fisher and Harrison (2005:155) refer to the need for training in aftercare and relapse prevention services, and concur that ongoing (i.e. aftercare) services should be specialised as they differ from in- and out-patient treatment in that aftercare focuses on the maintenance of changes

made during treatment. The following statements made by some of the participants underscore this statement:

*“‘Addiction’ moet ‘n gespesialiseerde gebied wees soos bejaardesorg. Ons kan nie ‘n gefokusde ordentlike diens op die been bring tussen als nie. Soos ek nou genoem het, dit moet tussen al die ander werk ingedruk word.”*

*“‘Bottomline’, ons dienste is beperk, en vrywilligers en groepe kan help, maar dan moet ons as ‘n span saamwerk. En dis makliker vir ‘n werker om netwerke te bou as dit ‘n spesialiteitsarea is. Anders is dit net nooit ‘n prioriteit nie. En almal moet gestandaardiseerde opleiding kry.”*

*“So if aftercare is your main focus area it would be easier.”*

Related to the latter statement, a participant also pointed to the **need for services to be available and accessible to CAAs following treatment**, which could be made possible **if aftercare is viewed as a specialised service**:

*“Daai ‘readiness for change equals availability of services’. As die kinders reg is vir behandeling moet daar dadelik opgetree kan word. Maar dan moet hulle wag vir afsprake en hulle kan nie by die groepe uitkom nie. ‘n Werker wat net op nasorg fokus kan hierdie probleem aanspreek.”*

Confirming this **need to develop aftercare services as a specialised field**, one participant reported that the Department of Social Development was attempting to address this issue when she stated:

*“Daar is wel nou ‘n skuif na meer gestruktureerde dienste. Die Departement het mos die nasorgwerker aangestel. Hy lei nou vrywilligers op om dienste te lewer en nasorgondersteuning te doen.”*

Apart from the fact that the participants saw aftercare service as a “specialised field” of service delivery to CAAs but that it was currently not the case in practice, the participants (in their comments) referred to the format and content of aftercare services currently available in practice. These accounts will be presented as the next sub-theme.

## **Sub-theme 2.2: Social workers' comments on the format and content of aftercare services in practice currently rendered to chemically addicted adolescents**

In cases where **aftercare services were rendered to CAAs**, the participants stated that these services **were offered in the format of working individually and in groups with these client-systems**. The following storylines attest to this:

*"We mainly work individually, like case work."*

*"I do group work.... Life skills programmes."*

A participant went on to state that the **aftercare services** rendered by his organisation **were mainly rendered through community work efforts** (i.e. community awareness, networking and training): *"We try to make it [referring to aftercare services] a community effort. So apart from the volunteers, we use welfare organisations and self-help groups. It's mainly people identified as persons who are involved in the community, like at schools or at the churches. The coordinators know the communities so they identify them [the volunteers]. The organisations have programmes in place, and then we establish networks between these services of different organisations. And we focus on this training, and then the coordinators monitor everything. They also must motivate all the role-players to stay involved."*

Relating to the **content and focus of the services rendered**, the participants stated the following:

*"Ons assesseer van vooraf."*

*"Ja, om nuwe 'challenges' te identifiseer en dan werk ons daarvolgens."*

*"Dit is gemik op aangebode situasies asook onderwerpe waarvoor hulle vra."*

*"Ons het ook 'n jeugprogram wat twee ure per dag aangebied word. Dit behels joga, oefening en sport en kuns."*

*"Ons dienste is baie 'life skills', soos kommunikasie, konflikhantering, besluitneming, veilige seks, en so."*

*“Die klem is hoofsaaklik op steun en ontlading.”*

*“Dan werk ons baie aan die ontwikkeling van insig. Ons sal byvoorbeeld verduidelik hoe die Wet [referring to Act 20/1992] werk en wat die gevolge van hul dade kan wees as hulle nie aandag gee aan die probleem nie.”*

*“Meestal gaan dit oor al die skade wat hulle aangerig het. Om dit reg te maak.”*

*“En ook verhoudings wat herstel moet word. O ja, en hoe om die ou vriende en temptasies te hanteer.”*

The literature consulted highlights the following with regards to the content and focus of aftercare: relapse prevention through the assessment of high-risk situations, how to cope with high-risk situations, the mobilisation and utilisation of support systems, and lifestyle changes (Marlatt & Gordon, 1985:46; Fisher & Harrison, 2005:162-170).

In view of the fact the chemical addiction may originate within the family system as a result of, and in relation to, the system dance going on inside the family, and the addiction which is subsequently maintained in the family (Gruber & Taylor, in Straussner & Fewell, 2006:3), the participants also referred to **rendering family services as part of their aftercare service delivery** to addicted adolescents.

*“We attempt to involve the family as well.”*

*“As hulle gemotiveerd is werk ons aan die gesinsverhoudinge en ook goed soos vertrou. Daar is mos maar baie bitterheid oor die skade... soos al die goed wat die kinders gesteel het.”*

*“Ons help met die heraanpassing in die gesin.”*

*“En ouerskap is iets waaraan ons deurlopend werk.”*

*“I continue with family therapy and assist when they need to deal with individual stuff that cannot be dealt with in groups.”*

According to Gruber and Taylor (in Straussner & Fewell, 2006:3), the family should be viewed as an integral part of aftercare services, considering that the family is an important potential treatment and recovery resource. In support of

this viewpoint, Saleeby (2006:199) believes that the development of social capital can be related to the external protective factor provided by the family of an addicted adolescent. Agreeing with these viewpoints, the Alberta Adolescent Recovery Centre in the United States (2007:2) views family therapy as part of aftercare as mandatory. It is advised by the latter that the family must develop insight regarding the dysfunctional communication patterns, rules, roles and boundaries, and make the relevant changes to ensure a family environment that is conducive to the recovery of the young person following treatment.

In the following statements the participants also referred to the way **support groups complement their aftercare service delivery**:

*“I try to involve NA and CAB, so then it’s a joint effort. They support and I do life skill training.”*

*“En ‘support’ groepe – jy kan maar opnoem dis hier. Ons verwys na AA, NA, Alateen, Tough Love en die Vigs groep.”*

*“Die AA vrywilliger wat ‘n hulpwerker by die groep is help wel, want hy motiveer lede om saam met hom twee keer per week AA groepe by te woon.”*

*“Die AA: Hulle kom twee keer per week bymekaar, reik uit na mense in herstel en is beskikbaar vr die afhanklikes.”*

*“Maar CAB trek nie baie van ons kliente nie. Ons verwys hulle, maar gee hulle die opsie, maar verreweg die meeste kies die AA groepe.”*

*“Oh, CAD is a nice connection we use. We refer our clients to them and it is really nice to know they support the clients too and not just us.”*

*“O ja, en CAD. Ons het ‘n sterk verhouding met hulle. Hulle gebruik ons kantore en ons kundigheid. Soos soms moet ons praatjies by hulle groepe lewer of aktiwiteite aanbied. Of hulle sal ‘n groeplid met huislike probleme na ons toe bring. En ons verwys weer kliënte na hulle groepe.”*

*“NA en AA. Ons gee vir die ouers en die kinders die kontak inligting, dan kan hulle dit gebruik. Ons AA is sterk en NA se groep hier raak ook nou sterker. Die kinders geniet nogal NA, maar AA is meer vir groot mense.”*

*“Die CAD en CAB help ook ons om die mense te motiveer en te ondersteun.....”*

In addition to support groups, the participants made reference to the fact that they **networked with other welfare organisations** in their **efforts to provide aftercare services and to benefit the CAAs**. The following quotations from the focus group interview transcripts make reference to this:

*“SANCA en ons [referring to the social worker’s organisation] verwys so heen en weer na mekaar. Dis ‘n lekker netwerk. Ja, en elkeen fokus op sy gebied en so kry die kind en die gesin ‘n beter diens. SANCA doen byvoorbeeld nie tuisbesoeke nie, so ons ‘cover’ weer daardie deel.”*

*“Jy werk in ‘n span. As daar organisasies is wat ‘n spesifieke diens lewer, verwys ons die kliënt, maar dit beteken nie ons los hom net nie. Ons gaan nog aan met die gesinsorg goed.”*

*“Tensy dit die hoof ‘issue’ is. So, as die ‘drugs’ die hoofprobleem is, dan lewer SANCA die diens en verwys net na ons vir gesinsorg, soos die ouers moet by ons oerleidingprogram inskakel en so.”*

*“Cape Mental Health is byvoorbeeld ‘great’ met die kinders wat psigoties is. Na die mediese onttrekking kan ons nog steeds niks doen as die kind psigoties is nie. Dan hanteer Cape Mental Health dit en dan kan ons dienste begin. So, ons het ook lekker ‘ties’ met die daghospitaal vir onttrekking en so aan. En hulle help ook wanneer iemand ‘relapse’, dan kan jy hom medies laat stabiliseer.”*

*“En soms gebruik ons NICRO en die werkloosheidkantoor se ‘youth desk’.”*

The participating social workers expressed a need for further knowledge to assist them with the rendering of aftercare services to CAAs, as discussed in the following theme.

### **Theme 3: Social workers expressed a need for further knowledge relating to aftercare services to chemically addicted adolescents**

The chemically addicted adolescents who participated in this study felt that some social workers lacked knowledge relating to adolescent chemical addiction (see Chapter 3, p. 128). Powis (in Becker, 2005:166) asserts that helping professionals often experience working with addicts as frustrating and unrewarding. In the opinion of this author, they often fail to recognise the addiction as a primary condition, focusing on underlying issues. As the primary condition is not the primary focus of the intervention process, progress is often limited, leading to the aforementioned frustration. Taleff (2006:2) continues with this line of thought and asserts that social workers' lack of knowledge pertaining to chemical addiction may lead to an inability to plan and execute services that would eliminate or, at the very least deal with, this social problem.

This theme focuses on the need for more knowledge specifically relating to aftercare services to CAAs as identified by the Social Work participants in this study. Meyer (2005:292-293) differentiates between three phases in the treatment of chemical addiction, namely detoxification, treatment programmes and aftercare. The participants specifically **requested more information relating to the aftercare component of the treatment.**

*“Like when you start to work here, they give you a manual, which is very nice, because then you have something to help you to get started. But it does not explain much about aftercare.... Just something on relapse prevention in general.”*

*“We have a nice manual in the office with information on addiction and nice aids to use during sessions. But it does not include aftercare stuff.”*

*“Yes, but it is nice when you are a young social worker to have that [referring to an information manual]..... Oh, they have something on relapse prevention....but ja, it [referring to aftercare] is not the main focus.”*

The social workers reported that a **lack of knowledge negatively impacts on their ability to plan and execute services successfully.**

*“I started working here in May. This is a new post and it is only aftercare. But I am the only one in our organisation who does it, so it is very new and nobody else really knows what works and what should be done and so. So I am feeling the pressure, because people want to see results from me, and I don’t know if I am on the right track.”*

*“It is the same with me. My post was created for aftercare in January, but it is new, so you have to start from scratch and you have to figure out what to do as you go along.”*

*“Nobody can tell us what works and what not so it’s like a bit difficult.....”*

Fisher and Harrison (2005:4) suggest that all helping professions need a basic knowledge base relating to chemical addiction, treatment and aftercare. This knowledge should lead to standardised methods of intervention. The authors add that this would prevent professionals from coming to misguided conclusions when assessing situations. Focusing on aftercare specifically, the authors conclude that a sound knowledge base regarding aftercare and relapse prevention will lead to relevant aftercare services.

In order to address the lack of knowledge regarding aftercare, as identified and confirmed by the participants in this study, the Department of Social Development (2008:14-15) developed a Draft Systems Model for Prevention and Aftercare. One participant referred to this draft as follows: *“The government gave an aftercare model. It’s only a draft and we have to make comments. It’s mainly theoretical, so it gives us an idea of what the focus should be, but it’s not a practical guide. And it’s only a draft, so it’s still somewhat vague, but it was something I could look at.”*

Concluding this theme, the literature studied by the researcher confirms that successful aftercare services should be based on evidence-based knowledge and experience (Fisher & Harrison, 2005:4; Juhnke & Hagedorn, 2006:61; Taleff, 2006:2).



In addition to the reported need for further knowledge regarding aftercare services to CAAs, the participating social workers spoke about obstacles when rendering these services, as presented in the next section of this discussion.

#### **Theme 4: Obstacles experienced by social workers in the rendering of aftercare services to chemically addicted adolescents**

The social workers who participated in the focus group discussions highlighted the following as obstacles during aftercare service delivery to addicted adolescents: a skills deficiency owing to a lack of training/uncertainty about the nature of training to equip community resources to render effective aftercare service; the lack of contact and alignment of programmes offered at treatment centres with aftercare service initiatives; lack of transport, inaccessibility and employment-related challenges; a high drop-out rate amongst CAAs and lack of commitment to aftercare services; difficulties experienced by CAAs in internalising new behaviour; the lack of time to render aftercare services owing to a lack of manpower and funds; and frustration when there is a lack of resources. The following sub-themes provide a description of these obstacles.

##### **Sub-theme 4.1: A skills deficiency owing to a lack of training/uncertainty about the nature of training to equip community resources to render effective aftercare service**

This problem was illustrated by the participants in the quotations below:

*“Ek is bekommerd oor die nasorggroepe wat by die staat fondse kry. Ons weet nie wie die groepe lei en wonder oor kwalifikasies, opleiding en standaarde. Hierdie geld gaan dus nie vir iets wat op bewese uitkomst berus nie”*

*“Maar dit kan ook ‘n probleem raak as die ondersteuners nie weet wat gaan aan nie. Hulle moet opgelei word. ‘n Pastoor van die ‘Dare to Care’ projek in Franschoek het nou die dag genoem hulle maak skade*

*want hulle weet nie wat hulle doen nie. Hulle wil help, maar hulle weet nie hoe nie. So vrywilligers moet opgelei word.”*

While these quotations refer to the fact that volunteers do want to help, but do not know what to do because of a lack of training, two of the participants referred to the fact that volunteers are indeed being trained. They stated:

*“I am not involved with patients. My job is to create networks in the Western Cape. I work with the substance abuse coordinators in the 12 districts. We try to train two volunteers per district, and the coordinators will then monitor the work of the volunteers and report to me. We have a training manual. We train them to run aftercare support groups.”*

*“CAD is nogal goed. Hulle [referring to the volunteers] word opgelei by Toevlug [an in-patient treatment programme], so hulle ken ‘addiction’ en ‘recovery’. Hulle kan miskien by die kinders betrokke raak. Ek weet op ander plekke het hulle al.”*

Fisher and Harrison (2005:4) argue that knowledge and training in chemical addiction and treatment should not be limited to social workers. They suggest that generalised training is needed for volunteers and other professions in the chemical addiction field, to ensure that all role-players work from a similar frame of conceptual reference. Majer et al. (2008:145), in focusing on other professional services, are of the view that the inclusion of the mental health profession in aftercare services to CAAs is crucial. It ensures that co-morbid substance-use disorders are addressed and that the emotional damage caused by the addiction is not ignored (cf. Mangrum & Spence, 2008:156; Kerwin, Walker-Smith & Kirby, 2006:180).

The need for standardised training of volunteers was referred to by the following utterance by a participant as: *“Ek dink ook behalwe dat jy moet noem dat dit ‘n spesialiteitsarea is, moet jy noem dat vrywillers opgelei moet word en dat dit gestandardiseer moet word.”*

The standardisation of training also refers to the standardisation of services, as highlighted in the following sub-theme.

#### **Sub-theme 4.2: The lack of contact between and alignment of programmes offered at treatment centres with aftercare service initiatives**

The view that aftercare as part of the complete treatment package (cf. Meyer, 2005:292-293) was confirmed by a participant stating: *“Dit [referring to aftercare] kan nie los of apart van behandeling staan nie”*. Contrary to this opinion, the majority of the participants referred to the lack of contact between and alignment of programmes offered at treatment centres with aftercare service initiatives as another obstacle in the rendering of aftercare services. The following storylines bear testimony to it:

*“Daar is nie ‘n gevestigde verhouding nie. Ook....ons weet nie wat die programme in die ‘rehab’ doen nie. Nasorg moet eintlik by hulle aansluit.”*

*“Ons [referring to the social workers in the field] en die mense by die rehabs het te min kontak.*

*“Maar ek dink nie dit [referring to new behaviour] kan in die ‘rehab’ heeltemal inge oefen word nie. Daar hoor die kliënt van al die goed en hy begin die nuwe gedrag probeer, maar dit moet by die huis deel gemaak word van sy lewe.”*

*“Maybe the rehabs should expose them to these groups [referring to aftercare groups] while they are there. And maybe connect them with groups in their areas while they are in treatment, then they will know the people and not be shy to go.”*

*“I think rehabs tell them about aftercare’s importance, but they still don’t realise that it is ongoing and that it is not really an option. They’ve got to do it.”*

*“Ja, die voordele van nasorg moet baie beklemtoon word in die ‘rehab’, dat die kind uitsien om dit by te woon.”*

*“They must be ready for aftercare to be open to aftercare.”*

This lack of contact between the social workers in die field providing aftercare services and the treatment centres causes the aftercare workers not to have

established relationships with the adolescents in treatment. The following statements serve as confirmation:

*“Ja, maar dit is ook waar dat die mense baie keer nie eens weet dat daar dienste is nie, of waar dit is nie [referring to aftercare services].”*

*“As hulle uit die sentrums kom is dit baie keer die eerste keer wat ons betrokke raak. Die ‘rehab’ doen deesdae die assesserings en die opnames, ons is baie keer nie deel daarvan nie. Net as dit ‘n statutêre geval is.”*

In addition to the need for contact between treatment centres and those providing aftercare, the alignment and integration of services, as well as involving the aftercare social workers and/or introducing them to the clients while they are in treatment, the participants also **stated that the adolescents need to be prepared for treatment:**

*“Die verskil kom in by die voorbereiding vir behandeling. As dit goed gedoen was is die kliënt meer gereed vir verandering wanneer hy by die ‘rehab’ kom en dan is hy gouer sterker.”*

*“[If they are well prepared for treatment]...dan is hulle ook minder bang vir weggaan van die huis en dan is die weerstand ook minder.”*

*“Ons [referring to the social workers in the field] en die mense by die rehabs het te min kontak. Hulle moet die kind goed ‘prepare’ vir nasorg, soos ons hulle goed moet ‘prepare’ vir treatment.”*

Two of the participants also noted **the involvement of the family in family conferences at the treatment centres**, where the aftercare worker is present, **could assist in the establishment of a personal relationship between the aftercare worker, the adolescent, and the family:**

*“Die gesinskonferensies by De Novo help ook baie vir die voorbereiding op nasorgdienste. Dit skep ‘n klimaat vir versoening en dan is dit ook makliker om aan te gaan met dienste, want die kind, die ouers en ons is by..... so, almal het ‘n vertrekpunt vir waar jy kan aangaan wanneer die kind by die huis kom.”*

*“Ja, die gesin verstaan mekaar en die afhanklikheid beter. Dan kan hulle krisesse beter hanteer.”*

In the literature, Sussman and Ames (2001:110) accentuate the need for communication and collaboration in view of alignment of the services provided between the treatment centres and aftercare service providers. A study in Germany conducted by Braig, Beutel, Toepler and Peter (2008:104) illustrates the need among addicted persons who receive treatment for information regarding aftercare services. In addition, participants reported that the interaction and cooperation between the sub-systems, as well as between the systems and field practitioners, were poor, and affected their ability to commit to aftercare (Braig et al., 2008:105-108).

#### **Sub-theme 4.3: Lack of transport, inaccessibility, lack of knowledge about aftercare services and employment-related challenges**

A study by Myers et al. (2007:1) conducted in the Western Cape concurs with these obstacles. They found that an inability to afford transport to services, the fact that clients have to take unpaid leave from places of employment to attend aftercare services, the fact that aftercare services were geographically inaccessible and a lack of awareness about the availability and location of services contributed to the underutilisation of services.

**The lack of transport, as well as the geographical inaccessibility of aftercare services limits client-system to utilise the services.**

*“Nasorg is ‘n groot behoefte.... maar die probleem is dat dienste nie eintlik toeganklik is nie.”*

*“Transport to support groups can also be a problem. The groups mainly gather at night and it can be dangerous. Especially for the ladies.”*

*“Ja, byvoorbeeld sommiges het nie vervoer nie en dis saans gevaarlik om in die strate te loop.”*

*“En toeganklikheid tot ander ondersteuning, soos die nasorggroepe is ‘n probleem.”*

*“So, groups must be more accessible in terms of distance and transport.”*

In addition to lack of transport and distance to aftercare initiatives, the **inability to attend aftercare programmes during day-time because of work obligations and fear of losing their employment were also identified as problems:**

*“O ja, en baie kliente kan nie in die dag by ons uitkom nie.”*

*“En baie begin werk of skoolgaan en kan nie in die dag by ons uitkom nie.”*

*“Werkgewers is dikwels onrealisties en dink hulle akkomodeer ‘n persoon as hy een keer per maand ons kan kom sien.”*

*“Die kinders is desperaat vir werk en bang om dit te verloor.”*

#### **Sub-theme 4.4: A high drop-out rate amongst chemically addicted adolescents and lack of commitment to aftercare services**

The Social Work participants reported a **high drop-out rate from aftercare services amongst CAAs**, and **attributed it to a lack of commitment to aftercare services.**

*“Ons ‘drop-out’ syfer by nasorg is net baie hoog. Na ‘rehab’ dink die kinders en die ouers hulle is ‘fine’ en ‘bother’ nie met nasorg nie. Dan as die ‘relapse’ kom, is hulle weer hier.”*

*“Oh, I struggle with a high drop-out figure. I think they see aftercare as work and they’re not committed to make an effort. It’s like that all over. I mean with me, people come in desperate and we start to prepare the person for treatment, then they drop out, then they return.... And so it goes.”*

*“Yes, they give their support before treatment because they are desperate, but then they think rehab will fix all the problems. Then we struggle to get them to come for aftercare.”*

This high drop-out rate might be ascribed to a **lack of motivation to commit to the aftercare services** as put into words by the participants:

*“Ja, die sentrums stuur ‘n verslag. ‘n Mens kan dan al sien of iemand gemotiveerd is.”*

*“Afhanklikes is baie keer ongemotiveerd. Hulle daag net nie op nadat hulle uit die sentrums kom nie.”*

*“Dit wys ook of hulle gemotiveerd is, as hulle nie opdaag nie, is hulle ongemotiveerd.”*

*“Ja, it’s like they lack motivation. Or insight....of how easy a relapse can happen. It goes back to that internal motivation we said.”*

*“Our clients are like...they come here desperate, but after treatment they think they are ok.”*

*“Maar as hulle nie wil nie [referring to attending aftercare services], kan ons nie agter hulle aanloop nie.”*

*“Like, they must decide for themselves that they want to stop, it must be what they want.”*

One participant suggested an explanation for the high drop-out rate: *“Some people after rehab.... it’s like they almost want to forget about the past and our aftercare efforts remind them.”*

Malhotra et al. (2007:1) concur that CAAs must learn to value their sobriety and commit themselves to change as the long-term goal of recovery. With reference to the lack of motivation stated above, Falkowski (2003:46) notes that in order to prevent relapses from occurring, the CAA must draw on his/her intrinsic levels of motivation. Intrinsic motivation is characterised by an eagerness to learn and grow, as well as a strong will to succeed. These characteristics lead to the will to make an effort to change. On the other hand, extrinsic motivation is associated with passive behaviour, and the characteristics include dependence on others, striving for approval from others, limited consequential thinking, and the peer group definition of what is right and what is wrong (Gouws et al., 2000:60; Bezuidenhout & Joubert, 2003:165-167).

#### **Sub-theme 4.5: Difficulties experienced by chemically addicted adolescents in internalising new behaviour**

Powis (in Becker, 2005:173-174) postulates that people addicted to chemical substances generally suffer from a fragile sense of self. They use acting-out behaviour, by means of overly self-assured and attention-seeking behaviour, to protect themselves. The low self-esteem can be linked with the shame they feel. An improved sense of self-worth could therefore contribute to behaviour change. In support of this viewpoint, Hepworth et al. (2006:526) state that behaviour is often motivated by hidden reasons, e.g. to protect a poor self-image, to deal with fear, and to hide feelings of incompetence. These authors advise that clients be empathically assisted to identify, interpret and deal with reasons behind their behaviours.

The social workers who participated in this study acknowledged the importance of the **change in behaviour**, and the fact that it **is not easy to achieve, as an obstacle to attend to during the rendering of aftercare services.**

*“Maar die kinders sukkel om nuwe gedrag te internaliseer.”*

*“Die kliënt moet na ‘rehab’ gehelp word om nuwe gedrag aan te leer.”*

*“Maar dis nie net vir afleer en aanleer nie. Die kliënt moet dit oefen tot dit natuurlik kom. Dis..... ‘n proses, eers oefen, dan uitleef.”*

The difficulties experienced in internalising new behaviour that were referred to by the Social Work participants were also described by the adolescent group who participated in this study (see Chapter 3, p. 135).

The social workers also mentioned that **the influence of the peer group adds to the challenges** already faced by addicted young people in internalising new behaviour that would aid recovery and maintain sobriety. They articulated it as follows:

*“Soms voel dit of hulle mekaar aansteek en dat dit die impak van die groep benadeel. Ons impak is dus nie sterker as die groep nie.”*



*“Ek doen soms klein groepies. Maar nie meer as vyf lede nie. Dan kan hulle mekaar ondersteun, maar jy jy moet ‘n goeie keuringsproses hê. Anders verlei hulle mekaar, dan werk dit nie. Dit moet gemotiveerde kinders wees met dieselfde belangstellings.”*

*“Die omgewingsinvloede is baie sterk. Die groeplede is almal baie gemaklik met ou siek gedragpatrone.”*

Different views regarding the role and influence of the peer group were found in the literature. On the one hand, the importance of the impact of the peer group is accentuated. Bezuidenhout and Joubert (2003:66) state that adolescents display the need to spend more time with their peers and less time with their families. This sentiment is echoed by Gouws et al. (2000:74), who note that the adolescent peer groups function as support, a reference to develop norms, and recreation. Acceptance by peers is an important motivational factor in adolescent behaviour. It influences the choices they make and their subsequent behaviour (Gouws et al., 2000:67). Regarding positive peer influences, Arterburn and Burns (2007:41) concur that peers assist each other to develop values and norms, and to change behaviour accordingly.

On the other hand, peer influences may pose the danger of limiting the recovery potential of CAAs. Dodge, Dishion and Lansford (2006:4) warn that group work with deviant peers (in this case substance-using peers) poses the threat that it segregates these adolescents from healthy peers, leads to labelling, and reinforces deviant behaviours. McWhirter et al. (2004:119) are of the opinion that peers strongly influence the adolescent's decision to relapse to chemical substance abuse, but also note that chemical substances replace the social activity of the addicted adolescent, which decreases the influence of the peer group (cf. Butts & Roman, 2004:195; Brandt & Delpont, 2005:165; Cook & Ludwig, in Dodge et al, 2006:66). Rejection by peers negatively impacts on the adolescent's self-confidence, which then leads to harmful choices. It is important to note that adolescents will conform to the values and norms of the group where they are being accepted, which impacts

on their ability to change behaviour successfully (Louw & Louw, 2007:281-282).

Summarising the above viewpoints, McNeece and DiNito (1998:218) and Bezuidenhout and Joubert (2003:66) stress that peer group and environmental changes are important aspects of relapse prevention. The peer group can assist in the maintenance of old harmful behaviour, or in the development of new healthy behaviour.

#### **Sub-theme 4.6: The lack of time to render aftercare services due to a lack of manpower and funds**

The participating social workers referred to a **lack of time to deliver proper aftercare services** which in turn **are brought about by a lack of manpower**.

*“Wat ons doen is net vure doodslaan, nie wat ek voel ons moet doen nie.[referring to rendering of aftercare services]”*

*“Dit maak dat daar min werk satisfaksie is.”*

*“Ja en dit [lack of time to render aftercare services] veroorsaak spanning, want jy voel altyd dat daar meer is wat jy wil doen.”*

*“Dit werk so: Ons glo dit moet baie aandag kry, maar ons kom net nie daarby uit nie [referring to the rendering of aftercare services].”*

*“Mannekrag is broodnodig.”*

*“Die gebrek aan kapasiteit in die kantoor maak dat ons net op krisishantering kan fokus.”*

*“Jy het ook mannekrag hiervoor nodig en daarmee saam fondse.”*

*“En fondse bly altyd ‘n probleem.”*

*“En hier sukkel ons om dinge reg te probeer doen as gevolg van ‘n tekort aan fondse.”*

*“Ja, jy kan nie die kantoor kapasiteit ontwikkel sonder geld nie.”*

One participant also referred to a **lack of physical space to render aftercare services** when she stated: *“Kantoorruimte! Hier is nie plek vir groepe nie en jy kan vergeet om aktiwiteite en so hier te doen, dis net te beknop.”*

The lack of manpower referred to above is confirmed in the literature. Oliphant (2009:12) notes that Social Work is fast becoming a scarce skill in South Africa, as between 50 and 60 social workers leave the profession every three months for better opportunities overseas. In March 2009, the former South African Minister of Social Development, Mr. Skweyiya, (as quoted by Chilwane, 2009:1) acknowledged that social workers did not receive the same support and acknowledgement as nurses and teachers in South Africa. He recognised the lack of manpower and referred to the South African government's retention and recruitment strategy in order to address this concern. Rosenberg (2008:27) asserts that the lack of manpower restricts the quality of services to CAAs. The author states that when a client (in this case a CAA) is ready for treatment (i.e. aftercare services to continue growth obtained in treatment programmes), this window of opportunity must be used to prevent further damage. Therefore, clients must be able to find someone to assist them, without waiting for an appointment (Rosenberg, 2008:238).

#### **Sub-theme 4.7: Social workers expressed frustration when there is a lack of resources**

The social workers who participated in this study linked the need to utilise resources with the availability of services as well as their inability to be available at all times.

*“Ek woon en werk in Ashton. So as daar 'n crises is dan kom hulle na ure na my huis toe. Dit is regtig swaar vir my, maar daar is geen hulpbronne nie...behalwe die predikante, so wat moet jy doen?”*

*“En ons kan nie 24/7 daar wees nie, maar mense sien dit nie so nie.”*

*“Lots of clients want to come when they need you, then you have to be available. But it is not possible. I mean, you have more than one client, and you need to have your own life too. You cannot work 24 hours a day and not burn out.”*

The responses from the Social Work participants study indicate that the utilisation of resources is based on binding and bridging social capital (The Western Cape Department of Social Development, 2009:1-2). They referred

to resources that enabled them to improve the quality of aftercare services, but also referred to frustrations in this regard. They said that employers did not always accommodate contact with the adolescents, parents or volunteers, and reported a concern regarding the involvement of schools and churches:

*“Ja, plaaseienaars is soms positief oor ons dienste, maar meestal is hulle net bekommerd dat die werk gedoen moet word.”*

*“Ons sukkel om ouers in werkstyd te kan sien. So as ons die bekeerdes wil gebruik, gaan ons dieselfde probleem kry.”*

*“Die kerke en skole bekommer my, want hulle het aktiwiteite wat adolossente in herstel kan help, maar hulle word nie regtig geakkomodeer en ingetrek nie. Dienste is op die gesonde kinders gemik. Ek dink die persone in beheer is nie werklik ingestel om ‘addicts’ te help nie.”*

On the other hand, the participants referred to employers, schools, church leaders, sport clubs and doctors as resources (individuals and institutions) that assisted them.

*“Ons werk mos hoofsaaklik op plase. Die boere en skole is ook ‘nice’ hulpbronne. Die skole sal enige iets wat ons voorstel of vra doen. Daar is geen weerstand nie. En boere help met die vervoer en betaal die mense as hulle in werkstyd vir ons moet kom sien.”*

*“Predikante... ons het ook ‘n dokter wat graag help met onttrekking en so. Maar die afhanklikes misbruik baie keer die mense wat wil help.... Hulle soek hulp as dit ‘n crises is, maar wil nie op die langtermyn ‘commit’ vir hulp nie.”*

*“I use schools and churches..... They help me to get to the kids, but nothing else.....”*

*“En ons het baie sport klubs. Ek help gereeld kinders wat wil sport doen en wegkom van ou vriende na sportklubs.”*

Regarding support groups, NA (Narcotics Anonymous), AA (Alcoholics Anonymous), CAB (Christelike Afhanklikheidsbond) and CAD (Christelike Afhanklikheidsdiens) were identified as resources while the following frustrations were identified:

*“Ons verwys die mense, maar daar is nie ‘n NA vir die kinders nie. En ook daardie vervoerkwessie...”*

*“Ja, ek wil nie mense daarheen verwys nie, want ek is onseker oor hul stabiliteit. Soos met die jeug-program kan dit negatiewe invloede versterk.”*

*“It’s like they don’t understand AA’s value, like you will be laughed at if you go there.”*

*“Dit sou ook baie gehelp het as NA by ons stabiel en gevestig was.”*

*“Ons het ook ‘n AA. Maar hulle is minder sigbaar... amper soos ‘n ‘click’. Die lede is al jare betrokke en ondersteun mekaar baie goed. Dit werk goed vir hulle. So nou en dan skakel nuwe mense wel suksesvol by hulle in. Maar AA wil nie die skade van die verlede vergeet nie, sodat jy kan onthou hoekom jy nugter wil bly. Maar party mense wil net aanbeweeg en vergeet.”*

*“En AA werk nie so lekker vir kinders nie. Ek dink dis maar dis dat die lede ouer is en die kinders is mos maar moeilik van al die ‘drugs’ en dinge.”*

*“Maar by die CAB is dit meestal net mense wat aan die VGK behoort.”*

In line with the aforementioned frustrations regarding accessibility, lack of compatibility with adolescent needs, and acceptance of these resources by clients, a participant reported the following: *“AA and NA... but our patients are not too keen to go. We give them the numbers, but I don’t think they use them...”*

The researcher found the following confirmation of the value of self-help groups in the literature. Often self-help groups are effective in supporting the addict and the family, and addressing the feelings related to the addiction (McNeece & DiNito, 1998:221-226; Goodwin, 2000:146). Self-help groups pose the following advantages (Powis, in Becker, 2005:170; Sheafor & Horejsi, 2006:353): they assist with improved social functioning; they use social support networks to enhance integration in society after in-patient treatment; they encourage mutual support by and from members; NA is based on the anonymity of its members, thus addressing the issue of confidentiality;

they develop hope and optimism through credible peers; and they model healthy recovery lifestyles.

On the other hand, Miller (2008:166) questions the validity of the NA 12-Steps Programme. The author views this programme as confrontational in nature. In addition, the fact that it places the emphasis on the fact that the client must accept the disease of addiction, could lead the client to hide behind the addiction and not take responsibility for his/her addiction. However, the author admits to the lack of social networks and support in our societies and therefore concurs that the NA self-help groups and the 12-Steps Programme are available and free of charge, making them accessible. In defence of the 12-Steps Programme, Gordon (2002:14-15) notes that these steps address the addiction, cognitive aspects, and behavioural changes, as well as spiritual development. The author concludes that this programme is a valuable tool to address the shortages of external resources; it is affordable and it assists in the problem of high drop-out rates from formal services.

#### **Theme 5: Social workers' views of the role of the family in aftercare to chemically addicted adolescents**

Fisher and Harrison (2005:192) consider the family to be a living, adaptable, goal-orientated, open system; comprised of sub-systems that are (owing to their common interests and system goals) continually in interaction with one another and their internal and external environment. The CAA is an indistinguishable part of the family. Family involvement is therefore a crucial component of aftercare services to addicted youngsters. The family needs assistance to develop insight into the dysfunctional communication patterns, rules, roles and boundaries that are part of the family system, and be guided to make the relevant changes to ensure a family environment that is conducive to the recovery of an addicted adolescent (Arterburn & Burns, 2007:14-15; Alberta Adolescent Recovery Centre, 2007:2).

Based on this view from the literature, this theme has portrayed the views of the participating social workers on the role of the family in aftercare to CAAs.

The comments from the participants have been grouped under the following sub-themes: 1) Families' lack of insight regarding recovery from chemical addiction; 2) training and support of the family regarding the impact of chemical addiction and the recovery process, 3) reintegration into the family in terms of development of a healthy family structure, and 4) addressing the family members' own problems to ensure a family system that is able to support the addicted adolescent following treatment. The views expressed in this theme correspond with the sentiments articulated by the adolescents, especially the need to rebuild their relationships with their families, and to be reintegrated into the family as part of their aftercare needs (see Chapter 3, p. 153).

### **Sub-theme 5.1: Families lack insight into the recovery process**

The lack of knowledge regarding recovery from chemical addiction, and the need to include services to the families of CAAs, were referred to in the following statements by the participating social workers:

*"I think the family don't understand that we cannot make people stop, and the addict just isn't ready."*

*"Ouers verstaan nie hoe hulle gedrag die kind se herstel beïnvloed nie."*

*"Ja as hulle nie deel van die proses is nie, is dit makliker vir die kind om na die ou leefstyl terug te val."*

However, the social workers were not sure whether this process should be addressed as a separate service or not. This can be seen in following utterances:

*"Maybe the families must be included in the whole process."*

*"I think rather separate and sometimes together... Like NA and NARANON. I mean, otherwise all the focus is on the addict and the families still don't work on themselves."*

Goodwin (2000:73) is of the opinion that the family should learn to identify and to understand the addiction, as well as the recovery process. In support of this viewpoint, Gorski (as cited in Fisher & Harrison, 2005:158) identifies the

following focus areas that should receive attention when the families are assisted to develop insight regarding the recovery process: The family and the addicted adolescent must recognise the addiction, recognise the need for lifelong abstinence, develop and use an ongoing recovery programme to maintain abstinence, and deal with other problems that may interfere with the recovery potential (Gorski as cited in Fisher & Harrison, 2005:158).

In order to address this lack of insight, the participants reported that families need to be trained to become supportive of the CAA, as discussed in the next sub-theme.

### **Sub-theme 5.2: Families need training and support to be able to support chemically addicted adolescents**

Families where the CAAs relapsed following previous treatment find it difficult to continue supporting further treatment. Allen-Meares and Garvin (2000:304) are of the opinion that these families are heavily affected by the substance abuse. The initial recovery gives hope to the parents, but the subsequent relapse causes disappointment, conflict and immense concern. This sentiment, as well as the discussion under the previous sub-theme relating to the fact that the family does not understand the process of change and recovery and therefore loses hope, is confirmed by the following statement by one of the participants: *“Like if they work according to the Model of Change, and then they will see how their support can help their children.”*

The literature provided the following view on the value of training and support of the family to become supportive of the CAA: According to the Matrix Institute on Addiction (2008a:23) and Keegan & Moss (2008:111), the benefits of family involvement in aftercare are associated with better treatment compliance and outcomes. If the family understands the process of recovery, it can contribute accordingly. The family also understands respective goals and roles pertaining to the aftercare. Family members can support one another; they are able to communicate openly and honestly, and to resolve conflict; they are able to change destructive behaviours in the family; and



family bonds are strengthened. Page and Page (2003:59-62) and Fuller (2007:7) describe the value of family support in that it assists the adolescent in recovery to develop resilience, and thereby to prevent relapses. Resilience is characterised by distancing the self from events and circumstances, and demonstrates the existence of a strong social network. According to Fuller (2007:7), acceptance and unconditional love from the family are essential to building resilience among CAAs. However, the author warns that it does not imply a lack of boundaries and discipline.

Support by the family is also an important way to deal with cravings. Gorski (2001:5) notes that CAAs and their families should learn to identify the early warning signs of a relapse. Furthermore, they should be assisted in learning how to manage these warning signs. Barber (2002:144) and Keegan and Moss (2008:111) add that the family can assist addicted members to deal with stress, motivate them to maintain changes made towards recovery, and assist and support them regarding environmental triggers.

However, the Social Work participants reported that the **families of CAAs often do not realise their significance following treatment.**

*“Families also don’t understand their role. When they’re desperate we must fix things, but they can’t see their role and that they need to be part of the process. They do not understand that their support is very important. We need to work on this issue as part of aftercare”*

*“It’s like they think only the addict needs it. It is like.... It’s between the social worker and the child and that they don’t have to be part of it. I think we need to have sessions with parents to teach them about this.”*

The following statements illustrate the fact that in **order to be able to develop support from the family, guidance to the parents is needed:**

*“Ouers het oerleiding nodig.”*

*“Dis ‘shocking’, ouers weet nie hoe om te wys hulle is lief vir hulle kinders nie..... En dissipline, roetine, sulke goed. Daar is soms net geen ‘skills’ by die ouers.”*

The Structural Approach developed by Salvador Minuchin and Associates accentuates the need to empower parents “to parent their children” as part of relapse prevention (Minuchin in McNeece & DiNito, 1998:222). Gouws et al. (2000:71) and Pires and Jenkin (2007:170) assert that the authoritative parental style appears to be the most effective, when parents are faced with problematic adolescent issues such as chemical substance abuse. Characteristics of this parental style which could be valuable when supporting the CAAs in the family include: clear limits and rules; being prepared to negotiate; assistance to deal with consequences of behaviours and choices, without protecting the adolescent; open communication; provision of warmth and care; consistency and clear boundaries that contribute to the adolescent’s ability to attain developmental tasks; affective relationships; support for the adolescent’s efforts to recover, and the ability to resolve conflict (cf. Saleeby, 2006:204). This parental style poses the added advantage that conflict with parents, typical of adolescence, should not be viewed as necessarily problematic. It can be used to develop communication, negotiation, and assertiveness skills (Louw & Louw, 2007:326).

Subsequent to the development of insight and knowledge into the value and nature of their role to support the CAA following treatment, the family should be assisted to enable reintegration of the adolescent into the family.

### **Sub-theme 5.3: The reintegration of the chemically addicted adolescent into the family**

Keegan and Moss (2008:131-133) advise that aftercare should assist CAAs and their families with reintegration by means of 1) rebuilding trust in relationships amongst them, 2) the development of a healthy self-esteem, and 3) acceptance of the addiction and recovery as a permanent lifestyle. Barrett and Ollendick (2004:337) note that family therapy as part of treatment and aftercare for adolescent addiction has strong empirical support. Parental support and caring is a vital key to reintegration into the family following treatment, and are identified by their availability, positive regard, kindness, and a sense of “you matter”. Allen-Meares and Garvin (2000:309) add the

following key family areas to be addressed in order to ensure successful reintegration: belief systems, organisational patterns and communication patterns. In support of this, Fraser (2002:122) asserts that relapse prevention should include the adjustment of family management practices.

The participating social workers acknowledged the value of **reintegration into the family as an important aftercare need**.

*“Maar ook... dis moeilik. As hulle by die huis terug is, dan is dit net.... Wat nou? Dis of hulle weer vir die wolwe gegooi word.”*

*“Hulle weet nie hoe nou nie [referring to how to continue with growth developed in the treatment centre]. In die sentrum is een ding, maar by die huis is dit moeilik.”*

*“Nasorg moet help met die aanpassing terug by die huis.”*

*“Ook... as hulle nie regkry om nugter te bly nie, dan isoleer hulle hulself en assosieer net met ander afhanklikes.”*

*“Ja. As hulle terugkom by die huis en daar is probleme om aan te pas, is die ‘temptations’ baie groot en dan kan hulle nie op hulle eie regkom nie. So..... as nasorg dan nie gebeur nie, is die behandeling ook daarmee heen.”*

The social workers, however, did not provide much information regarding what this process should entail. The literature highlights the following focal points regarding the elements in the family's total ecosystem that should be addressed: all attitudes, behaviour patterns, relationships and roles in the family and other relevant systems (Fisher & Harrison, 2005:200; Hepworth et al., 2006:261-264). Reintegration into the family should assist the adolescent to master **developmental tasks**, including: finding a place in society; acquiring interpersonal skills; cultivating tolerance for the differences between people and groups; making own decisions; developing self-confidence; becoming comfortable with own values; learning new roles related to independent adulthood; and developing a group identity (Gouws et al., 2000:67-68). Parental interest, understanding, approval, acceptance, trust, guidance, example, and discipline are factors contributing to the adolescent's ability to master developmental tasks that should be included in services

aimed at the reintegration into the family (McNeece & DiNito, 1998:221; Gouws et al., 2000:67; Mans, 2000:10).

In the family system, chemical substance-related behaviour leads to **communication patterns** that tend towards avoidance of real cooperation and responsibility, and become distorted and incongruent on verbal and non-verbal levels (Fisher & Harrison, 2005:200; Hepworth et al., 2006:261-264). According to the United Nations (2003:4) and Gruber and Taylor (in Straussner & Fewell, 2006:15), the risk of relapse is high if adolescents are exposed to family conflict and poor communication, and are unable to deal with family tension following treatment. Therefore, either the home environment must change or the way the addicted adolescent relates to the environment must change (United Nations, 2003:14). Aftercare services aimed at altering communication patterns in the family could assist in the family's ability to allow the youngster to reintegrate into the family.

Another aspect that impacts on the adolescent's ability to reintegrate into the family is **family boundaries**. Fisher and Harrison (2005:200) assert that functional families have supple, penetrable boundaries that are not too diffuse or too rigid. The authors describe this aspect as follows: They have an appropriate "us-feeling" that does not imply an "us-against-the-world-feeling". In the case of the addicted adolescent, it is important to understand and to deal with the typical isolation of the addicted family system because the boundaries appear either diffuse or rigid. If the boundaries are rigid, no information is allowed in or out. Because of the "don't talk rule" in the family, there is an agreement to remain silent and maintain an attitude of "We don't air our dirty linen and we don't need anything from anybody". If the family boundaries are diffused, then there is no sense of unity in the family, and people move in and out without any control. Because no limitations exist, the situation can be described as chaotic.

Concluding this discussion, **family rules** also impact on the potential to reintegrate successfully into the family. The following are informal but binding rules of the addicted family, all of which are for the purpose of facilitating

denial of reality. 1) The adolescent's substance abuse is the most important aspect in the family life and all other family members' priorities and needs are overshadowed by the addiction. 2) The addiction is viewed as the cause of the family problems. 3) Every person in the family ought to be an enabler. 4) No family member may discuss what really happens in the family with other family members or outsiders, and 5) no one may say how they really feel (Fisher & Harrison, 2005:195-198; Hepworth et al., 2006:247).

The ability to support the CAA to reintegrate into the family following treatment is influenced by the family members ability to address own problems, as discussed next.

#### **Sub-theme 5.4: Family members must be supported to address their own problems that impact on recovery potential of chemically addicted adolescents**

The need to address family members' own problems was identified as follows:  
*"Dikwels het hulle self probleme wat dringend moet aandag kry."*

McWhirter et al. (2004:123) warn that adolescents are placed at risk when they have to deal with family problems and enter into life roles before acquiring the necessary life skills. The importance of addressing the problems of other family members as part of aftercare becomes apparent. The participating social workers specifically focused on **abuse of chemical substances as an area to address among family members**. Utterances referring to this were:

*"En as die ouers in vrye tyd drink, dan is dit wat die kinders leer."*

*"Dis baie waar. Die ouers drink, so die kinders drink, want dis al wat hulle ken."*

*"Ek sukkel met die gesinne en die gemeenskap wat drank en dwelms gebruik asof dit normaal is. En dit orals beskikbaar, selfs onder graad drie kinders. Hoe moet die kinders sterk bly?"*

On the other hand, it is important to note that the fact that family life does not always improve, does not have to mean that CAAs cannot recover. They need assistance in dealing with the situation, and to use other resources, such as schools and churches (Saleeby, 2006:204).

In the discussion to follow a description of social workers' suggestions on practical guidelines for rendering aftercare services to CAAs will be presented.

### **Theme 6: Social workers' suggestions with reference to the development of practice guidelines for rendering aftercare services to chemically addicted adolescents**

In 2005, the Western Cape Drug Forum (2005:3) identified the need for the development of aftercare services, indicating the lack of focus on aftercare as part of treatment. The following statements also highlight **the need to develop aftercare guidelines to assist social workers working with CAAs in the Western Cape:**

*“So, ons probeer nou om ‘n ordentlike program te ontwikkel.”*

*“Maar daar is nie ‘n gevestigde plan of program wat ons kan volg vir nasorg nie.”*

*“En dan doen ons op die einde eintlik niks nie.”*

*“Ja, soos ons nou werk slaan ons net vure dood en niks dienste is deurlopend nie.”*

*“Ons het ‘n ‘manual’ oor middelafhanklikheid, maar nasorg word nie spesifiek gedek nie.”*

*“I think it is because social workers just work with what is in front of them, but they don't have a plan.”*

Based on the suggestions of the social workers' with reference to the development of practice guidelines for rendering aftercare services to CAAs, this sub-theme was divided into several sub-themes. Each of these will now be presented.

**Sub-theme 6.1: Practice guidelines for rendering aftercare services to chemically addicted adolescents should be standardised, and structured in a step-by-step format**

One of the social workers suggested that **aftercare guidelines should be structured** in such a way that they could be used **as a manual to ensure that services are standardised** and stated: *“Ek sal hou van ‘n nasorg ‘manual’. Dan het jy alles bymekaar. En dan werk mense dieselfde. Dit skep so half ‘n standaard.”*

In line with this concept of a manual to assist them to deliver standardised aftercare services, the participants perceived **aftercare guidelines as a way to plan their workloads, and to develop aftercare plans for their adolescent clients.**

*“Deur dit in jou werksplan in te werk.... So jou bestuur van jou werkslading en beplanning en so aan.”*

*“Yes, the whole process. You can adjust it, but at least you have a basic plan.”*

*“It should enable us to assess the needs are at that moment. Like, I have a programme, but I change it as I see they need something else.”*

Still focusing on a standardised aftercare plan, the following statements refer to **the need for guidelines which include regular contact between the social worker and the addicted adolescent, and which lead to a structured process of service delivery:**

*“Gereelde kontak [a timeframe for contact between the social worker and the client] en ‘n set menu [a specific structure regarding the contents of the aftercare plan].”*

*“Ja, dienste moet ‘n gevoel van sekuriteit skep [referring to the structure of the contents of the aftercare guidelines].”*

*“Dit moet roetine bied [referring to the structure of the contents of the aftercare guidelines], wat ‘n gevoel van veiligheid kan verhoog.”*

Fisher and Harrison (2005:42-46) refer to the Disease Model of Addiction, and suggest that the structure of aftercare should assist the aftercare worker to identify and assess symptoms following treatment (i.e. aftercare needs), and plan aftercare services accordingly.

Referring to the value of a standardised aftercare plan, the Social Work participants proposed that the **guidelines should include a format to develop a working contract which could assist them to motivate clients to continue with aftercare services following treatment.**

*“Yes, but I think it must be like a contract. If you want help you must sign up for from preparation right up to aftercare.”*

*“Ek het al gedink, miskien moet mens voor die tyd ‘n kontrak aangaan.”*

*“Ja, soos reg by aanmelding dan sê jy dis hoe behandeling lyk en jy verduidelik van hoe werk die voorbereiding, die ‘treatment’ en ook die nasorg. Dan sal hulle sien dis alles deel van een proses. Ek dink dis wat ons moet doen, dan verstaan hulle nasorg is nie ‘optional’ nie.”*

*“You develop a treatment plan and contract. Services start only after that. That might help to get everybody ready and on board.”*

Epstein and Brown (2002:168-169) postulate that contracts should be viewed as working agreements. The authors concur that working agreements represent a degree of commitment, but must not be rigid.

The participating social workers suggested that **aftercare guidelines should be structured in a step-by-step, attainable, task-centred and clear manner:**

*“The programme must be step by step....clear and easy to follow.”*

*“Ek dink enige iets is beter as soos dit nou gaan.... Maar dit moet taakgesentreerd wees.... dit moet uitvoerbaar wees.”*

*“En dit moet asseblief duidelik wees. Nou doen jy dit, dan doen jy dat. Elke ou kan dit mos dan aanpas soos hy wil.”*

*“Soos ‘n resep.”*

*“Dit moet prakties wees.”*



Marlatt et al. (2002:4) agree that aftercare guidelines should assist the social workers to provide these clients with knowledge and coping skills that could lead to self-efficacy, and should be associated with improved treatment outcomes. The programme should therefore be task-orientated to enhance ownership and make it easy to implement.

Finally, a participant suggested that the **guidelines should enable social workers to measure their input and the impact of the measures** by stating: *“En dit moet meetbaar wees. Dan kan ‘n mens makliker bewys dit werk en dan kry jy makliker borge.”*

**Sub-theme 6.2: Practice guidelines relating to aftercare services to chemically addicted adolescents should be visual, written in easy language, and should include practical and fun activities**

The need for guidelines to be visual, in easy language and include practical and fun activities was reported by the majority of the participating social workers (22 of 29) in this study. The following statements illuminate the social workers' suggestions to **include fun activities, practical examples, and activities specifically aimed at adolescents:**

*“En tiener hulpmiddels, soos DVD’s en musieksentrums en so.”*

*“Ek dink dit moenie skolerig wees nie. Meer aktiwiteite en hulpmiddels. Maar bekostigbaar.”*

*“There must be a fun element... even guess speakers and outings.”*

*“Ja, visueel en kort en kragtig.”*

*“Die program moet ook goed bemark word. Hulle moet wil kom – die ‘fun’ faktor.”*

*“Aktiwiteite en praktiese goed.”*

*“Dit moet die boodskap gee. Kinders verloor gou belangstelling.”*

*“And be creative. Like to have fun without drugs.... Insight must be developed.”*

*“Soos ‘n hulpverleningsplan. Jy gee ‘n visuele prentjie van die hele proses.”*

Falkowski (2003:34-44) asserts that aftercare services should include practical lifestyle programmes, which also address cravings and withdrawal symptoms, and which are cost-effective. Arterburn and Burns (2007:162) suggest that music and movies are valuable aids to assist addicted adolescents to deal with stress.

One participant suggested that **motivational elements should be included when developing practice guidelines for the client-system concerned**, and explained it as follows: *“Dit [referring to the motivational elements in the aftercare programme] kan soos ‘n aftik lys hanteer word. Dit sal die kind ook hoop gee en motiveer om aan te hou. Soos ‘rewards’ vir elke fase wat voltooi is. Dan vier mens die klein ‘achievements’. O ja, die prentjie moet ook wys van ‘n ‘relapse’ en wat om te doen om terug te kom in die proses. Dan gee hulle nie moed op nie.”*

Regarding rewards for progress made, Sussman and Ames (2001:112) are of the opinion that extrinsic motivation (motivation obtained from external factors such as rewards) in terms of rewards for positive changes in behaviour could be valuable as long as it is performance-dependent.

The participating social workers also acknowledged **the cognitive challenges among CAAs**, and suggested the following on **how to accommodate these when developing practice guidelines for aftercare**:

*“Ja, en nie te moeilik nie. Die geletterdheid van die ‘addicts’ is maar baie keer sleg.”*

*“Alles moet amper soos speel wees. En eenvoudig.”*

*“Dit moet ook leesbaar wees en maklik om te gebruik. So, jy kan fotostate maak en die kliënt kan dit ook verstaan.”*

*“Ja, en nie hoë woorde nie.”*

*“Iets soos ‘n boekie met prentjies wat ‘n boodskap uitdra en met takies wat die kind kan doen.”*

*“Die kliënt moet ook die riglyn kan verstaan. Dit moenie hierdie vreeslike klomp idees wees nie...iets prakties.”*

In the literature, the following arguments confirm these concerns regarding the cognitive challenges among chemically addicted clients in aftercare. Perkinson (2008:275) refers to ongoing assessment of the cognitive impairment, to start at the beginning of the aftercare process and continue to identify cognitive repair. This should result in an aftercare plan that is congruent with the current abilities of the client, and includes referral to resources that can deal with this aspect. Gouws et al. (2000:39) refer to cognitive development as an important aspect to consider when services aim to assist CAAs to progress on an intellectual level as part of preparation for a vocation. Sheafor and Horejsi (2006:1) propose that creativity in guidelines for specific services (in this case aftercare services) should include flexibility and persistence, leading to a continued effort to encourage and facilitate change, and the ability to change intervention plans and techniques.

### **Sub-theme 6.3: Guidelines relating to the management, linking and networking of resources**

The participants commented on the **guidelines relating to the management, linking and networking amongst resources** as follows:

*“Shows [referring to the guidelines] how to connect the client with the support groups. I think we can do more there.”*

*“Iets soos die ABBA-netwerk. Die netwerk [referring to the ABBA network of different role-players in the field of chemical addiction] maak dinge wel makliker. Die rolspelers bou ‘n verhouding op en dit maak dienslewering makliker.”*

*“Die rolspelers leer ook binne die netwerk van afhanklikheid sodat ons as ‘n span uit een mond werk.”*

*“Soos jy kan agterkom is netwerke ‘n groot ding. Dan kan jy net baie beter werk.”*

*“Dis my werk, maar ek dink al die werkers wat met ‘addiction’ werk moet met hulle [referring to self-help groups] ‘n verhouding bou. Dienste kan so meer beskikbaar en deurlopend wees. Ons moet as ‘n span dienste lewer.”*

*“Dit [referring to aftercare services by different organisations/role-players] moet in spanverband wees. Netwerke moet dus goed wees.”*

*“‘Bottom line’ is, jy moet werk aan goeie verhoudings met hierdie mense [referring to the value of networks], dan werk julle as ‘n span.”*

Fisher and Harrison (2005:155) identify a lack of multi-disciplinary services and/or the lack of networking between different services as part of aftercare. These services should be co-ordinated by the social worker, and be seen as an ongoing process (cf. Treatment for Alcohol and Other Drug Abuse, 2007:1-2). Building on this, Etheridge and Hubbard (2000:1762) and Ducharme, Mello, Roman, Knudsen and Johnson (2007:123) agree that services often focus on some of the core focus areas (i.e. services that are directly related to the diagnosis and treatment of chemical addiction) and/or some of the support focus areas (i.e. services that address co-occurring problem areas and needs), but often do not include all. This can be attributed to the fact that the service fields of the different organisations determine which services are included and which not. The latter authors note that organisation involved with aftercare services to addicted adolescents should ensure that all of the focus areas are included in such services, or that networks are developed to ensure that clients have access to all the services. In order to address this need, Weyers (2001:149-150) refers to the social planning model. The use of this practice model is appropriate under different conditions: when there is a lack of necessary services and facilities; when there is a lack of, or poor, coordination and cooperation between different community organisations; when existing services are ineffective or irrelevant; and when social problems are not dealt with, and social needs are not met sufficiently.

Apart from management, linking and networking amongst resources, the participants, also identified the **resources that they felt should be included when aftercare services are planned:**

*“Rehabilitasiesentrums, die landros, polisie, maatskaplike werkers, dokters, skole en kerke.”*

*“Ja, die polisie moet hierdie situasie as prioriteit beskou.”*

*“Vennootskappe met kerke, skole en die polisie kan ook help om kinders binne die gemeenskap te help.”*

In the literature the researcher found confirmation of the importance of schools as a resource in aftercare to CAAs. The former South African Minister of Education, Ms Pandor, addressed this pressing situation by introducing legislation that enables school staff to test students for chemical substances. Specific procedures were introduced to protect the staff and the learners (Government Gazette, 2008:136). It is structured in such a way that the Constitution of the Republic of South Africa (1996) is not violated in terms of human dignity and privacy (Government Gazette, 2008:144). In support, Johnson and Lazarus (2008: 20) note that schools reach more than one billion children worldwide, and therefore have the opportunity to affect their development, adjustments and recovery from stressors, and should be used as a resource for aftercare services. The role of the school is to educate the adolescents regarding the impact and dangers of chemical substances, assist them to develop the ability to distinguish between pleasant and unpleasant consequences of chemical substance use, assist to develop friendships outside the chemical substance culture, and assist in dealing with problems and developing healthy leisure-time habits to combat boredom. The school can also ensure that it presents and facilitates youth activities to encourage the development of a healthy lifestyle, and to increase among learners the sense of belonging (Pretorius & Le Roux, in Pretorius, 2005:274; 278; 298). In addition, the role of schools can include addressing the previously discussed problem of the high drop-out rate from aftercare services (Barrett & Ollendick, 2004:337).

Regarding the value of churches as a resource in aftercare services to CAAs, both Falkowski (2003:46) and Keegan and Moss (2008:125) identify strong bonds with churches as a valuable resource to be utilised to prevent relapses from occurring.

In addition, **the importance of including medical resources** was expressed as follows:

*“En hulle help ook wanneer iemand ‘relapse’, dan kan jy hom medies laat stabiliseer.”*

*“It must focus on networks. Like with all these dual diagnosis, you need to be able to refer them for psychiatric stuff to the right people.”*

*“Oh and the clinics for medication and medical help with the children with dual diagnosis – tik [referring to methamphetamine] and paranoia and depression and stuff is our new reality.”*

### **The value of volunteers and their inclusion in the network of resources**

was also described in the following terms:

*“Op die plase..... Daar is min nugter gesinne. Maar die nugter mense is bekeerdes en die ander mense vertrou en respekteer mekaar. Mens kan hulle dalk beter gebruik.”*

*“Dis baie waar. Die ouers drink, so die kinders drink, want dis al wat hulle ken. Die bekeerdes kan die kinders ondersteun.... en amper soos rolmodelle wees. Die bekeerdes op die plase kan geleer word om na ure dienste op die plase te lewer.”*

*“Ons kan ‘volunteers’ ook gebruik in groep aktiwiteite. Toesig is noodsaaklik en een persoon per sessie is nie genoeg nie.”*

*“Ja, ons kan die ‘volunteers’ beter benut en saam met hulle werk, nie apart nie.”*

Concluding this sub-theme, a participant suggested the following regarding the role of the aftercare worker relating to the management, linking and networking amongst resources: *“Maar dan ook dat die maatskaplike werker se rol meer as mentor en fasiliteerder moet wees.”*

### **Sub-theme 6.4: Aftercare services should be provided through case work, group work and community work as primary methods of Social Work service delivery**

The participating social workers suggested that **all three the primary methods of Social Work service delivery should be included in the**

**guideline stipulations for rendering aftercare services to CAAs.** The following statements make reference to this:

*“Case and group work must focus on skills to maintain sobriety and then community work focuses on support.”*

*“Idees vir groepwerk sal ook baie help.... Ja, selfs hulpmiddels vir werkswinkels as jy met ‘n groot groep werk.”*

*“Groepe moet klein en hanteerbaar wees.”*

*“Group work: like say 4 to 5 clients in a specific area. Then you start a group and then you plan it like eventually they become an independent self-help group. But that is more like community work. Development.”*

The case and group work methods were linked by the participants, confirming the viewpoint of Keegan and Moss (2008:111), who note that group work is normally part of a greater treatment plan, and is not used in isolation, but rather in combination with case work.

*“Yes, but the guidelines must be for case and group work.”*

*“Yes, with case work and groups you must help them to practice a new life style until they feel comfortable.”*

Hepworth et al. (2006:457) state that Social Work services to individuals and families aim to alter relationships and communication patterns, in order to enhance the growth and development of all the family members. Compton, Galaway and Cournoyer (2005:260) expand on this, and relate case work to the empowerment of clients to identify and utilise social support.

With reference to group work Jacobs, Masson and Harvill (2002:2) suggest that group work can assist social workers to deliver services to a larger number of clients, and can be cost- and time effective. Keegan and Moss (2008:11) note that groups provide the addicted adolescent with a supportive environment where mutual understanding and acceptance create an atmosphere conducive to change. This method works well with adolescents, as peer support assists them to share techniques that work when dealing with cravings, temptations and life problems (Keegan & Moss, 2008:111).

While the previous comments by the participants specifically referred to aftercare services being rendered to CAAs through the case and group works methods of service delivery, the participants also referred to interventions in the community at large. They referred to community work efforts to deal with the tolerance and availability of chemical substances in the community, fear of victimisation when attempting to change toward a sober lifestyle, working from a developmental framework to create healthy community lifestyles, changing the community's perceptions of CAAs and the development of halfway houses in the quotations below. Their comments reflect their concerns regarding the tolerance and availability of chemical substances in the communities where they worked, as well as their clients' fear of victimisation when attempting to change toward a sober community.

*“Ons grootste beperking, myns insiens is die beskikbaarheid en aanvaarbaarheid van ‘drugs’ in die gemeenskap. Dit hou verband met misdaad. Die behoefte om te oorleef binne so ‘n omgewing is soms groter as die mag van die dwelms [referring to the need to address environmental cues that could lead to relapses].”*

*“Definitief die plaasomgewing. Almal drink en dis moeilik vir iemand wat wil ophou.”*

*“Oe, en sjebeens. Die arme kind kan hom nie draai nie, dan is daar ‘n dagga zol of ‘n bierbottel!”*

*“Mense word dikwels geviktimizeer om hul krimenele leefstyl te handhaaf, wat herstel baie moeilik maak.”*

*“Hulle vrees byvooreeld vir hulle familie se veiligheid en ons kan dit nie waarborg nie.”*

Swanepoel (2002:32-50) notes that when a social worker becomes involved in community work, the people affected by the situation (in this case CAAs and their families) as well as all the relevant institutions and policy makers, should be involved in the process. With specific reference to the victimisation of community members, Weyers (2001:237) advises that the social action model of community work assists the community to take deliberate action which aims to alter community systems for the greater good. This model is related to Swanepoel's view as described above, in that the social worker mobilises and



utilises a power base that assists the community to regain their inherent power. Weyers (2001:238) points out that the social worker makes use of this model in community work to assist the community to address their fears, as well as the frustration regarding the availability of chemical substances, by creating a power base, in order to enforce their will (in this case the will to maintain a sober lifestyle following treatment).

Regarding the tolerance of chemical substances in communities, Kotler (1986) proposes that the social marketing model in community work be used to design, implement and control programmes seeking to increase the acceptability of a social idea, cause or practice in a target group (in this case accepting the advantages of intolerance to chemical substances).

Concerning the need to enable communities to engage in healthy lifestyles, the participants reported that community work efforts should be founded in working from a developmental framework.

*“Ja, ontwikkelingsgerig. Dis in elke geval wat van ons verwag word [referring to the requirements of the White Paper on Social Welfare of South Africa (1997:43)]. Dan kan mense dit op die ou einde self aan die gang hou [sustainability and empowerment].”*

*“Ek dink die mense wil beter leef, veral op die plase, maar ek dink net hulle glo nie hulle kan nie [the need for empowerment].”*

*“En die plase is ver van alles. Mense weet nie wat anders as drink om in hulle vrye tyd te doen nie [referring to the need to develop relaxation facilities and opportunities].”*

*“Maar in die dorp weet mense ook nie meer hoe om gesonde vrye tydsebesteding te doen [referring to a lack of knowledge in the community regarding how to spend free time] nie. Die ding is net dat daar nie alternatiewe op die plase is nie.”*

Social development as a model of community work mobilises and assists the communities to take ownership of their social problems (Visser, 2007:149-150). Regarding community work efforts aimed at altering lifestyles, the Annual Report of the Department of Social Development of the Western Cape

(2005-2006:8) acknowledges the need to assist CAAs in recovery with changes in lifestyles, and advises that diversion from chemical substances is needed, and that the community work method should be aimed at developing youth activities to address this aspect of relapse prevention. Regarding community development and focusing on service delivery in South Africa, the national goals of the White Paper on Social Welfare (1997) are to render social development services to the poor and the vulnerable. Social development is an approach combining social and economic development as its goals (Gray, 2006:55).

The social workers who participated in this study also viewed changing the community's perceptions of CAAs in order to ensure reintegration into the community as a need to be addressed through community work.

*“Ja, en om die verhoudings in die gemeenskap weer reg te maak, nie net in die gesin nie. Want niemand vertrou hierdie kinders na wat hulle als aangevang het nie. So hulle sukkel om nog ‘n kans te kry [referring to the community's perceptions of CAAs]. Dan gee hulle [CAAs] moed op.”*

*“And maybe an outreach programme. Yes, to help them to develop something like.... A sense of purpose. It can help them to focus on new things and learn new behaviour. And this will help them to be experienced more positively by the community”*

Regarding the restoration of relationships between the community and addicted adolescents, Gouws et al. (2000:39) advise that developing a concern about social issues is an essential component of cognitive development during adolescence that leads to integration in the community. Saleeby (2006:202) confirms this viewpoint and refers to the involvement and contribution in community affairs that can lead to a sense of purpose and belonging on the one hand, and acceptance by the community on the other hand.

The following comment refers to the development of a specific aftercare service in communities: *“Selfs iets soos ‘halfway houses’. Waar die kind eers*

*in die gemeenskap leer aanpas voor hy weer huis toe gaan. Dit help dan met reïntegrasie. Dis deel van van hoe dienslewering moet lyk.”*

Community work in terms of the social planning model can assist social workers to develop resources that can be utilised in order to create sustainable change (Weyers, 2001:149). Maffli, Schaaf, Joran and Guttinger (2008:31) refer to residential aftercare services/recovery homes/halfway houses that assist CAAs to systematically reintegrate into the community. The authors attribute the following values to this service. These houses can provide addicted adolescents with a safe environment, fellowship with other recovering adolescents, and professional support following treatment. The adolescent is then prepared to reintegrate into the community in a gentle way, ensuring the availability and utilisation of aftercare services. This service provides CAAs with a recovery climate, and is especially valuable for adolescents who have already relapsed and thus suffer from low self-efficacy (cf. Moos & Moos, 2004:89; Arterburn & Burns, 2007:157). The purpose is to provide a warm supportive environment where these young people are supported to reintegrate into society, and the family is prepared for his/her return following treatment. It provides both the adolescent and the family with an opportunity to adapt to the changes, which is needed for full reintegration (Alberta Adolescent Recovery Centre, 2007:3).

#### **Sub-theme 6.5: Suggestions relating to the content to be included in guidelines for aftercare services to chemically addicted adolescents**

One participant in the present study suggested the following in connection with **the contents of guidelines pertaining to aftercare services** to the client-system under discussion: *“Dit moet opvoedkundig, sosiaal en terapeuties wees.”*

The participants also suggested that **the contents of the aftercare guidelines should be motivational in nature:**

*“It sounds like motivational interviewing is needed. And a lot of people don’t know what it means. So maybe it can include some guidelines on that.”*

*“Something on the Model of Change. That will help to get families and addicts to become realistic and motivate them to stick it out.”*

In explaining “motivational interviewing”, Fisher and Harrison (2005:110) and Sheafor and Horejsi (2006:554) refer to Miller and Rollnick’s definition of the former concept as a classic technique employed to enhance the intrinsic motivation among people suffering from chemical addiction to enter and maintain recovery. Sussman and Ames (2001:111-112), Pienaar (2005:11) and Powis (in Becker, 2005:172-173) refer to the Phases of Change as developed by Prochasku and Diclemente, and advise that social workers should be skilled in motivational interviewing, and use this technique to improve readiness for change before planning intervention strategies.

Another participant aired the view that the planning of **aftercare services should be based on a needs-assessment of the client’s situation**: *“You assess their situation after treatment, because sometimes it changed while they were in rehab. And then you plan around what they need at this moment.”*

The literature states that effective aftercare needs to address not only the chemical addiction, but also the associated needs and problems. Intervention plans must be individualised and adapt to clients’ changing needs (Etheridge & Hubbard, 2000:1762). Research by Ducharme et al. (2007:122) and Elssheik, (2008:304) shows that services addressing the needs in various life domains improve retention in treatment and aftercare, and therefore address the concern about the high drop-out rate among CAAs. Such services also have a positive effect on treatment outcomes. In support of this, Etheridge and Hubbard (2000:1762) divide services to chemically addicted persons into two focus areas, which are described in Table 4.3 below.

**Table 4.3:** Core and supportive service areas in aftercare

<b>Core services</b> Services that are directly related to the diagnosis and treatment of chemical addiction	<b>Support services</b> Services that address co-occurring problem areas and needs
<ul style="list-style-type: none"> <li>• Intake assessment and processing</li> <li>• Treatment plan</li> <li>• Behavioural therapy</li> <li>• Substance use monitoring</li> <li>• Clinical case management</li> <li>• Pharmacotherapy</li> <li>• Self-help and support groups</li> <li>• Continuing care (aftercare that builds on the above)</li> </ul>	<ul style="list-style-type: none"> <li>• Medical services</li> <li>• Mental health services</li> <li>• Childcare services</li> <li>• Transportation services</li> <li>• Housing services</li> <li>• HIV and AIDS services</li> <li>• Vocational and educational services</li> <li>• Family services</li> <li>• Financial services</li> <li>• Legal services</li> </ul>

The social workers participating in this study referred to the following **focus areas to be included in the contents of the aftercare guidelines:**

*“Like, time management and leading a balanced life.”*

*“They [referring to the CAAs] need to protect themselves from dangerous situations and places. They must have a plan for every moment.”*

*“Because they need to learn what to do during the times they used to do drugs.”*

*“Also, they must have a plan for what to do when they are tempted.”*

*“To stay clean... Like hobbies, how to make relationships better.”*

*“Dit moet help dat hulle wegfokus van hulle ou leefwyse af.”*

*“En nuwe opsies vir hulle bied [referring to chemical substance-free activities to replace chemical substance-related activities].”*

*“One thing I saw since I started [referring to when she started working with CAAs in recovery]: no education.... Like you educate them, but not like sessions where you just give information. They have done all of that in rehab.”*

*“Like, they don’t need info on drugs and what it does to you. They need activities that help them to stay sober, so my focus is more like not to use and how to stop.”*

*“Die werkers moet kinders help om nuwe gedrag in te oefen, kennis is nie genoeg nie.”*

*“Ja, ‘assertiveness’ is baie nodig met al die ‘drugs’ in hierdie gemeenskap.”*

*“En selfgeldig. Die kind moet sterk voel. Hy moet kan nee sê.... So, ja, groepdruk moet hanteer word.”*

*“En dit moet maar die behoeftes wat hulle vir jou van noem dek. Maar ek weet die stres van ‘cravings’ is iets wat altyd ‘n ‘issue’ is.”*

*“Die kinders se selfbeeld moet ontwikkel word... soos selfvertroue.”*

*“How to plan a balanced life style.”*

*“Werk hou hulle besig en gee menswaardigheid terug.”*

Gouws et al. (2000:2-7), Teesson et al. (2002:87-89), Falkowski (2003:43-44), Sheafor and Horejsi (2006:339) and Keegan and Moss (2008:112) identify the following focus areas that should be included in aftercare programmes for CAAs:

- Enhancing commitment to change (reviewing negative aspects of the use of chemical substances and the advantages of abstinence)
- Identifying causes of relapses (people, places, things, events)
- Reintroducing useful strategies (problem-solving skills)
- Addressing education and vocational needs
- Development of relationships skills
- Development of decision-making skills
- Assistance with dealing with frustration
- Development of independence
- Development of conflict-management skills
- Identification with peer group, as well as the ability to be assertive within the group
- Development of a value system
- Addressing spirituality and development of spiritual interests
- Identification of and dealing with cravings and triggers, referring to people, places and things
- Assistance with dealing with withdrawal symptoms
- Assistance with lifestyle modification
- Identification of alternatives to the use of chemical substances

The following statements identify **the inclusion of spirituality as part of the content**:

*“Spiritual well-being must not be neglected.”*

*“My ervaring is dat geloof ‘n groot rol speel. As mense na die sentrum aktief by die kerk inskakel, is dit net of dit vir hulle makliker is om nugter te bly.”*

Concerning the train of thought about spirituality, Van Wormer and Davis (2003:205) note that spiritual healing as part of the recovery process often goes unrecognised. They assert that spiritual healing plays an important role in the development of a sober identity. A study conducted by Elssheik (2008:311) showed that 85% of the participants found spiritual involvement as a useful aspect in efforts to prevent relapse. According to the Disease Model of Addiction, addiction is a mental, physical and spiritual disease, and addressing the spiritual needs of the addicted person is part of total recovery from the addiction (Sweet, 1999:240; Bekker, 2003:52-53). Spirituality poses the advantage of assisting these young people in recovery to obtain a personal value system and a sense of purpose, which will positively impact on the development of a sober identity and self-efficacy (Gouws et al., 2000:118).

Following the discussion of the findings related to the perceptions and experiences of aftercare by the participating social workers, the next section will conclude this chapter with a comparison with the findings obtained from the CAAs who participated in this study.

#### **4.4 Conclusion**

In accordance to task objective 2 (see p. 36), as stipulated in Chapter 1, this chapter has focused on the perceptions and experiences of aftercare as revealed by social workers who rendered aftercare services to CAAs in the Western Cape. The findings as discussed in this chapter were based on the data obtained by means of discussions conducted with seven focus groups comprising 29 social workers who were involved in aftercare services to CAAs. Based on the analysis of this data, the following conclusions were reached:

- The social workers acknowledged that recovery from chemical addiction was a life-long process, and perceived aftercare to chemically addicted adolescents as essential for life-long recovery.
- Aftercare was viewed as an essential part of treatment to prevent relapses that should not be viewed as optional.
- The social workers viewed aftercare as a “specialised field” of service delivery, but reported that it was currently not the case in practice.
- The social workers specifically requested more information relating to the aftercare component of the treatment.
- The social workers reported that a lack of knowledge negatively impacted on their ability to plan and execute services successfully.
- Current services were mainly based on the case work and group work methods of Social Work intervention, although one participant worked according to the community work method.
- The contents of current services were planned according to specific needs of clients, but mainly focused on:
  - Life skills,
  - General support,
  - Development of insight into the consequences of the addiction,
  - Dealing with damage from the chemical addiction,
  - Reparation of relationships,
  - Family therapy.
- The social workers reported the following obstacles when delivering aftercare services to the adolescents:
  - A skills deficiency owing to a lack of training/uncertainty about the nature of training,
  - The lack of contact and alignment of programmes offered at treatment centres with aftercare service initiatives,
  - Lack of transport to services,
  - Inaccessibility of services,
  - Lack of knowledge about aftercare services,
  - Employment-related challenges,



- A high drop-out rate amongst chemically addicted adolescents and lack of commitment to aftercare services,
- Difficulties experienced by clients in internalising new behaviour,
- The lack of time to render aftercare services owing to a lack of manpower and funds,
- A lack of resources.
- The reintegration in the family should be addressed by means of the following:
  - The development of insight regarding chemical addiction and the recovery process,
  - Training and support to be able to support chemically addicted adolescents,
  - Assistance to support the chemically addicted to reintegrate into the family,
  - Support to address their own problems that impacted on the recovery potential of the clients.
- Guidelines should be standardised and structured in a step-by-step format, as well as visual, written in easy language, and it should include practical and fun activities.
- Guidelines should include management, linking and networking amongst resources.
- Guidelines should be based on the case work, group work and community work methods of Social Work.
- The following factors should be included in the content of the aftercare guidelines:
  - To include educational, therapeutically and social activities.
  - To be motivational in nature.
  - To be based on a needs-assessment of the client's situation.
  - To focus on the development of a recovery plan and balanced lifestyle that will assist with time management and the ability to become involved in chemical substance-free activities.
  - To assist adolescents with the development of life skills such as assertiveness and stress-management.

- To assist adolescents with the development of a healthy self-esteem.
- To include activities to assist in the internalisation of new behaviour.
- To assist adolescents with the development spiritual well-being.

In summary, a comparison between the findings related to the aftercare needs of CAAs (as described in Chapter 3) and the findings related to the perceptions and experiences of social workers who rendered aftercare services to CAAs is illustrated in Table 4.4 below.

**Table 4.4:** A summarising comparison between the findings obtained from the chemically addicted adolescents and the social workers

<b>Findings</b>	
A sound knowledge base regarding addiction and recovery is needed for social workers who render aftercare services to chemical addiction	
Chemically addicted adolescents	A knowledge base includes knowledge relating to addiction, as well as the 12-Step Recovery Programme of NA.
Social workers	Current knowledge consists of information regarding addiction, but very little information on aftercare services is available, leaving aftercare workers unsure of what is expected of them.
Chemically addicted adolescents need access to services and support following treatment	
Chemically addicted adolescents	There is a concern regarding the availability and accessibility of Social Work aftercare services, which negatively impacts on the development of a personal, trusting relationship with their aftercare workers.
Social workers	Social workers are not able to be available to all their aftercare clients at all times. They report a need to utilise volunteers and support groups to assist them in this regard.
The focus of aftercare services includes life skills that would enable chemically addicted adolescents to complete adolescent life tasks and to develop resilience	
Chemically addicted adolescents	Dealing with peers; dealing with defence mechanisms; development of a positive self-image; management of anger and stress; development of assertiveness skills; development of budgeting skills; development of time-management skills; becoming involved in hobbies and sport; dealing with cravings and triggers; development of problem-solving and decision-making skills; dealing with emotions; finding work and returning to school; and spiritual involvement.
Social workers	Life skills, including the development of a recovery plan; a balanced lifestyle that would assist with time management and the ability to become involved in chemical substance-free activities; assertiveness skills; and the development of a healthy self-esteem.
The importance of internalising new behaviour that would contribute to efforts to remain sober following treatment	
Chemically addicted adolescents	The adolescents reported that the ability to change old substance use-related behaviour would increase their resilience and decrease relapse potential.
Social workers	Chemically addicted adolescents need assistance to internalise new behaviour following treatment. The peer group could be used in this regard, but the influence of peers could also become a restriction if continued contact with chemical substance-using peers took place.
The reintegration in the family following treatment is seen as a focus area in aftercare services to chemically addicted adolescents	
Chemically addicted adolescents	Chemically addicted adolescents need the assistance of aftercare workers to repair the relationship with their families. They reported a need to be supported and cared for by family members.
Social workers	Aftercare should include the family. They should be assisted to develop insight regarding recovery, develop parental skills, and be enabled to deal with own problems that impact on their ability to provide support to chemically addicted adolescents following treatment.

<b>Resources should be available to assist social workers with their efforts to deliver aftercare services, as well as to support chemically addicted adolescents following treatment</b>	
Chemically addicted adolescents	The adolescents reported a need to attend support groups, but reported a need to be assisted to utilise this support.
Social workers	Social workers should use community resources such as other professions, volunteers, and support groups, when rendering aftercare services.
<b>Services of treatment centres and aftercare services should be coordinated</b>	
Chemically addicted adolescents	The adolescents requested that the aftercare workers should become aware of the content of the treatment programmes the adolescents attended to be able to assist them to continue with the growth achieved during treatment.
Social workers	Treatment and aftercare services should be coordinated to ensure standardised treatment and to assist the chemically addicted to continue with the process of recovery which was started at the treatment centre.
<b>The quality of aftercare services is negatively influenced by a lack of a trusting, personal relationship between the aftercare worker and chemically addicted adolescents motivation to participate and commit to aftercare services</b>	
Chemically addicted adolescents	Chemically addicted adolescents viewed a lack of assessment of their personal needs, a judgemental attitude of aftercare workers, and a lack of passion for their work as the contributing factors that harmed the relationship with aftercare workers.
Social workers	Social workers viewed chemically addicted adolescents' lack of motivation to participate and commit to aftercare services as the reason for the lack of a relationship.
<b>Motivational interviewing is a valuable technique in aftercare services</b>	
Chemically addicted adolescents	Previous experiences were identified in this regard. The adolescents reported that motivational interviewing led to a trusting relationship with their aftercare workers. On the other hand, they viewed judgemental attitudes of their aftercare workers as an aspect that harmed the development of motivation for treatment and participation in aftercare services.
Social workers	The lack of motivation to participate in aftercare services among chemically addicted adolescents was identified as an obstacle in service delivery. The value of this technique was identified.
<b>The individual needs of chemically addicted adolescents relating to aftercare services should be acknowledged</b>	
Chemically addicted adolescents	The adolescents reported that the assessment and acknowledgement of their individual aftercare needs would lead to a trusting personal relationship with aftercare workers.
Social workers	Social workers reported that aftercare guidelines should provide them with a broad plan to work to. However, it should be adapted according to the individual needs of chemically addicted adolescents.
<b>Guidelines should be structured in a step-by-step format, be in easy language and include fun activities</b>	
Chemically addicted adolescents	Services should be delivered on their level, and language should be clear and understandable.
Social workers	The guidelines should be structured in such a way that the chemically addicted adolescent would be able to use and understand the contents. The step-by-step format should lead to standardised service delivery
<b>Parental use of chemical substances needs to be addressed as part of aftercare services</b>	
Chemically addicted adolescents	The participants reported that parental use of chemical substances impacted negatively on their ability to reintegrate into the family.
Social workers	The social workers expressed a concern regarding the impact of parental use of chemical substances on the recovery potential of the chemically addicted adolescents following treatment.
<b>Reintegration in the community is an area to be addressed through aftercare services</b>	
Chemically addicted adolescents	The adolescents were concerned regarding the availability of chemical substances, and the chemical substance sub-culture in their communities. They reported that it harmed the reintegration in the communities.
Social workers	The social workers reported that community work should address the availability of chemical substances in the community, as well as the reintegration in, and acceptance by, the community.

The findings of this research study (Chapters 3 and 4), together with an exploration of existing technology formed the foundation of the aftercare guidelines (described in Chapter 6). Elements inherent to aftercare models and guidelines and suggestions found in the literature will be discussed in the next chapter (Chapter 5).

## CHAPTER 5

### IDENTIFYING THE FUNCTIONAL ELEMENTS INHERENT TO MODELS AND GUIDELINES AND SUGGESTIONS IN LITERATURE RELATING TO AFTERCARE SERVICES

#### 5.1 Introduction

In Chapter 1, the researcher provided background to, and rationale for, the present research endeavour (see pp. 1-12). The research problem (see p. 12) was based on a limited literature review with the exclusive aim of framing the research problem, as is customary in qualitative studies (Creswell, 2009:21). The literature and comments from practitioners working in the field of substance abuse and addiction indicated a need to address the lack of focus and content on aftercare services to chemically addicted adolescents (CAAs) as part of services to this client-system (cf. Meyer, 2005:292-293).

In order to address the abovementioned need, the researcher decided to undertake a research project from a qualitative approach, falling within the ambit of applied research. As her research design, she chose Rothman and Thomas's (1994:3-51) Intervention Design and Development (IDD) model, with specific reference to Phases 1 and 2, Step 2 of Phase 3, and Step 1 of Phase 4 of this model. Chapter 2 dealt with the way the research methodology was applied in this study. Chapters 3, 4 and 5 relate to the following task objectives that were formulated in relation to this study.

Chapter 3 related to **task objective 1**, namely: to explore and describe the specific aftercare needs of relapsed chemically addicted adolescents following treatment relating to services by social workers. Data were obtained from 31 CAAs who had previously undergone treatment, had had contact with social workers following treatment, had relapsed thereafter, and who had subsequently returned to treatment centres in the Western Cape. The method of data collection took on the form of compiling a narrative around the topic:

“The things social workers can help me with to maintain my sobriety after treatment”.

Chapter 4 related to **task objective 2**, namely: to explore and describe the experiences of social workers in relation to rendering aftercare services to CAAs. Data were obtained through focus group discussions with seven focus groups comprising of 29 registered social workers employed by the Department of Social Development and NGOs, who were specifically involved in providing aftercare services to CAAs in the Western Cape. The data obtained from the two sample groups were subsequently analysed and presented as themes, sub-themes and categories in Chapters 3 and 4 of this report.

In this chapter, the outcome of **task objective 3**, namely: to identify the functional elements inherent to models, guidelines and suggestions from literature relating to aftercare services to chemically addicted persons will be presented. This activity relates to the third step in Phase 2 of the IDD-model of Rothman and Thomas (1994:33), and concerns itself with the search for functional elements inherent to different service models, practice guidelines, and suggestions from literature already available relating to the social technology (i.e. guidelines for aftercare services by social workers to CAAs) the researcher aims to develop. The models, guidelines and suggestions that were found in the literature referred to aftercare to chemically addicted persons in general, and not specifically to chemically addicted adolescents. The researcher therefore studied aftercare models and guidelines and suggestions applicable to chemically addicted client-systems. The common denominator was chemical addiction, and the aftercare models, as well as guidelines and suggestions from literature were thus also related to CAAs. The functional elements that were identified, and subsequently described in this chapter, were therefore related specifically to CAAs when the guidelines were developed (as provided in Chapter 6).

Strydom et al. (1007:335) and Bender (2007:77) concur that the identification of functional elements inherent to already existing models, guidelines and

suggestions for practice in use, enable a researcher to design relevant interventions during the third phase of the IDD-model of Rothman and Thomas (1994). The next chapter (Chapter 6) relates to **task objective 4**, namely: to develop aftercare practice guidelines for chemically addicted adolescents following treatment based on the information obtained from task objectives 1, 2 and 3.

In this chapter, the researcher will present the results of the literature search on models, and practice guidelines and suggestions from literature relating to aftercare service delivery in the field of chemical addiction. The “What?” and “How?” of aftercare service delivery will be described, and evaluated in terms of strengths and weakness relating to their functionality to the proposed guidelines, presented in the next chapter of this document.

In order to identify the functional elements inherent to models relating to aftercare services, the goal of this research endeavour, to develop guidelines in this regard, was considered. As a backdrop, the following discussion provides a description of the terms “**practice guidelines**” and “**practice model**” as discovered in the literature that was studied.

Guidelines are “advice or instructions given in order to guide or direct an action” (Business English, 2009). Timberlake, Zajicek-Faber and Sabatino (2008: 77) advise that practice guidelines be based on best practice, which should lead to “optimal ways of delivering services to meet an ideal standard of care for a given client population under given circumstances”. In the present case, the latter refers to CAAs and specifically the rendering of aftercare services to these youngsters by social workers. With reference to the involvement of social workers, Fisher and Harrison (2005:155-156) suggest that the ideal is for social workers to form part of the discharge process from treatment settings. The authors note that the advantage would be that all relevant parties (including the social workers and families) would be involved in the planning and development of a formal aftercare and relapse-prevention plan prior to the client’s discharge. They, consistent with the findings of this study (Chapters 3 and 4), note that this is seldom the case,

and conclude that social workers are often left to develop aftercare plans on their own, pointing to a need for guidelines.

In making suggestions about the content of practice guidelines, Hofstee (2006:159) recommends that practice guidelines should emanate from practice, and be based on the findings of research endeavours (i.e. in this case be based on research findings and literature as presented in Chapters 3 and 4), as well as to existing theory (presented in this chapter). The guidelines should also be feasible and clear, explaining the “How?”, “Where?” and “Why?”. In addition, Proctor and Staudt (2003:230) suggest that outcome targets should be developed, after which associated interventions for each target should be described. Target outcomes and associated interventions may be conceptualised as goals and objectives of interventions (Compton et al., 2005:198). Brause (2000:131) is in agreement with the previously mentioned descriptions of guidelines, and places emphasis on the researcher being clear about the target audience (i.e. the client-system), and relating to research findings when developing practice guidelines. Howard and Jenson (1999:360) note that, apart from a scientific foundation, guidelines must also be user-friendly and manageable to address possible obstacles of potential resistance from practitioners and costs.

Linking the term “model” to guidelines, Toseland and Rivas (2005:120) describe a model as a concept that includes indicators/behaviours relevant to a particular situation that provides guidance to others. Another description is provided by Weyers (2001:8; 14), who describes a practice model as a unique way of looking at the nature of a situation and the different ways to deal with the situation. The author refers to a “practice model” as a “framework” that provides an outline of ideas, enabling the practitioner to understand situations, forming the foundation for services directed to create social change.

In view of the fact that the Disease Model of Addiction formed the conceptual framework and point of departure for this study (see Chapter 1, p.4), this theoretical framework will become the focus of discussion in the next section

of this chapter, as practice guidelines should emanate (amongst others) from practice models.

## 5.2 The Disease Model of Addiction

The literature search regarding the practice models relating to aftercare services to CAAs, as discussed in the sub-sections that follow, was conducted from the conceptual framework of the Disease Model of Addiction. Introducing the different models for aftercare, the researcher decided to provide a short sojourn into the realm of the basic nature of the Disease Model of Addiction.

White (2000:47) asserts that the term “chronic drunkenness” (i.e. the first implication that intoxication is a chronic condition) originated in the civilisations of ancient Egypt and Greece. Early work related to chemical addiction was primarily focused on alcoholism. The first groundwork for the Disease Model of Addiction in America was done by Benezet (in White, 2000:47) in 1774, providing the first effort to describe the “chronic drunkard”. Building on Benezet’s work, Rush (in White, 2000:47) covered the following in a pamphlet on addiction in 1784: 1) medically cataloguing the signs of acute and chronic drunkenness; 2) medically confirming the progressive nature of chemical addiction; and 3) developing the first effort to treat addiction in a special facility. The Disease Model of Addiction is founded on the impact of chemical substances on the neurological system. In 1829, Sweetser reported a “morbid alteration” in the major structures and functions of the human body due to chemical substances (White, 2000:48).

The Disease Model of Addiction is credited to Jellinek (1960), who described the progressive nature of addiction in terms of symptoms associated with each stage in the progressive continuum of addiction. In addition to the stages and associated symptoms of addiction, the author included **symptoms of recovery** from addiction (specifically relevant for the purpose of this study), and developed the “Jellinek Curve of Addiction” (see Annexure H) to chemical substances and recovery from chemical addiction (Jellinek, 1960:13). Based on Jellinek’s research, which was presented to the World Health Organisation



and the American Medical Association, the term “disease” relating to chemical addiction became used in 1965 by the American Medical Association. It originally referred to alcoholism and was later generalised to addiction to all chemical substances (Alcohol and Drug Treatment Referrals, 2009:1).

Further support for the neurological impact of chemical substances was provided by research conducted by NIDA (2000:1), showing that widespread alterations in brain activity, brought about by chemical substances, lead to cravings and loss of control. Clark (2009:1) concurs that the Disease Model of Addiction to chemical substances fits “the definition of a physical ailment, involving an abnormality of structure in, or function of, the brain that results in behavioural impairment.” Building on this description, the author states that this model assumes that addiction to chemical substances is chronic and progressive in nature. The Disease Model of Addiction therefore is founded on the view that recovery from chemical substances is a life-long process, owing to the irreversible nature of cravings and impaired control. This view accentuates the importance of aftercare following in/out-patient treatment (Clark, 2009:1).

Opponents of the Disease Model of Addiction are of the opinion that it can lead to avoidance of self-responsibility, leading to a dependency on others to deal with the addiction (Clark, 2009:2). Miller (2008:166) agrees with this, and explains that the fact that it places the emphasis on the client’s acceptance of the disease of addiction could lead the client to hide behind the addiction, and not take responsibility for his/her addiction. Clark (2009:2) also reports a concern that this model leads to labelling, which hampers efforts to lead a fully balanced lifestyle.

In defence of the Disease Model of Addiction, McLellan et al. (2000:689) postulate that this model is based on research showing brain changes due to the addiction to chemical substances. The authors assert that this model thus views addiction as a primary disease that is treatable, but not curable (cf. Fisher & Harrison, 2005:43). McLellan et al. (2000:689) suggest that when one renders services to chemically addicted client-systems from the

framework of the Disease Model of Addiction, one needs to keep in mind: 1) the progressive nature of chemical addiction, 2) the loss of control over the intake of the substance, and 3) withdrawal when the use of chemical substances is terminated or interrupted. In addition, Clark (2009:1) suggests that the physical, cognitive, emotional, social and spiritual functioning (related to the impact of chemical substances) should be the focus areas to address in both treatment and aftercare.

Focusing on the recovery process, and therefore aspects that need attention during aftercare, Jellinek's curve of recovery (Jellinek, 1960:13), premised on the Disease Model of Addiction, provides the following guidelines to be focused on in the process of recovery from chemical addiction:

- Development of an honest desire to receive help and assistance;
- Commitment to abstinence;
- Personal stocktaking, dealing with emotions, and confronting defence mechanisms;
- Deriving hope from contact with sober addicts in self-help groups;
- Physical maintenance, including nourishment, relaxation and exercise, care of personal appearance, and sleep;
- Renewed family relations;
- Making new friends;
- Development of new interests;
- Development of own values;
- Making first steps to economic stability, including continuing training/education;
- Becoming content with sobriety;
- Recognising rationalisations (dishonesty);
- Commitment to ongoing recovery efforts.

(The participating CAAs also included some of these focus areas in the aspects they would like to be assisted with during aftercare (see Chapter 3).)

Working within the framework of the Disease Model of Addiction, Gorski (1990:125-133) makes the following suggestions for goals of recovery from

chemical addiction: 1) developing of insight regarding the disease, and the need for abstinence from all chemical substances; 2) developing an ongoing recovery plan; and 3) recognising and treating other problems that may interfere with the recovery. The latter two goals are specifically relevant for aftercare. Fisher and Harrison (2005), also working from the framework of the Disease Model of Addiction, suggest that the process of treatment of chemical addiction be divided in the following phases: 1) Assessment and diagnosis of addiction (i.e. according to Jellinek's phases of addiction and recovery), 2) client engagement and motivational interviewing, 3) treatment of addiction, 4) relapse prevention and recovery, 5) the use of support groups to sustain changes made in treatment, 6) and inclusion of the family in order to ensure the restoration of family homeostasis that was impaired by the addiction. The fourth to the sixth steps mentioned above are relevant to the present research endeavour).

Subsequent to the description of the development of the disease model, its conceptual framework and evolution and suggestions and practice guidelines evolving from this model, the researcher studied the different aftercare models which will be discussed in the following sub-sections of this chapter. They are:

- Draft Systems Model for Prevention and Aftercare
- Relapse Prevention Therapy (RPT)
- Cenaps Model for Relapse Prevention
- Matrix Model for Recovery and Relapse Prevention
- Treatment Process Model
- Texas Christian University (TCU) Treatment System

### **5.2.1 The Draft Systems Model for Prevention and Aftercare**

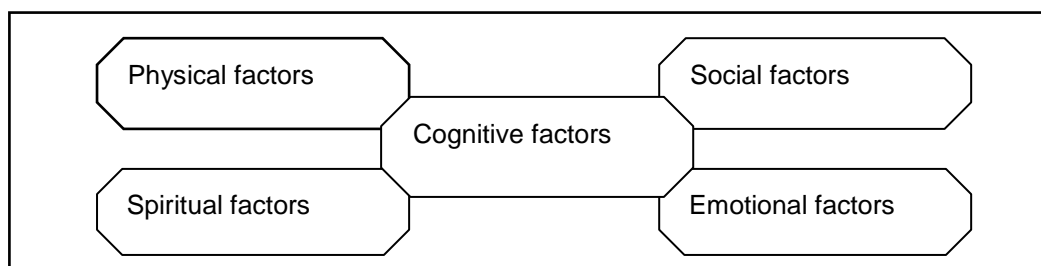
This Draft Systems Model for Prevention and Aftercare was developed by the Western Cape Department of Social Development (2008). It is proposed that treatment of chemical substance abuse should address the different needs of different populations. This draft, however, focuses specifically on the needs of adults suffering from chemical addiction (Department of Social Development

Western Cape, 2008:1). The Draft Systems Model for Prevention and Aftercare addresses three levels of care, namely prevention, treatment, and aftercare (the latter being the focus of this discussion). The target groups to be included are: 1) the chemically addicted person, 2) the family, and 3) peers (Department of Social Development Western Cape, 2008:1).

Aims of aftercare as presented in this Draft Systems Model for Prevention and Aftercare, and consistent with the viewpoints of the Disease Model of Addiction, are to assist chemically addicted persons to: 1) remain chemical substance-free, and 2) to develop their full potential following treatment. The subsequent objectives are: a) motivation to continue with aftercare, b) personal development and coping skills (in relation to coping with peers, environment and family), c) lifestyle change, and d) continued development on physical, intellectual, spiritual, economic and social levels. Recovery from chemical addiction is viewed as a lifelong process, implying that the utilisation of resources is essential for successful reintegration (Department of Social Development Western Cape, 2008:1-3). The researcher viewed these to be functional elements inherent to this model and subsequently incorporated these in the practice guidelines presented in the next chapter of the report.

In studying this Draft Systems Model for Prevention and Aftercare, the researcher found the system approach to be inherent to this model because the focus of service delivery is on different systems that impact on the client-system's well-being. This approach focuses on "the configuration client-environment-social problem as a unit" (New Dictionary for Social Work, 1995:64). "Systems" refer to a whole set of units, in interaction with each other and influencing one another, in a specific relationship (Van Niekerk & Prins, 2001:29). Van Niekerk and Prins (2001:30) highlight the impact of systems on each other. They state that when addressing a problem or need by changing a system related to the client's situation, it can be expected that this will lead to change in the client's life. The systems approach is also related to the bio-psychosocial components that need to be considered when working in the Disease Model of Addiction paradigm (Clark, 2009:1), as illustrated in Figure 5.1 below.

**Figure 5.1:** Bio-psychosocial factors (as adapted from Van Niekerk & Prins, 2001:32; Clark, 2009:1)



The systems approach is based on the ecosystems perspective. The ecosystem perspective focuses on the interplay between the client and his/her environment, using a multidimensional assessment (Sheafor & Horejsi, 2006:89-90). Meyer and Mattaini (in Mattaini, Lowery & Meyer, 2002:3-19) argue that the services from an ecosystem perspective explore and address the chemical addiction, as well as the factors related to the addiction on an intrapersonal-, interpersonal and environmental level of functioning. Linking this statement to the present study, the social worker works with CAAs and their families (intra- or interpersonal level), while acknowledging and addressing the impact of peers (interpersonal level) and the community (environmental level). Van Wormer and Davis (2003:17-18) postulate that the ecosystem perspective contributes to the development of the client-system's resilience, and note that the focus is on building strength on intrapersonal, interpersonal and environmental levels. The authors suggest that the following focus areas be included in service delivery to chemically addicted persons when working from an ecosystem perspective:

- Identify and develop a sober identity (developing a healthy self-image);
- Increase motivation through motivational interviewing, thereby developing the need for personal control and choice;
- Create hope through activities that lead to a sense of achievement, and
- Include family members and community institutions to ensure the utilisation of resources. The researcher incorporated these suggestions made by the authors above into the practice guidelines aiding social workers to render aftercare services to CAAs following treatment (see Chapter 6).

The Draft Systems Model for Prevention and Aftercare was developed based on the social developmental approach (Department of Social Development Western Cape, 2008:1), which also underscores the guidelines for service delivery as stipulated in the White Paper of Social Welfare of South Africa (1997:43). According to this approach, service delivery is multi-disciplinary in nature (i.e. emphasising the importance of networks), and services should be focused on basic material, physical and psychosocial needs (Weyers, 2001:63). The following suggestions on the characteristics of service delivery from this approach, which are included in the Draft Systems Model for Prevention and Aftercare, are provided by the White Paper of Social Welfare of South Africa (1997): capacity building (i.e. the development of life skills); voluntary participation; self-help groups; advocacy; and informal education.

Based on the suggested characteristics of service delivery from a social developmental approach as described above, the Draft Systems Model for Prevention and Aftercare proposes that aftercare services should place emphasis on the following aspects, which the researcher viewed to be of significance and incorporated into the practice guidelines presented in the next chapter:

- The development of the client's full potential by maintaining sobriety,
- Linking the client with resources and services in the community,
- Equipping and strengthening the client with coping mechanisms to deal with challenges,
- Promoting and sustaining a healthy and sober lifestyle,
- Successfully reintegrating the client into the family and community,
- Encouraging clients to broaden their support system.

Regarding reintegration into the family and community following treatment, the following areas are highlighted as focal points for service delivery in the Draft Systems Model for Prevention and Aftercare (Department of Social Development Western Cape, 2008:17-19):

- **Access to services to assist the chemically addicted person to develop an individual reintegration plan.** Chemically addicted persons

should have access to services that assist them to develop a reintegration plan outlining 1) activities, 2) services and 3) resources that would be utilised during the reintegration process. The client must be involved in the planning to ensure that he/she buys into the reintegration (cf. Fisher & Harrison, 2005:43). In addition, all the people who will be involved in the reintegration process must be part of this process. Emphasising the link between treatment and aftercare, it is suggested that the date of release from the treatment centre and reintegration should be reflected in the plan, to ensure that all parties involved are prepared to assist the client once he/she returns home following treatment.

- **The development of a family reintegration plan:** The family of the chemically addicted person must be consulted and helped to develop their own reintegration plan which will be helpful in assisting the person following treatment. The family reintegration plan should be planned, implemented and managed by the family themselves.

It is suggested in the Draft Systems Model for Prevention and Aftercare that the action plan for service delivery, and the utilisation of these services, should outline: 1) the time, 2) the frequency, 3) the place, and 4) the nature of contact (meetings, interviews, telephonic contacts or home visits). It should also 5) specify the person/s responsible for providing aftercare. Other factors to be considered are:

- Active involvement of chemically addicted persons in the aftercare process;
- Crucially, gaining the consent of the clients for aftercare treatment, emphasis being the benefits and challenges of behavioural change;
- The provision of counselling/group work services in order to deal with emotions experienced;
- Designing the aftercare treatment jointly and setting measurable and attainable goals;
- The conclusion of every aftercare session being a mutually agreed plan for the next session (Department of Social Development Western Cape, 2008:19-20).

Although this draft was specifically designed for adult persons, the researcher found that it links to the data obtained from the participants in the present study, therefore also relating to CAAs. Table 5.1 below provides a reflection on the strengths, weaknesses and identified functional elements of the Western Cape Draft Systems Model for Prevention and Aftercare (Western Cape Department of Social Development, 2008):

**Table 5.1:** Strengths, weaknesses and functional elements of the Draft Systems Model for Prevention and Aftercare

Strengths	Weaknesses	Functional elements <sup>8</sup>
<p>It aims to assist with the maintenance of sobriety The focus is on clients' intrapersonal, interpersonal and environmental level of functioning by means of utilisation of resources through the use of the ecosystems perspective and the systems approach In line with the requirements for service delivery as stipulated in the White Paper of Social Welfare of South Africa (1997) Specifically developed for chemically addicted persons in the Western Cape</p>	<p>No specific focus on the unique needs of addicted adolescents Does not include practical guidelines regarding community work actions to address the identified concerns relating to availability and tolerance of chemical substances, although the value of networks and resources is accentuated</p>	<p>Services are aimed at the chemically addicted person, family and peers to assist in reintegration into the family and the community It includes a multidimensional assessment of the client's needs Making use of case work and group work methods Aims to assist in maintaining sobriety Objectives:</p> <ul style="list-style-type: none"> <li>• coping skills</li> <li>• lifestyle change</li> <li>• developing a healthy self-image</li> <li>• increase intrinsic motivation</li> <li>• activities that lead to a sense of achievement</li> <li>• linking the client with resources and services in the community</li> <li>• encouragement to broaden their support system</li> <li>• development of an aftercare plan for the client, as well as for the family</li> </ul>

The following two sections will focus on the Cenaps Model for Relapse Prevention by Gorski (1988) and the Relapse Prevention Therapy Model (RPT) by Marlatt and Gordon (1985). Fisher and Harrison (2005:157-162) and Lessa and Scanlon (2006:295) note that these two models appear to be the main models of relapse prevention utilised by aftercare service providers. Both these models are based on the Disease Model of Addiction. The core difference between these two models (that will be described in broader terms later in this chapter) is that, according to the Cenaps Model of Relapse Prevention, the initial intake of the chemical substance is viewed as a relapse. On the other hand, the RPT model suggests that the initial intake does not

<sup>8</sup> These functional elements were incorporated in the developed practice guidelines to aid social workers in rendering aftercare services to CAAs following treatment (see Chapter 6).



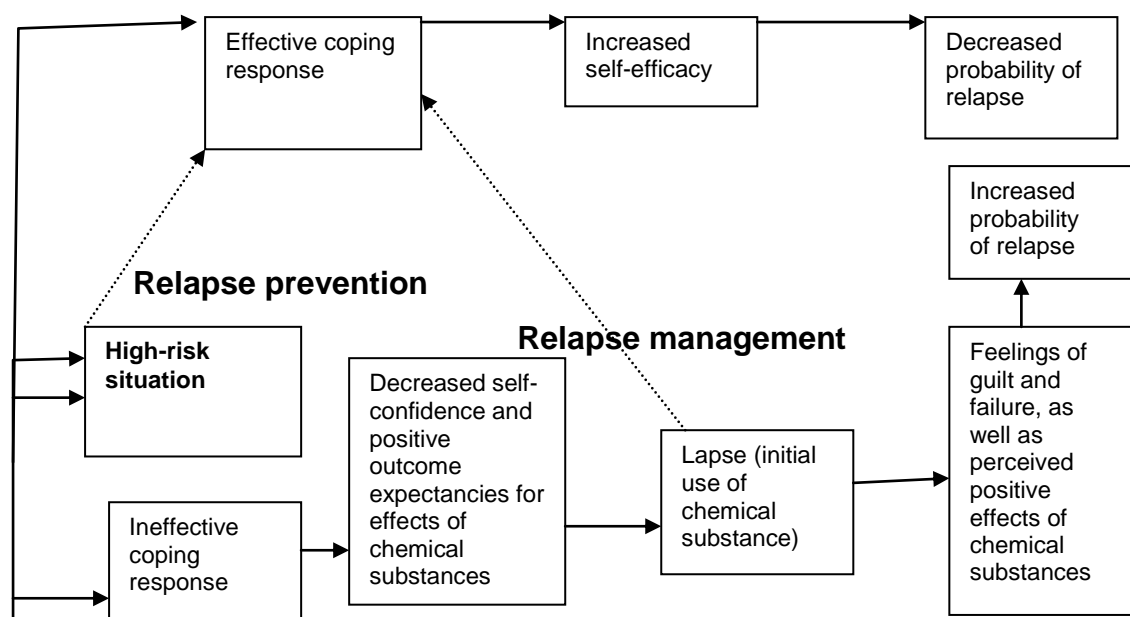
necessarily result in a relapse, but that it could be viewed as a lapse. Both models, however, acknowledge the tendency to relapse (Gordon, 2003:10). Lessa and Scanlon (2006:295) are of the opinion that the other aftercare/relapse prevention models were adapted from these two models. The authors note that the focus is on relapse prevention as well as continued treatment, which is especially valuable when treatment periods are insufficient, to internalise new behaviours and perceptions.

### **5.2.2 Relapse Prevention Therapy (RPT) Model**

The RPT model was developed by Marlatt and Gordon (1985:46) for aftercare services to chemically addicted persons. The specific emphasis is on the prevention of relapses, thereby maintaining sobriety. Similar to the Draft Systems Model for Prevention and Aftercare discussed above, this model does not specifically focus on adolescents.

The systems approach, as discussed in the previous sub-section, is also related to the RPT model. According to this model, relapse prevention services focus on the identification and redress of risk factors that might lead to relapses and the identification and development of protective factors regarding interpersonal, intrapersonal, environmental and physiological aspects (Marlatt et al., 2002:3) as described in the figure below. Fisher and Harrison (2005:307) define “risk factors” as events, situations and perceptions that could lead to substance use. “Protective factors” on the other hand, are biological, psychological and social characteristics associated with the ability to “survive and thrive in adverse circumstances” (Compton et al., 2005:45). The figure indicates what the outcome of an effective and also an ineffective coping response will be. As illustrated here, the coping response (which is related to either risk or protective factors) of the chemically addicted person in recovery will determine the outcome of a high-risk situation.

**Figure 5.2:** Marlatt and Gordon's (1985:42) Relapse Prevention Model



Concluding from the figure above, the RPT model highlights a central role for high-risk situations and for the addict's response to those situations. Relapse potential is reduced by effective coping responses. The addicts in recovery have confidence that they can cope with the situation. On the other hand, persons with ineffective coping responses will experience decreased self-confidence, which, together with the expectation that the use of the chemical substance of choice will have a positive effect, can result in an initial lapse. This lapse, in turn, can result in feelings of guilt and failure. These feelings, along with positive outcome expectancies, can increase the probability of a relapse (Marlatt & Gordon, 1985:42).

The RPT is also based on the cognitive-behavioural approach. This approach attributes the client's present problem behaviour to "learning processes, and the formation of maladaptive perceptions" (Compton et al., 2005:425). In the context of chemical addiction, Keegan and Moss (2008:98) describe the value of this approach as a way to address unrealistic negative ideas and attitudes, while different behaviour is adopted by replacing chemical substances with joyful activities. Building on this sentiment, as well as the description of this model in Figure 5.2 above, Perkinson (2008:93) relates thoughts to events. Events lead to thoughts; the thoughts lead to feelings, which in return

determine reactions or behaviours. This approach thus aims to alter thoughts in order to change behaviour.

Regarding the implementation of the RPT model, Teesson et al. (2002:84-87) suggest the following focus areas to be attended to when providing aftercare services, also confirmed by the CAAs who participated in this study (see Chapter 3), and evaluated by the researcher to be functional with the result that it was subsequently incorporated in the aftercare practice guidelines presented in Chapter 6:

- Motivational enhancement training,
- Management of cravings,
- Dealing with high-risk situations,
- General coping skills (stress-management, problem-management),
- Management of withdrawal symptoms,
- Social skills (assertiveness, communication skills).

Other suggestions that were found in the literature applicable the cognitive-behavioural approach inherent to the RPT model include:

- Life skills, including anger-management, refusal skills (i.e. the ability to say “No” to the temptation to use chemical substances), and relaxation (Dodgen & Shea, 2000:119);
- Coping responses, including problem-solving, decision-making skills and dealing with feelings of guilt and failure (Marlatt & Gordon, 1985:46);
- Addressing risks and protective factors regarding interpersonal, intrapersonal, environmental and physiological factors (Marlatt et al., 2002:3).

Sussman and Ames (2001:122) refer to the Self-Management and Recovery Training Programme, which is also related to the cognitive-behavioural approach, as well as the RPT model. It is based on the assumption that addictive behaviour is learned behaviour that interferes with healthy activities, and therefore focuses on habit change by means of a four-point plan, namely:

- Consideration of the cost of the addiction and the benefits of recovery (self-awareness),
- Coping with urges (development of alternative reactions to temptations),
- Solving life problems such as conflict,
- Balancing and enduring satisfaction (Sussman & Ames, 2001:122).

When implementing the RPT Model, Marlatt et al. (2002:20-21) suggest that the following aspects should receive attention during the provision of aftercare services:

- Teaching the client-system coping strategies,
- Assistance with drawing maps to present high-risk situations visually,
- Guidance in evaluation of honesty and cognitive decisions,
- Providing support and guidance on how to affect lifestyle changes,
- Assistance with a lapse: Practical plan to prevent relapse.

Marlatt et al., (2002:24) suggest that the following specific strategies be employed in this model:

- Self-monitoring: assess behaviours in situations;
- Efficacy-building: goal-setting and role-plays;
- Lapse-management: reminder cards regarding an emergency plan ;
- Cognition restructuring: a lapse is a mistake, not a failure; substance use is hazardous;
- Development of decision-making skills;
- Coping skills: relaxation and stress-management.

In conclusion, the cognitive-behavioural approaches included in this model place the emphasis on life skills that address the ability to cope with high risks. The aim is therefore to assist the chemically addicted person in recovery to become confident that he/she will be able to deal with high-risk situations. Dodgen and Shea (2000:119), however, warn that it is essential not to confuse confidence with an unrealistic sense of “I don’t have to worry.” On the other hand, according to Marlatt et al. (2002:5), a lapse does not imply that it will necessarily lead to a relapse. It could be viewed as a learning and

confirming experience, thus becoming a “breakthrough” instead of a “breakdown” in the recovery process. Table 5.2 below illustrates the strengths, weaknesses and functional elements identified in the RPT model.

**Table 5.2:** Strengths, weaknesses and functional elements of the Relapse Prevention Therapy model

Strengths	Weaknesses	Functional elements <sup>9</sup>
<p>It focuses on prevention of relapses            It addresses a lapse as a learning opportunity            It aims to assist with the maintenance of sobriety            Risk factors are acknowledged as contributors to relapse, and services aim to identify and address these risks            Protective factors are viewed as contributors to resilience, continued growth, and subsequently the maintenance of sobriety</p>	<p>No specific focus on the unique needs of addicted adolescents            Does not provide guidance or suggestions relating to actions to address the identified concerns about availability and tolerance of chemical substances</p>	<p>The aim is to address risk factors and protective factors            The cognitive-behavioural approach underscores:</p> <ul style="list-style-type: none"> <li>• addressing unrealistic negative ideas and attitudes</li> <li>• adoption of different behaviour by replacing chemical substances with joyful activities</li> </ul> <p>Focus areas:</p> <ul style="list-style-type: none"> <li>• Motivational enhancement training</li> <li>• Management of cravings</li> <li>• Dealing with high-risk situations</li> <li>• General coping skills</li> <li>• Management of withdrawal symptoms</li> <li>• Development of social skills</li> <li>• Development of life skills</li> <li>• Dealing with feelings of guilt and failure</li> <li>• Lifestyle changes</li> <li>• Assistance with a lapse</li> <li>• Practical plan to prevent relapse</li> </ul>

### 5.2.3 Cenaps Model for Relapse Prevention

The Cenaps Model for Relapse Prevention, developed by Gorski (1988), is similar to the RPT model discussed in the previous sub-section, as the emphasis is on the maintenance of sobriety that is obtained through relapse prevention. Similar to the Draft Systems Model for Prevention and Aftercare discussed earlier in this chapter, this model includes the different stages of treatment. According to Sussman and Ames (2001:109), this model can be divided into six periods, the latter three of which fall within the ambit of aftercare services:

- Pre-treatment period: recognition of the addiction;
- Stabilisation period: dealing with withdrawal;
- Early recovery period: the acceptance of the addiction and development of non-chemical coping strategies;

<sup>9</sup> Most of these functional elements were incorporated in the developed practice guidelines to aid social workers in rendering aftercare services to CAAs following treatment (see Chapter 6).

- Middle recovery period: development of a balanced living goal;
- Late recovery period: personality and behavioural changes;
- Maintenance period: continued growth and development.

This model is also premised on the Disease Model of Addiction. It builds on the philosophy that addiction to chemical substances leads to physical, psychological and social problems. The model is also founded on the 12-Steps Programme of Narcotics Anonymous (NA) (Gorski, 1990:125-133). The Cenaps model includes cognitive and behavioural approaches. The following discussion will provide some possible links between these two approaches and the aims of the present research endeavour.

The *behavioural approach* (in the context of interventions to chemical addicted client-systems) is based on the assumption that chemically addicted persons should develop insight into the benefit of not using chemical substances (implying the inclusion of the cognitive approach), and change their behaviour based on this insight (Keegan & Moss, 2008:108). The inclusion of this approach in aftercare services is supported by Marlatt et al. (2002:3), who suggest that changing addictive behaviours means: 1) to understand the reasons behind behaviours (again leaning towards the inclusion of the cognitive approach), 2) to “unlearn” negative behaviours associated with the substance abuse, and 3) to replace them by learning positive behaviours. The following suggestions were made in the NIDA (2008:8-9) document Principles of Drug Addiction Treatment, when addressing substance abuse-related behavioural changes among chemically addicted persons:

- Provide rewards for change in behaviour and/or teach clients to reward themselves for behaviour changes;
- Include task-orientated activities associated with desired behaviours, starting with the easiest activities, to increase the feeling of accomplishment, and moving to more complex activities;
- Provide opportunities for the rehearsal of new behaviours;

- Teach stimulus control through the avoidance of trigger situations and learning to participate in new activities;
- Teach clients to control urges by recognising the former and changing thoughts and feelings.

Perkinson (2008:93) highlights the value of the behavioural approach when dealing with chemical addiction. The author explains that addiction leads to the notion of a “quick fix” where the addict neglects the possibility of other ways of dealing with situations. Although a “quick fix” does not last long, it assists the addict in coping. The behavioural approach assists chemically addicted persons to explore practical alternative behaviours to address these situations, thereby replacing the “quick fix” with a “real fix”. This approach aims to unlearn old behaviour and replace it with new behaviour. The author concludes by explaining that chemically addicted persons need reinforcement to be able to identify the difference between the consequences of chemical-induced behaviour and sober behaviour (Perkinson, 2008:93).

As stated above, The Cenaps Model for Relapse Prevention is also premised on the cognitive approach. McLeod (2003:80) explains the value of the *cognitive approach*, noting that the client may not be “consciously aware of the true motive or impulses behind his or her actions”. Therefore, chemically addicted persons should learn to understand themselves, in order to understand the motives behind their behaviour, and to move toward positive change. Also focusing on the advantages of this approach, Hepworth et al. (2006:391-402) describe the cognitive approach as one that acknowledges that a cognitive process has an impact on perceptions, which leads to an impact on behaviour. The approach assists the client to modify: 1) beliefs, 2) faulty thought patterns/perceptions, and 3) destructive behaviour. The authors postulate that this model is suitable to:

- Gain awareness of dysfunctional thoughts and perceptions that impair functioning;
- Address low self-esteem, unrealistic expectations, irrational fears, depression and lack of assertiveness; and to

- Use with other interventions (Hepworth et al., 2006:391-402).

In the context of interventions to chemically addicted client-systems, the cognitive approach is used to assist them to change their perceptions about themselves and their abilities, in order to enhance self-efficacy, and to contribute to positive change (Barr & Parrett, 2001:16; Barrett & Ollendick, 2004:338). Allen-Meares and Garvin (2000:276) support this sentiment and link the behavioural and cognitive frameworks. Focusing specifically on adolescents, the authors advise that appropriate changes by the adolescents should be rewarded, and that inappropriate behaviour should be sanctioned. The aim of this action could therefore be to establish a different perception regarding the rewards for sobriety versus the rewards for “drugging” (cf. Perkinson, 2008:93).

The focus areas to be included when developing guidelines for the rendering of aftercare services to chemically addicted persons inherent to the characteristics of Cenaps Model are:

- The recognition of the addiction;
- Dealing with prolonged withdrawal symptoms;
- Recognition of the need to abstain from all chemical substances;
- The acceptance of the addiction (i.e. dealing with defence mechanisms that prevent the client from accepting the addiction), and development of non-chemical coping strategies;
- The recognition and treatment of other problems that may interfere with the recovery;
- Separation from people, places and things that threaten recovery, and the development of a social support network;
- The development of an ongoing recovery plan;
- The termination of harmful behaviour and thoughts;
- Learning how to manage emotions and behaviour;
- Learning new emotions and behaviours;
- Identifying and changing mistaken core beliefs about the self, others and the world;



- Maintaining continued growth and development (Gorski, 1988:127-128; Sussman & Ames, 2001:109).

Fisher and Harrison (2005:156) postulate that the main difference between the RPT model discussed previously and the Cenaps Model of Relapse Prevention (presently under discussion) is that the former acknowledges that relapses could be lapses that have the potential to become a learning opportunity. On the other hand, the latter views a lapse as a relapse, implying that it is the cessation of the recovery process (Fisher & Harrison, 2005:156). The strengths, weaknesses and functional elements of the Cenaps Model of Relapse Prevention are described in the table below.

**Table 5.3:** Strengths, weaknesses and functional elements of the Cenaps Model of Relapse Prevention

Strengths	Weaknesses	Functional elements <sup>10</sup>
<p>It focuses on prevention of relapses It aims to assist with the maintenance of sobriety</p>	<p>No specific focus on the unique needs of addicted adolescents Does not provide guidance or suggestions about actions to address the identified concerns relating to availability and tolerance of chemical substances</p> <p>It views a lapse as a relapse, thereby not acknowledging it as a learning experience It uses cognitive and behavioural approaches separately.</p>	<p>The following stages of treatment are included in aftercare:</p> <ul style="list-style-type: none"> <li>• Middle recovery period: development of a balanced living goal</li> <li>• Late recovery period: personality and behavioural changes</li> <li>• Maintenance period: continued growth and development</li> </ul> <p>Elements associated with the behavioural approach to be included in aftercare:</p> <ul style="list-style-type: none"> <li>• Rewards for change in behaviour</li> <li>• Task-orientated activities associated with desired behaviours</li> <li>• Rehearsal of new behaviours</li> <li>• Stimulus control</li> <li>• Control of urges</li> </ul> <p>Elements associated with the cognitive approach to be included in aftercare:</p> <ul style="list-style-type: none"> <li>• Awareness of dysfunctional thoughts/perceptions</li> <li>• Addresses low self-esteem, unrealistic expectations, irrational fears, depression and lack of assertiveness</li> </ul> <p>Focus areas of the Cenaps Model:</p> <ul style="list-style-type: none"> <li>• Recognition of the addiction</li> <li>• Dealing with prolonged withdrawal symptoms</li> <li>• Abstinence from all chemical substances</li> <li>• Acceptance of the addiction, and development of non-chemical coping strategies</li> <li>• Recognition and treatment of other problems related to the addiction</li> <li>• Separation from people, places and things that threaten recovery</li> <li>• Development of a social support network</li> <li>• Development of an ongoing recovery plan</li> <li>• Identification and management of emotions and behaviours</li> <li>• Maintaining continued growth and development</li> </ul>

<sup>10</sup> Most of these functional elements were incorporated in the developed practice guidelines to aid social workers in rendering aftercare services to CAAs following treatment (see Chapter 6).

Other models related to aftercare services and also applicable to CAAs that were considered by the researcher included the Matrix Model for Recovery and Relapse Prevention, the Treatment Process Model, and the TCU Treatment System. Each of these models will be presented in the ensuing part of this chapter.

#### **5.2.4 The Matrix Model for Recovery and Relapse Prevention**

This model was created by the Matrix Institute on Addiction (2008b) to address chemical addiction through both treatment and aftercare services. This model draws heavily on combinations of the relapse prevention models that were described above. Studies relating to principles of chemical addiction treatment conducted by the American National Institute on Drug Abuse (NIDA, 2008:6) gave preference to the Matrix Model based on a positive reaction associated with this model. The view relating to relapses as a learning opportunity, as well as the inclusion of the cognitive-behavioural approach, as discussed under the heading Relapse Prevention Therapy (RPT) underscores this model (Matrix Institute on Addiction, 2008b:1).

Characteristic of the Matrix Model for Recovery and Relapse Prevention are the following:

- Focusing on lifestyle changes;
- The content of the programme is on relapse prevention education;
- A not-judgemental approach is adopted when relapses occur ;
- Motivational interviewing is proposed to encourage chemically addicted persons to discuss relapses, while dealing with defence mechanisms;
- Inclusion of families by means of individual and group therapy;
- Encouragement of chemically addicted persons and their families to use self-help groups (Matrix Institute on Addiction, 2008b:1).

In view of relapse prevention as part of this model, NIDA (2008:11-49) proposes that the following must be kept in mind:

- Treatment should include networks with schools and community facilities;

- Treatment programmes shorter than three months should be considered as inadequate and require more focused aftercare;
- Areas to address during aftercare may include motivation for change, skills in dealings with cravings, development of skills to participate in non-chemical substance-using activities, problem-solving skills, and relationships;
- Treatment of chemically addicted persons who enter any form of treatment involuntary does not necessarily result in poor outcomes.

The characteristics of the Matrix Model for Recovery and Relapse Prevention are similar to the RPT Model, but include treatment as part of the focus, similar to the Draft Systems Model for Prevention and Aftercare. The involvement of families in aftercare, dealing with relapses by means of motivational interviewing, and the use of self-help groups are highlighted by this model. Table 5.4 below illustrates the strengths, weaknesses and functional elements of the Matrix Model for Recovery and Relapse Prevention.

**Table 5.4:** Strengths, weaknesses and functional elements of the Matrix Model for Recovery and Relapse

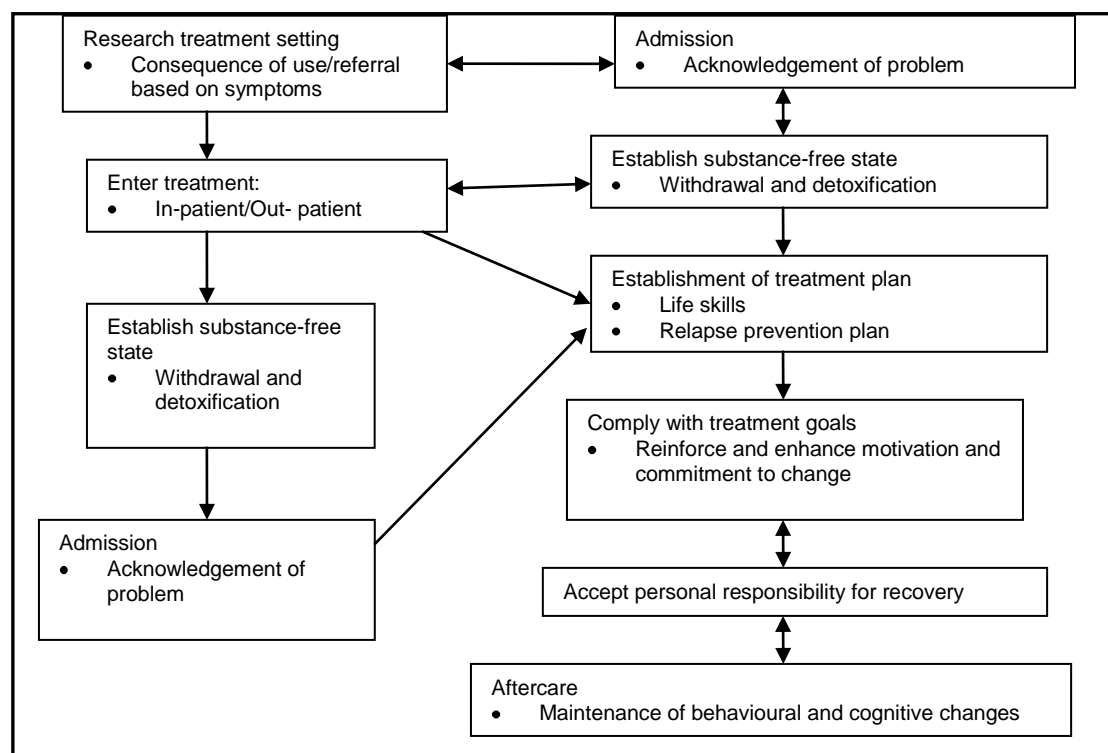
Strengths	Weaknesses	Functional elements <sup>11</sup>
Draws on the functional elements of RPT and Cenaps Models It links treatment and aftercare It focuses on prevention of relapses Relapses are seen as a learning opportunity It aims to assist with the maintenance of sobriety	No specific focus on the unique needs of addicted adolescents Does not provide guidance or suggestions about actions to address the identified concerns relating to availability and tolerance of chemical substances	Service delivery is based on the cognitive-behavioural approach Characteristic of aftercare are: <ul style="list-style-type: none"> <li>• Lifestyle changes</li> <li>• Relapse prevention education</li> <li>• A non-judgemental approach when relapses occur</li> <li>• Motivational interviewing to deal with relapses and defence mechanisms</li> <li>• Inclusion of families</li> <li>• Implementation of individual and group therapy</li> <li>• Encouragement to use self-help groups</li> <li>• Includes networks with schools and community facilities</li> <li>• Enhancement of motivation for change</li> <li>• Skills in dealings with cravings</li> <li>• Skills to participate in non-chemical substance-using activities</li> <li>• Problem-solving skills</li> <li>• Relationship skills</li> </ul>

<sup>11</sup> Most of these functional elements were incorporated in the developed practice guidelines to aid social workers in rendering aftercare services to CAAs following treatment (see Chapter 6).

### 5.2.5 Treatment Process Model

The Treatment Process Model is described by Sussman and Ames (2001:103). Like the Draft Systems Model for Prevention and Aftercare and the Matrix Model for Recovery and Relapse Prevention (presented earlier in this chapter), this model acknowledges that aftercare should form part of the whole treatment process. According to the Treatment Process Model, the chemically addicted client-system is involved in the process of preparation for treatment, treatment, and aftercare. This involvement entails: 1) the identification of an appropriate treatment programme, 2) the entering of the treatment programme, 3) the establishment of a substance-free state, followed by 4) the admission of addiction, and 5) motivation to continue with aftercare (Sussman & Ames, 2001:103). Figure 5.3 provides an illustration of the treatment process, of which aftercare is the crucial component to maintain change.

**Figure 5.3:** The Treatment Process Model (as adapted from Sussman & Ames, 2001:103)



The behavioural and cognitive approaches, as described under the heading Cenaps Model for Relapse Prevention, underscore this model, as the focus is on: 1) the development of insight into the addiction and recovery, 2) the development of intrinsic levels of motivation, and 3) the development of new behaviours that will assist the addict in efforts to maintain sobriety. However, Sussman and Ames (2001:104) advise that these two approaches be used in combination, as supported by the RPT model. Aftercare, according to the Treatment Process model, is focused on the maintenance of behavioural and cognitive changes made in treatment.

In order to ensure sustainable change, Sussman and Ames (2001:103) suggest that aftercare workers request the following information from treatment centres in order to ensure coordination of service delivery:

- The content of the treatment programme
- The behavioural and cognitive changes made in treatment, and
- An account of any needs subsequently identified by the therapists at the treatment centre at the end of the treatment period (Sussman & Ames, 2001:103).

Table 5.5 below illustrates the strengths, weaknesses and functional elements of the Treatment Process Model.

**Table 5.5:** Strengths, weaknesses and functional elements of the Treatment Process Model

Strengths	Weaknesses	Functional elements <sup>12</sup>
It supports the link between the different stages of treatment	No specific focus on the unique needs of addicted adolescents Does not provide guidance or suggestions about actions to address the identified concerns relating to availability and tolerance of chemical substances No suggestions relating to the implementation of this model were found in the literature.	Focus of aftercare: <ul style="list-style-type: none"> <li>• Motivational techniques to continue with aftercare</li> <li>• Maintenance of behavioural and cognitive changes</li> </ul> Focus of coordination of service delivery: <ul style="list-style-type: none"> <li>• content of treatment programme,</li> <li>• behavioural and cognitive changes made in treatment</li> <li>• Identification of any subsequent needs to be addressed in aftercare</li> </ul>

<sup>12</sup> Most of these functional elements were incorporated in the developed practice guidelines to aid social workers in rendering aftercare services to CAAs following treatment (see Chapter 6).

### **5.2.6 The TCU (Texas Christian University) Treatment System**

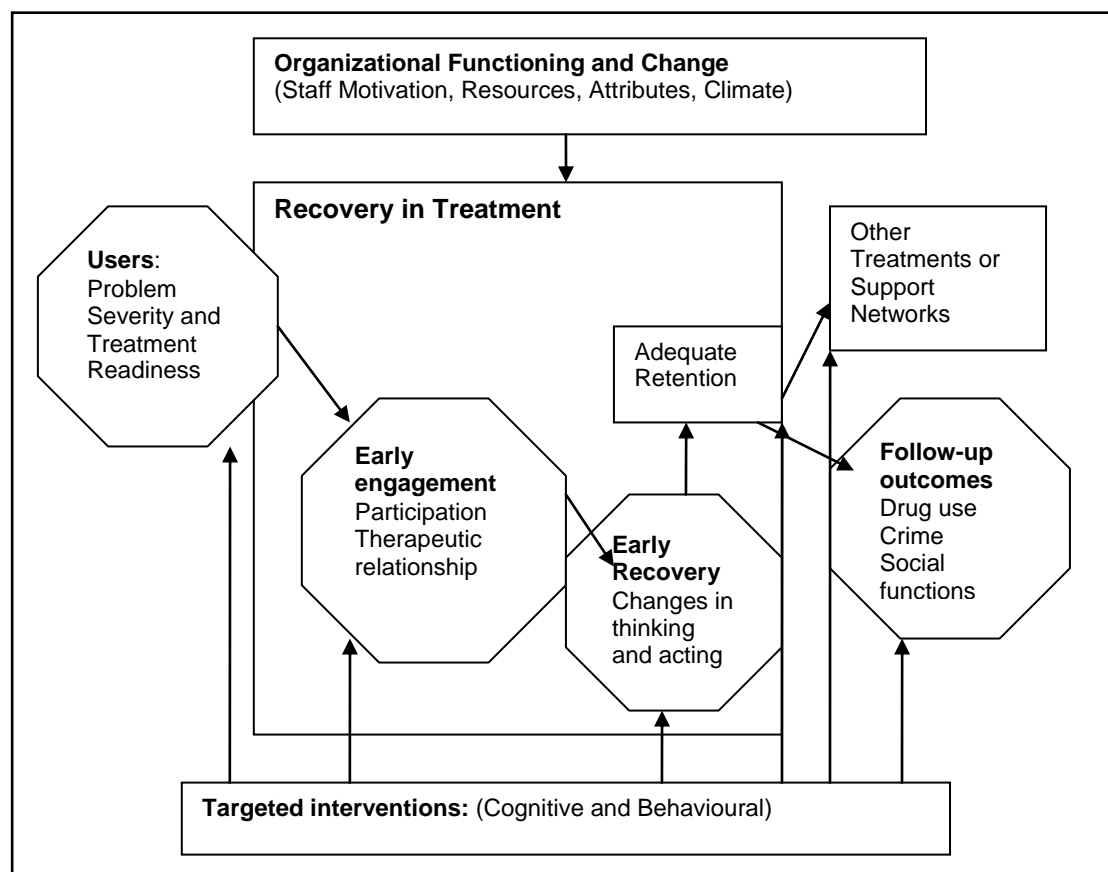
The TCU Treatment System model was developed at the Texas Christian University in America and is described by Simpson (2005). Similar to the abovementioned models, the focus is on the treatment of chemically addicted persons in general. Simpson (2005:1) states that the focus of this model is on the assessment of: 1) the special needs of the client to ensure satisfaction with the outcomes of the intervention process, as well as 2) organisational factors related to the programme's effectiveness and adaptability. This model is founded on the cognitive-behavioural approach (as described previously), aiming to alter thoughts and belief systems in an effort to change behaviour (Simpson, 2005:1).

Similar to the Treatment Process Model discussed in the previous subsection, the TCU Treatment System relates to an assumption that treatment of chemical addiction is an ongoing process, which includes a series of events, including aftercare. The emphasis is on repeated assessments throughout treatment, (i.e. prior to admittance to treatment programmes in the beginning, middle and final stages of the treatment programme, as well as throughout the aftercare process) (cf. Fisher & Harrison, 2005:43). Simpson (2005:2) asserts that studies show ongoing assessments impact positively on the outcome of the treatment process.

The interrelatedness of this organisational structure with the psychosocial intervention process is accentuated, as illustrated in Figure 5.4 below. Simpson (2005:2) points out that, on the one hand, regarding the organisational structure, the motivation of staff; availability, mobilisation and utilisation of resources; as well as the climate of organisations rendering services to chemically addicted persons play an important role in the outcome of services. On the other hand, services should be focused on the psychological and social needs of the client (with emphasis on altering dysfunctional thoughts, beliefs and behaviour). This psychosocial intervention focuses on preparation for treatment, treatment (focusing on behavioural and cognitive change), motivation to continue with treatment, utilisation of

resources/networks, and aftercare. In addition, this model acknowledges the need to address social issues such as chemical substance use (tolerance and availability) in the community, and to address chemical substance-related crimes in the community (Simpson, 2005:2).

**Figure 5.4:** TCU Treatment System components for psychosocial interventions (Simpson, 2005:5)



Simpson (2005:3) postulates that assessments and interventions have been “functionally detached” in the past. Pieces of this process operated independently and did not inform each other about impact or deficiencies. The TCU Treatment System therefore attempts to ensure that preparation for treatment; treatment, and aftercare form a unity within which chemically addicted persons are enabled to recover from their addiction. Strengths, weaknesses and functional elements of the TCU Treatment System are summarised below.

**Table 5.6:** Strengths, weaknesses and functional elements of the TCU Treatment System

Strengths	Weaknesses	Functional elements <sup>13</sup>
<p>It supports the link between the different stages of treatment Treatment is seen as an ongoing process It acknowledges the need to address social issues:</p> <ul style="list-style-type: none"> <li>• substance use (tolerance and availability)</li> <li>• addressing chemical substance-related crimes</li> </ul>	<p>No specific focus on the unique needs of addicted adolescents No suggestions relating to the implementation of this model were found in the literature.</p>	<p>It focuses on repeated assessments of:</p> <ul style="list-style-type: none"> <li>• the client's special needs</li> <li>• organisational factors to increase effectiveness and adaptability of services</li> </ul> <p>Psychosocial intervention based on the cognitive-behavioural approach focuses on:</p> <ul style="list-style-type: none"> <li>• Alteration of thoughts</li> <li>• belief systems</li> <li>• behaviour</li> </ul> <p>The organisational structure must be assessed and adjusted according to</p> <ul style="list-style-type: none"> <li>• the motivation of staff</li> <li>• availability, mobilisation and utilisation of resources</li> <li>• organisational climate</li> </ul>

Apart from the previously discussed models, the researcher in her quest to determine the current state of technology available (i.e. models for rendering aftercare services to chemically addicted client-systems) found guidelines and suggestions for practice applicable to the goal of the study, namely: to develop guidelines for social workers in assisting them in rendering aftercare services to CAAs. This information will be presented in the next section of the chapter.

### **5.3 Guidelines and suggestions from literature about rendering aftercare services to chemically addicted adolescents**

In addition to, and related to, the characteristics of the Disease Model of Addiction and the functional elements of the practice models relating to aftercare services (referred to above), the researcher extended the literature search and looked at other information sources related to intervention in general and treatment of chemical addiction (especially aftercare treatment) specifically for functional elements to be included in the guidelines. The extended literature search covered the following focus areas (based on requests from both interest groups participating in this study): 1) task-orientated guidelines to increase resilience, 2) the nature the recovery from addiction, 3) life skills to assist CAAs to develop recovery lifestyles, 4) family

<sup>13</sup> Most of these functional elements were incorporated in the developed practice guidelines to aid social workers in rendering aftercare services to CAAs following treatment (see Chapter 6).



services, 5) motivational interviewing to assist CAAs to develop intrinsic levels of motivation, and 6) the NA 12-Steps Programme. These focus areas will be discussed in the following sections.

### 5.3.1 Task-orientated activities to increase resilience

Task-orientated activities relate to the task-centred approach, which is typically associated with efforts to enhance resilience through social service delivery (Sheafor & Horejsi, 2006:104). Compton et al. (2005:433) state that the task-centred approach aims to identify tasks (activities) that will assist the client to solve problems and learn new coping behaviour. The task-centred nature of service delivery leads to workable intervention goals and to a cooperative therapeutic relationship between the social worker and the client. This approach is not specifically related to aftercare services to CAAs, but relates to the models discussed in the previous section, as illustrated in the table below.

**Table 5.7:** Relation between aftercare models and task-centred approach

Aftercare model	Associated approach	Suggested task-centred activities evaluated by the researcher to be functional and who were incorporated in the aftercare practice guidelines present in Chapter 6 of this report
RPT Model	Cognitive-behavioural approach	Learn how to manage cravings Learn how to manage stress constructively Learn how to manage anger appropriately and constructively Learn how to use refusal skills when tempted to use substances Learn to identify and utilise relaxation skills Learn how to implement problem-solving skills Learn how to implement decision-making skills (Marlatt & Gordon, 1985:46; Dodgen & Shea, 2000:119; Teesson et al., 2002:84-87)
Cenaps Model	Behavioural approach	Include task-orientated activities in the recovery plan to assist in the internalisation of new behaviour, and to create a sense of achievement Rehearsals of new behaviours Stimulus control in order to implement skills to deal with cravings and temptations (NIDA, 2008:8-9)
	Cognitive approach	Dealing with prolonged withdrawal symptoms (Gorski, 1988:127-128)
Matrix Model	Cognitive-behavioural approach	Dealing with urges Skills to participate in sober activities Problem-solving skills Lifestyle changes (Matrix Institute on Addiction, 2008b:1)

The above table indicates that task-orientated activities to deal with problems/needs typically associated with recovery can be addressed through

the use of the task-centred and cognitive/behavioural/cognitive-behavioural approaches in combination.

Sheafor and Horejsi (2006:104) advise that the social worker structures an intervention plan that includes action steps/task-centred activities by the client to improve resilience and self-efficacy. The task-centred approach is specifically related to the behavioural approach discussed above as it assists with the development of new behaviours (NIDA, 2008:8-9). In view of this, Hepworth et al. (2006:363-377) suggest that the following considerations be kept in mind when deciding upon and developing task-centred activities to alter old behaviour and develop new behaviour:

- Need to be linked to a timeframe in order to reduce or alter the target problem as seen by client;
- Need to be concrete and functional;
- Are based on the premise that people are able to solve their own problems, while the social worker gives guidance;
- Are systematic and short-term interventions in order to keep clients motivated and focused;
- Provide immediate feedback;
- Prevent clients from just talking and producing no action/change;
- Can be used as part of open-ended treatment;
- Actively involve clients.

Compton et al. (2005:433) relate the task-centred approach discussed above and another approach, namely the “solution-focused approach”. The authors suggest that these two approaches may be used in combination, assisting the client to develop a plan, consisting of specific tasks, to address problems. The latter approach is also associated with the RPT model (see p. 241). Through the solution-focused approach, the social worker facilitates change by enabling the client to identify and expand on actions that could lead to the effective solution to problems (Sheafor & Horejsi, 2006:105). O’Connell (2005) argues that this approach increases self-efficacy and leads to sustainability of changes made in treatment and aftercare. The author suggests that the client

is assisted to become able to: 1) identify problems, and 2) consider different solutions, before 3) dealing with the problem.

### 5.3.2 The recovery process of chemical addiction

As discussed earlier in this chapter, the Disease Model of Addiction acknowledges the neurological impact of chemical substances. Based on this, the Matrix Institute on Addiction (2008c:24), in discussing “triggers and cravings” comments on the importance of keeping in mind the impact of the stages of recovery<sup>14</sup> on the chemically addicted client-systems’ ability to take part in, and their level of involvement in, aftercare services. It is noted that the withdrawal/honeymoon stage lasts approximately one to three weeks, while the abstinence stage lasts approximately six to 20 weeks. The adjustment stage that follows lasts at least another 20 weeks. The Matrix Institute on Addiction (2008c:24) suggests that the abstinence and adjustment stages primarily impact on how aftercare activities and programmes should be structured. Despite the fact that withdrawal symptoms are primarily associated with withdrawal/honeymoon stages in recovery, these symptoms can still be present following treatment, and can often direct the behaviour and thoughts of the chemically addicted client-system (Matrix Institute on Addiction, 2008b:2-31). In view of this and in supporting the view of the TCU Treatment System, continued assessment throughout the intervention process is essential, as the needs of the addict will change as he/she moves through the stages of recovery.

The characteristics inherent to the stages of recovery (Matrix Institute on Addiction, 2008b:2-31) to be included in the practice guidelines were identified as follows:

- *The withdrawal stage’s* characteristics include exhaustion, insomnia, disordered thinking, memory problems, cravings, depression, low energy and irritability. These symptoms often need professional medical and

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<sup>14</sup> The researcher considered information about *the stages of recovery* as prerequisite knowledge for rendering aftercare service to CAAs and incorporated these as part of the practice guidelines for aftercare services to CAAs.

psychiatric treatment. It is advised that the CAA should develop a structure (i.e. a framework based on a treatment goal and objectives), including time-management regulating attendance of school, treatment programmes, recreational activities, self-help groups, sport, and association with sober friends, exercise, family activities and involvement in church activities.

Assistance with the: 1) avoidance of triggers, 2) reduction of anxiety and 3) replacement of the addictive lifestyle is also needed.

- *The honeymoon stage* is characterised by over-confidence, difficulty in concentrating, memory problems, intense feelings and mood swings, use of substitute substances, and the inability to prioritise. Triggers to be addressed are:
  - People (dealers, friends and groups);
  - Things (paraphernalia, money, music, movies, secondary chemical substance use);
  - Places (bars/clubs, neighbourhoods, streets);
  - Times (idle times, stressful events, holidays, celebrations, weekends);
  - Emotional states (anxiety, anger, frustration, fatigue).

Techniques to use during this stage include: 1) the recognition of chemical substance-use thoughts, 2) visualisations (i.e. diverting thoughts away from chemical substances), and 3) snapping (i.e. using a rubber band to “snap” as a way to divert attention away from chemical substances).

- The *abstinence stage* is characterised by the realisation of the consequences of the addiction and the challenges of recovery, as well as the initial adjustment to a recovery lifestyle. Suggested focus areas in aftercare during this stage include:
  - Changing old behaviours (i.e. substance-related behaviours);
  - Anger-management;
  - Diagnosing depression and referral for professional help;
  - Dealing with cravings;
  - Dealing with irritability and mood swings;

- Dealing with perceptions;
  - Developing a social network to combat isolation;
  - Dealing with slips;
  - Attending to family problems.
- The *adjustment stage* follows the initial adjustments relating to a recovery lifestyle in the abstinence stage discussed above. This stage is characterised by the need to reintegrate back into the family and society. Suggested areas to form part of aftercare services in the adjustment stage include:
    - Problems with relationships;
    - Time-management to combat boredom;
    - Development of recovery goals;
    - Dealing with feelings of guilt and shame;
    - Addressing school and career problems (Matrix Institute on Addiction, 2008b:2-31).

### 5.3.3 Life skills associated with a recovery lifestyle

In addition to the stages of recovery, Toseland and Rivas (2005:286-312) refer to three levels of intervention (i.e. intrapersonal, interpersonal, and environmental interventions) when addressing life skills and lifestyle changes. Intrapersonal interventions to be included as functional elements in the practice guidelines focus on:

- Identification and discrimination among thoughts, feelings and behaviours;
- Recognition of associations between specific thoughts, feelings and behaviours;
- Analysis of thoughts, feelings and behaviours;
- Changing distorted or irrational thoughts, feelings and behaviours. (Toseland & Rivas, 2005:286-294)

These intrapersonal interventions tie in /correspond with the cognitive-behavioural approach included in the RPT model of aftercare discussed earlier in this chapter.

The second level of intervention as described by Toseland and Rivas (2005:294-302) refers to interpersonal interventions. This level of intervention ties in with the Cenaps Model of Relapse Prevention, as it aims to develop new behaviour in a group setting by means of “learning by observation” (i.e. making use of role models) and role-playing (internalising new behaviour by practising in a safe environment among peers). The authors identify the following types of role-plays: practising own roles, role reversal, and on-the-spot interviews to be included as functional elements in the practice guidelines.

The last level refers to environmental interventions. According to Toseland and Rivas (2005:302-304) this level of intervention entails connecting members to concrete resources and expanding members’ social networks. The researcher came to the conclusion that there is a link between this level of intervention and the previously discussed Draft Systems Model for Prevention and Aftercare, as both seem to focus is on connecting community members to concrete resources, expanding social networks, and planning a physical environment to facilitate goal achievement.

The United Nations’ Office on Drugs and Crime (2003:20) also suggests that aftercare services should focus on factors on interpersonal, intrapersonal and environmental influences that could put chemically addicted persons at risk for relapses (i.e. risk factors), or that could contribute in preventing relapses from occurring (i.e. protective factors). This viewpoint is also underscored by the RPT model. It is suggested by The United Nations’ Office on Drugs and Crime (2003:20) that the protective factors should be included in the development of life skills and alterations of lifestyles as part of aftercare services (i.e. to be included as functional elements in the practice guidelines).

**Table 5.8:** Risk and protective factors for adolescent substance use and abuse (United Nations, 2003:21-23)

Sector	Risk factors	Protective factors
Individual	<ul style="list-style-type: none"> <li>• Sense of hopelessness</li> <li>• Attitude that favours substance abuse</li> <li>• Low self-esteem</li> <li>• Poor coping skills</li> </ul>	<ul style="list-style-type: none"> <li>• Good coping skills</li> <li>• Strong value system</li> <li>• Optimism</li> </ul>
Peers	<ul style="list-style-type: none"> <li>• Perceptions of peer approval of use of chemical substances</li> <li>• Association with chemical substance-using peers</li> <li>• Gang affiliation</li> </ul>	<ul style="list-style-type: none"> <li>• Social skills</li> <li>• Association with peers who engage in healthy lifestyle activities</li> <li>• Intolerance of chemical-substance use</li> </ul>
Family	<ul style="list-style-type: none"> <li>• Chaotic home environment</li> <li>• Family conflict</li> <li>• Low bonding</li> <li>• Family: tolerant to chemical substance use</li> <li>• Inconsistent parenting skills</li> <li>• High expectations</li> </ul>	<ul style="list-style-type: none"> <li>• Social support for parents</li> <li>• Clear rules and monitoring strategies</li> <li>• Strong bonds</li> <li>• Strong family norms</li> <li>• Support and care of members</li> <li>• Structure and boundaries</li> </ul>
Community	<ul style="list-style-type: none"> <li>• Availability of chemical substances</li> <li>• Exposure to violence</li> <li>• Poverty</li> <li>• Poor law enforcement</li> <li>• "Gangsterism"</li> <li>• Tolerance</li> </ul>	<ul style="list-style-type: none"> <li>• Access to support services</li> <li>• Community norms against violence and chemical-substance use</li> <li>• Community networking</li> </ul>
School	<ul style="list-style-type: none"> <li>• Poor academic performance</li> <li>• No sense of belonging</li> <li>• Peer rejection</li> <li>• High expectations</li> </ul>	<ul style="list-style-type: none"> <li>• Academic guidance and support</li> <li>• Acceptance and care from teachers</li> <li>• Acceptance by peers</li> <li>• School norms against use of chemical substances</li> <li>• Recognition</li> </ul>

Consistent with the abovementioned suggestions by the participants in this study regarding focus areas to be included in the practice guidelines, the literature studied (cf. Durant & Thakker, 2003:41; Fisher & Harrison, 2005:166-169) by the researcher indicated two focus areas when addressing aftercare services, namely: lifestyle alterations and the development of life skills<sup>15</sup> that would increase resilience.

Regarding *lifestyle alterations*, Fisher and Harrison (2005:166-169) suggest that the following areas should be addressed when chemically addicted persons in recovery are assisted to develop a healthy lifestyle:

- Leisure time, focusing on hobbies and exploring new interests;

<sup>15</sup> The researcher incorporated these focus areas as part of the practice guidelines for aftercare services to CAAs.

- Support systems, focusing on attending support group meetings, rebuilding friendships and relationships harmed by the addiction, and building new friendships and relationships;
- Social and communication skills, focusing on listening skills, showing interest in others, and the development of anger-management, conflict-management and assertiveness skills;
- Self-care, focusing on hygiene, nutrition and dress;
- Educational/vocational guidance, focusing on guidance and support to enhance achievements and the ability to make sensible career choices;
- Financial planning/budgeting, focusing on skills to budget and manage money, as well as dealing with debt caused by the addiction;
- Relationships, focusing on how to choose friends and partners, and how to deal with relationship problems;
- Balance/time-management, focusing on the development of balance between work, relaxation, and socialisation.

With reference to the inclusion of *life skills* in aftercare guidelines, Durant and Thakker (2003:41) refer to the Disease Model of Addiction, and note that the impact of chemical substance addiction on neurological functioning leads to a constant false sense of positive emotions and the denial of negative emotions. Advising on focus areas to address in this regard, the authors conclude that the chemically addicted client-system is faced with: 1) withdrawal symptoms, 2) poor self-image, and 3) painful emotions in recovery, but is unable to deal with them owing to a lack of skills.

Page and Page (2003:59-62) relate life skills to the development of resilience. The authors postulate that through acquiring life skills, resiliency is enhanced by developing:

- the ability to do one thing well to the advantage of oneself and others;
- a helpful attitude;
- the ability to ask for help;
- the ability to distance the self from events and circumstances (i.e. triggers);



- a strong social network.

In line with the discussion above, Sturgeon and Keet (in Becker, 2005:153) concur that the impact of chemical substances on the addicted adolescent's emotions needs to not only be addressed during treatment, but also during aftercare, encouraging reintegration into society, and building resilience. The authors suggest that services should encourage positive mental health by means of the following:

- The development of individual resources such as self-esteem, optimism and self-efficacy;
- The enhancement of a positive sense of well-being;
- The development of the ability to initiate, develop and sustain mutually satisfying relationships;
- The building of resilience through the development of the ability to deal with life problems.

#### **5.3.4 Including families in aftercare services**

In addition to alternating lifestyles and developing life skills through aftercare services to chemically addicted client-systems, the literature recommends that the family should be included in aftercare services when addressing altering lifestyles among CAAs. Literature relating to service delivery to the family of CAAs as part of aftercare was discussed in Chapter 3 (see p. 153) and Chapter 4 (see p. 198). Specific guidance on the role of the family that should be clarified and developed through aftercare services (i.e. to be included as functional elements in the practice guidelines) was found in the Matrix Institute on Addiction's document on *Families in Recovery* (2008a:27-30). It is suggested that the focus of family services should be on:

- Improvement of relationships, including dealing with emotions relating to the substance abuse;
- Enhancement of abstinence from all chemical substances through the development of insight regarding the impact of parental modelling and example;

- Use of support systems in the community, including self-help groups;
- Recognition of and dealing with emotions;
- Becoming supportive instead of co-dependent;
- Development of new, healthy roles;
- Developing and distinguishing between own interests, as well as family interests;
- Development of healthy communication styles;
- Acceptance of a new lifestyle;
- Monitoring self for lapses to prevent going back to the role of enabler.

(The suggestions provided above were evaluated by the researcher to be functional with the result that it was subsequently incorporated in the aftercare practice guidelines presented in Chapter 6.)

### **5.3.5 Motivational interviewing as a technique<sup>16</sup> in aftercare services to chemically addicted adolescents**

Motivational interviewing was referred to under the discussion of the cognitive-behavioural approach and the RPT model as discussed previously. Focussing further on this technique, Teesson et al. (2002:87) suggest that motivational interviewing is used to provide an environment conducive to change of perspectives, thoughts and behaviour. Building on this suggestion, Fisher and Harrison (2005:110) and Sheafor and Horejsi (2006:554) describe the motivational interviewing technique by Miller and Rollnick (1991) as a “classic technique” in enhancing intrinsic motivation among people suffering from chemical addiction to enter and maintain recovery. Powis (in Becker, 2005:172-173) and Sussman and Ames (2001:111-112) relate motivational interviewing to the Phases of Change as developed by Prochasku and Diclemente (in Sussman & Ames, 2001:112), and advise that social workers assess readiness for change before planning intervention strategies. This section will provide the reader with suggestions on the implementation of this technique within the framework of the Phases of Change, as provided by Powis (in Becker, 2005:172-173).

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<sup>16</sup> Motivational interviewing as a technique was evaluated by the researcher to be functional and was incorporated in the aftercare practice guidelines.

- **Pre-consideration phase**

Chemically addicted clients who show a lack of insight regarding the impact of their addiction may be viewed as clients who are in the pre-consideration phase. No consideration regarding addressing the chemical substance addiction exists. It is difficult to build a relationship with chemically addicted client-systems in this phase as they are likely to view the involvement of the social worker as a threat to their “drugging careers”. “Motivational interviewing” during this phase implies subtle confrontation during the assessment phase of the intervention process. Involving the client in the assessment process could lead to: 1) introspection regarding feelings associated with the current situation; 2) recognition of the damages caused by the chemical addiction; and 3) a non-threatening relationship with the social worker in which, without being judged, the client becomes aware of a need to address the chemical addiction.

- **Consideration phase**

The chemically addicted client may still be unaware that there is a problem and may be surprised that others identify his/her lifestyle and substance use as a problem. He/she should receive information and feedback regarding the impact of the chemical addiction from family, peers, school and the social worker during this phase, to enhance awareness. Powis (in Becker, 2005:172) warns that force and aggressive confrontation during this phase will have a negative effect on progress. During this phase addicts are ambivalent regarding their problem and change as a result of the addiction. They are, however, aware that others identify a problem and are unsure whether to consider or resist change. Motivational interviewing is used to create awareness regarding the risks, costs and damage caused by their substance use-related behaviour. The following techniques of motivational interviewing are suggested for implementation during this phase to motivate clients towards change: warmth, empathy, respect, honesty, and truthfulness. In order to deal with the ambivalence typically associated with this phase, the therapist should use open questions, reflective listening, and supportive statements.

- **Determining phase**

The social worker has the opportunity to help the client to move to the action phase. During this phase, techniques for motivational interviewing can assist the addict to identify and determine change strategies that are: 1) acceptable, 2) attainable, 3) effective, and 4) appropriate.

- **The action phase**

During this phase chemically addicted clients will act deliberately toward change, because ambivalence and resistance have made place for readiness. The therapist will be aware of the readiness when the client stops arguing, denying and protesting; when he/she is calm and is able to make self-motivating statements and ask questions regarding change; when he/she talks about the future after change, and starts to experiment with change. The suggested steps during this phase are as follows: 1) formulating recovery goals; 2) determining options to reach the goals; 3) developing a recovery plan; and 4) developing a support plan (utilising resources).

- **The maintenance phase**

During this phase, the chemically addicted clients try to maintain the changes brought about by their actions during the action phase. Motivational interviewing during this phase will be focused on the development of specific techniques to continue and maintain behavioural change. The importance of including a sustainability plan in the initial recovery plan is therefore of great importance.

- **Relapse phase**

An important issue during the maintenance and relapse phases is to create an environment and therapeutic relationship where the chemically addicted client feels safe to: 1) discuss problems, 2) maintain behavioural change and (3) report relapses.

### 5.3.6 The 12-Steps Programme of Narcotics Anonymous (NA)

The researcher deemed it necessary to include this section in this chapter for the following reasons: Consistent with the characteristics of the systems approach included in the Draft Systems Model for Prevention and Aftercare (Department of Social Development Western Cape, 2008:1-3) described earlier in this chapter, this programme addresses the cognitive, behavioural and spiritual needs of chemically addicted persons (Ritsher et al., 2002:711; Majer et al., 2008:146). Furthermore, both the sample groups referred to the 12-Step programme (see Chapters 3 and 4). Sussman and Ames (2001:119) state that the 12-Steps Programme is related to the cognitive-behavioural approach, associated with the previously discussed RPT aftercare model. The authors mention that although research on the success of these programmes is limited because of the anonymity of members, studies that have been conducted indicate a positive relationship between the attendance at meetings and the maintenance of recovery.

Fisher and Harrison (2005:166) postulate that the only requirement for members of NA, a self-help group, is the desire to stop using chemical substances. The authors note that this group is characterised by the anonymity of its members, the sponsor-system where members act as guides and support networks to one another, and the use of the 12-Steps Programme. Fisher and Harrison (2005:175) describe this programme as a way of life for NA members, and note that it is spiritual in nature. The sponsors assist fellow-members to continue doing the 12-Steps following treatment (Fisher & Harrison, 2005:176). The 12-Steps Programme is formulated in the "Big Book" of Alcoholics Anonymous (AA) (Alcoholics Anonymous, 2001). The same steps are also implemented by members of NA. The Cenaps Model for Relapse Prevention (Gorski, 1990:125-133) as discussed in the previous section is based on the 12-Steps Programme. Table 5.9 below provides some guidelines regarding the nature of the 12-Steps as well as their implementation as part of aftercare services. Consistent with Fisher and Harrison's (2005) suggestions for the process of treatment of chemical addiction, the 12-Steps follow the following phases: 1) assessment

and commitment to become involved in service delivery, 2) cognitive and behavioural change, 3) making amends, and 4) maintaining change.

**Table 5.9:** The 12-Steps Programme (Alcoholics Anonymous, 2001)

Phases	Characteristics	Steps	Suggested implementation <sup>17</sup>
Assessment and commitment to become involved in service delivery	Valuable during the pre-contemplation and contemplation phases of the Phases of Change	1. We admitted we were powerless over alcohol (chemical substances), that our lives had become unmanageable	Identifying the physical, mental, social and spiritual damage caused by the chemical addiction Calculating the damage
		2. We came to believe that a Power greater than ourselves could restore us to sanity	Listing efforts made to address the addiction Developing insight into the outcome of each of the efforts Identifying how basic needs are influenced by the addiction
		3. Made a decision to turn our will and our lives over to the care of God as we understand Him	Identifying possible options and resources that can assist the addicted person to enter a recovery lifestyle
Cognitive and behavioural change	Related to the cognitive-behavioural approach and the action phase of the Phases of Change	4. Made a searching and fearless moral inventory of ourselves	Identifying feelings that impact on perceptions and behaviour
		5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs	Discussing the impact of these feelings and identifying alternative reactions
		6. Were entirely ready to have God remove all these defects of character	Identifying actions and reactions that are/were harmful, thereby creating an awareness of harmful behaviours Making a list of behaviours that need to be addressed
		7. Humbly asked Him to remove our shortcomings	Identifying goals and objectives related to the behaviours that need to change
Making amends	Addresses feelings of guilt Making amends must focus the attention on the well-being of the person who was harmed, and not on the chemically addicted person	8. Made a list of all persons we had harmed, and became willing to make amends to them all	Identification of the persons who were harmed by the chemical addiction Assistance to become aware of the impact of old behaviour on others Addressing feelings involved with making amends to these people
		9. Made direct amends to such people when possible, except when to do so would injure them or others	Prioritising the list of people who need to be contacted Preparation for the contact Discussion of the outcomes

<sup>17</sup> Most of comments under “suggested implementation” were incorporated in the developed practice guidelines.

Maintaining change	The last three steps relate to the maintenance and relapse phases of the Phases of Change	10. Continued to take personal inventory, and when we were wrong, promptly admitted it	Recovery lifestyle plan
		11. Sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out	Recovery lifestyle plan
		12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics (chemically addicted persons), and to practise these principles in all our affairs.	Recovery lifestyle plan

#### 5.4 Conclusion

Through this research endeavour, the researcher's aim was to develop practice guidelines assisting social workers rendering aftercare services to CAAs following treatment. Task objectives 1, 2 and 3 were executed to assist the researcher to implement task objective 4, and realise the aforementioned aim. The outcomes of task objective 1 (i.e. to explore and describe the specific aftercare needs of relapsed CAAs following treatment relating to services by social workers) and task objective 2 (i.e. to explore and describe the experiences of social workers in relation to rendering aftercare services to CAAs) resulted in the following suggested focus areas to be included in the aftercare guidelines:

- A sound knowledge base regarding addiction and recovery
- Access to services and support following treatment
- Life skills to enable CAAs to complete adolescent life tasks and to develop resilience
- Support for internalising new behaviour that would contribute to efforts to remain sober following treatment
- Support regarding the reintegration into the family
- The development and utilisation of resources

- Coordination of services by treatment centres and aftercare services
- Development of a trusting, personal relationship between the aftercare worker and CAA
- Motivational interviewing as a valuable technique in aftercare services
- Assessment of individual needs of CAAs relating to aftercare services
- Guidelines to be structured in a step-by-step format, in easy language and including fun activities
- Addressing parental use of chemical substances
- Reintegration into the community

The outcome of task objective 3 of this research study, namely to review literature that relates to aftercare services to CAAs was illustrated in this chapter. The conceptual framework from which this study was conducted is the Disease Model of Addiction. In addition to this framework, the Western Cape Draft Systems Model for Prevention and Aftercare provided the researcher with some guidance as to the focus areas to be included in practice guidelines for aftercare services to CAAs. Aftercare models that were studied were the RPT model, Cenaps Model for Relapse Prevention, The Matrix Model for Recovery and Relapse Prevention, the Treatment Process Model, and the TCU Treatment System Model. Suggestions and guidelines related to the findings of this study were obtained through a literature study related to task-orientated activities to increase resilience, the recovery process of chemical addiction, life skills associated with a recovery lifestyle, motivational interviewing, inclusion of the family, and the NA 12-Steps Programme.

The findings and conclusions regarding the data obtained from the interest groups (as discussed in Chapters 3 and 4), as well as the literature studied, as discussed in this chapter, provided the researcher with a knowledge base from which to work when developing practice guidelines to aid social workers in their rendering of aftercare services to CAAs following treatment. These guidelines will be discussed in Chapter 6.



## CHAPTER 6

### A MANUAL WITH PRACTICE GUIDELINES FOR AFTERCARE SERVICES TO CHEMICALLY ADDICTED ADOLESCENTS FROM A SOCIAL WORK PERSPECTIVE

#### 6.1 Introduction

The research problem for this study was founded on feedback from practitioners in the field of adolescent chemical addiction, which pointed to the fact that the rendering of aftercare services to them, as well as the guidelines according to which these services should be rendered, were in practice deficient and lacking (see p. 9). As a result, the goal of the present study was to address this problem through the development of practice guidelines (i.e. interventions and strategies) for aftercare (cf. Fisher & Harrison, 2005:133). The guidelines presented in this chapter have been specifically designed from a Social Work perspective in an effort to provide social workers with a framework from which they can assist adolescents recovering from chemical addiction to develop skills for coping with high-risk situations in order to prevent relapses (cf. Sheafor & Horesji, 2010:541).

A manual with aftercare guidelines emerged as a result of the following task objectives: 1) to explore and describe the specific aftercare needs of relapsed chemically addicted adolescents (CAAs) following treatment relating to services by social workers to them (Chapter 3); 2) to explore and describe the perceptions and experiences of social workers regarding aftercare to CAAs (Chapter 4); and 3) to review literature that relates to aftercare services to chemically addicted persons (Chapter 5).

Before presenting the manual in this chapter, the researcher will, by way of introduction, unpack the concept “guideline”, and indicate the pointers found in literature which should be taken into consideration when developing guidelines to aid service rendering.

Guidelines are “advice or instructions given in order to guide or direct an action” (Business English, 2009). In the context of this study, they will be advice or instructions given in order to guide or direct aftercare Social Work service delivery to chemically addicted adolescents (CAAs).

Timberlake et al. (2008: 77) advise that guidelines should be based on best practice (i.e. practices that are supported by empirical data). Proctor (2004:228-231) is in agreement with this viewpoint, and adds that best practices are founded on evidence. The author describes the need for evidence-based practice as the challenge to utilise knowledge to the advantage of practice. On the one hand, researchers must produce and disseminate practice-relevant approaches, and on the other hand, practitioners should adopt and use these approaches. The author warns that “overuse of unhelpful care, under-use of effective care, and errors in execution of care” are often caused by a lack of practice guidelines based on research-based knowledge (Proctor, 2004:228). In line with these viewpoints, the design phase of the IDD-model (implemented in this research study) is based on the formulation of intervention constructs (i.e. practice guidelines) as the systematic conversion of the research findings into practice applications (Rothman & Thomas, 1994:25-28). In this case the research findings (empirically and literature-wise) were converted into practice guidelines to be utilised by social workers rendering aftercare services to CAAs following in- or out-patient treatment.

In the literature, corresponding viewpoints, described in Table 6.1 below, were found on what to take into consideration when developing guidelines for a specific procedure or service (e.g. aftercare services to CAAs). These viewpoints are also consistent with the social worker participants’ identified need for guidelines to be visual, written in easy language, and including practical and fun activities, as described in Chapter 4 (p. 209). The next section of this chapter will provide the reader with a manual containing practice guidelines for aftercare services to CAAs from a Social Work perspective.

**Table 6.1:** Pointers to consider when constructing guidelines

<p><b>Howard and Jenson (1999:360)</b></p> <ul style="list-style-type: none"> <li>Guidelines must be based on a scientific foundation.</li> <li>Guidelines must be user-friendly.</li> <li>Guidelines must be manageable in addressing possible obstacles (e.g. potential resistance from practitioners and costs).</li> </ul>	<p><b>Brause (2000:131)</b></p> <ul style="list-style-type: none"> <li>Guidelines must be aimed at specific outcomes.</li> <li>Guidelines must be clear about the target audience.</li> <li>Guidelines must relate to research findings.</li> </ul>	<p><b>Proctor and Staudt (2003:230)</b></p> <p>Guidelines must be based on outcome targets, after which associated interventions for each target are described.</p>	<p><b>Proctor (2004:228-231)</b></p> <ul style="list-style-type: none"> <li>Best practices are founded on evidence.</li> <li>The need for evidence-based practice is the challenge to utilise knowledge to the advantage of practice.</li> <li>Researchers must produce and disseminate practice-relevant approaches.</li> <li>Practitioners should adopt and use research results.</li> </ul>	<p><b>Hofstee (2006:159)</b></p> <ul style="list-style-type: none"> <li>Practice guidelines emanating from a research study should relate to the findings of the study.</li> <li>Practice guidelines emanating from a research study should relate to existing theory.</li> <li>Practice guidelines should be feasible and clear, explaining the how, where and why.</li> </ul>	<p><b>Sheafor and Horejsi (2006:82-86)</b></p> <ul style="list-style-type: none"> <li>Practice guidelines are the foundation of how, when and under what conditions the social worker can facilitate change.</li> <li>They focus on a micro, mezzo and/or macro level of intervention.</li> <li>They utilise perspectives, theories and models which can be used separately or in combination.</li> <li>They are based on an empirical foundation.</li> <li>They should include the client in the drawing up of the intervention plan.</li> <li>They should lead to affordable and accessible services.</li> </ul>
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**A MANUAL WITH PRACTICE GUIDELINES FOR UTILISATION BY  
SOCIAL WORKERS RENDERING AFTERCARE SERVICES TO  
CHEMICALLY ADDICTED ADOLESENTS**

## **Preface**

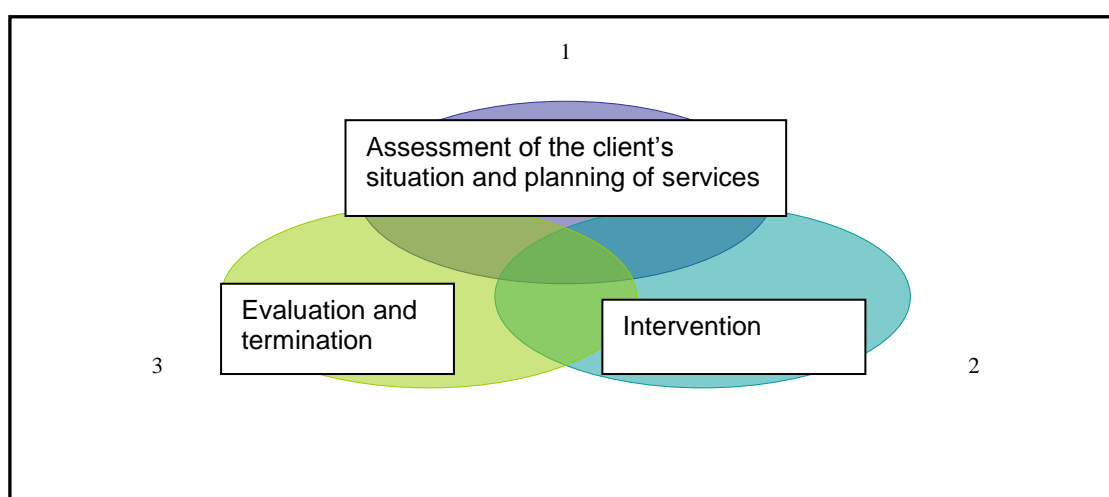
The impact of chemical substances on chemically addicted adolescents (hereafter referred to as CAAs) includes changes in behaviour, mood and thought, and is associated with self-defeating behaviour (Barber, 2002:2; Schlebush, 2005:135). The result is that this addiction tampers with one of the most important developmental stages in life, posing a specific challenge to social workers involved in this field (United Nations Office on Drugs and Crime, 2002:22). Treatment of adolescent chemical addiction includes three phases, namely: detoxification, treatment programmes, and aftercare (Meyer, 2005:292-293). The literature places emphasis on the importance of aftercare, and an aftercare period of between 12 and 24 months is advised (McNeece & DiNito, 1998:93; Dodgen & Shea, 2000:139; Health Resources, 2004). However, findings from a research project focussing on “Aftercare to CAAs: practice guidelines from a Social Work perspective” point to a lack of emphasis on aftercare services in terms of the availability of these services and the “how to” render such services, which impacts negatively on the relapse potential among CAAs following in- or out-patient treatment.

In response to the former, and by means of utilising specific phases and steps in the Intervention Design and Development (IDD) Model of Rothman and Thomas (1994:3-51), practice guidelines from a Social Work perspective relating to the provision of aftercare services to CAAs were develop which will be presented in this manual.

The content of this manual is based on the findings of research which focussed on the specific aftercare needs of CAAs, the perceptions and experiences of social workers in relation to rendering aftercare services to CAAs, and literature that relates to aftercare services.

Rossi and Freeman (as quoted by Rothman & Thomas, 1994:187) advise that guidelines that are designed by means of the IDD-model should relate to clear **goals**, which are in turn related to **specific strategies** to realise these goals. In addition, the social worker rendering aftercare services to CAAs needs to possess a **knowledge base** related to chemical addiction, as well as to the recovery process, as a prerequisite for providing these services to this client-system (Juhnke & Hagedorn, 2006:68). In view of the fact that the aftercare practice guidelines were developed from a Social Work perspective, the former are presented according to the Social Work intervention process, as described in the figure below:

**Figure 1:** The Social Work intervention process (adapted from Hepworth, Rooney, Rooney, Strom-Gottfried & Larson, 2006:34-42)



These stages of intervention are interrelated, meaning that the social worker can move back and forth between the different phases. The manual will be presented according to these three phases, in the following order:

- The assessment of CAAs' aftercare needs and planning of aftercare services
- Aftercare intervention (i.e. goal attainment)
- Evaluation and termination of aftercare services.




As a fellow practitioner in the field of adolescent chemical addiction, I would like to provide the following pointers on how to approach CAAs and how to use this manual:

- Keep in mind that each person's map of the world is as unique as their thumbprint. No two people will understand the same sentence the same way. So, in dealing with CAAs, try not to fit them into your concept of what they should be (cf. Erikson & Bradshaw in Alpaslan, 2005:1).
- The way in which this manual is presented is one way to provide CAAs with aftercare services, but not the only way. This manual can be adapted with great confidence to suit the individual needs of the CAA and the style of the social worker. Therefore, be confident, but creative and innovative and keep the following statement of Marler (1956:23) in mind when using the manual: ***“Think not of yourself as the architect of your career; but as the sculptor. Expect to have to do a lot of hard hammering and chiselling and scraping and polishing.”***

Marichen van der Westhuizen

## THE ASSESSMENT AND PLANNING OF AFTERCARE SERVICES

**Key:** In the discussion to follow three symbols will be used regularly:

Symbol	Meaning
	This symbol focuses on information that the researcher deemed a knowledge-base prerequisite. In other words: the social worker needs to possess this knowledge to provide aftercare services to the CAA
	This symbol relates to a specific functional aid - A functional aid can be any activity, medium, intervention technique and structured experience that are deliberately employed by the social worker to help realise a goal in intervention for the purpose of creating insight, helping towards an attitude change, and influencing a change in behaviour (Du Preez & Alpaslan, 1992:19-20). The functional aids provided in this manual are all focussed on assisting the social worker with introducing and initiating the goals of aftercare services to CAAs.
	This symbol introduces the strategy on how to implement the knowledge base and the functional aid.



Assessment is viewed as the first stage in Social Work service delivery, and is also an ongoing task throughout, in this case, the aftercare process. It is used to: 1) identify the client's intra- and interpersonal strengths and weaknesses, as well as environmental ones (i.e. needs) which must be taken into consideration when planning and rendering services; 2) measure the progress in addressing the assessed needs; and 3) assess readiness to terminate services (Simpson, 2005:1; Powis, in Becker, 2005:168).

In the context of aftercare, **the first assessment takes place once formal in- or out-patient treatment is terminated and prior to the commencement of aftercare services.** The adolescent's needs and strengths are identified, as well as resources needed to address these needs. The *goal* of the assessment is to empower clients, facilitate collaborative evaluation of the situation, and ensure mutual decision-making. This goal includes the following *steps*: 1) purposeful information gathering; 2) appraising the demands of the person-problem-environment interactions; 3) mobilising the client to discover strengths/resources; 4) negotiating and prioritising goals; 5) exploring and planning interventions; 6) developing an intervention plan; 7) establishing a monitoring system; and 8) entering a working agreement (Timberlake, Zajicek-Faber & Sabatino, 2008:243). An overview of the goals during the **assessment and planning stage** for aftercare services are illustrated in Table 1 below.

**Table 1:** The goals and objectives for the assessment and planning phase of aftercare intervention services to chemically addicted adolescents, and the knowledge and strategies required by social workers to realise the goals and objectives

Goals	Objectives	Knowledge base prerequisite	Functional aid and strategy to realize the goals and objectives
<p>Assessment of the chemically addicted adolescent's functioning and recovery needs following treatment</p>	<p>Assessment of the phase of addiction in which the adolescent functioned prior to entering treatment, the adolescent's functioning in terms of the recovery process, and the adolescent's strengths, needs, and resources available/needed in the aftercare phase</p>	<ul style="list-style-type: none"> <li>• The aim of the assessment process</li> <li>• Steps to be taken during assessment</li> <li>• Understanding the phases in the process of addiction and cravings associated with each phase</li> <li>• Assessing the stages of recovery and the characteristics inherent in each phase</li> </ul> <p>Utilising <u>motivational interviewing</u> as a functional aid to motivate the resistant adolescent to commit to aftercare</p> <ul style="list-style-type: none"> <li>• Pre-consideration phase</li> <li>• Consideration phase</li> <li>• Determining phase</li> <li>• Action phase</li> <li>• Relapse phase</li> </ul> <p>Compiling a profile of the chemically addicted adolescent's individual aftercare needs</p>	<ul style="list-style-type: none"> <li>• A focused discussion and assessment of the phase of addiction into which the adolescent fitted prior to treatment and the craving responses associated with each phase</li> <li>• An exercise to identify the phase of recovery and the withdrawal symptoms associated with the identified phase</li> </ul> <ul style="list-style-type: none"> <li>• Drawing an "eco-diagram" to assess the impact of the addiction as displayed at the beginning of treatment</li> <li>• Compiling an inventory on previous efforts to deal with the addiction and the outcome of these efforts</li> <li>• Developing a "pros and cons list" associated with being addicted versus being sober</li> <li>• A discussion to Identify focus areas for recovery</li> </ul> <p><u>Conduct an individual profile assessment through:</u></p> <ul style="list-style-type: none"> <li>• Drawing an eco-diagram of the individual needs and efforts to address these needs</li> </ul>



		<p>Compiling a profile of the chemically addicted adolescent's family in terms of the needs of the adolescent regarding support by the family in aftercare</p> <p>Compiling a profile on the chemically addicted adolescent's community in terms of the needs of the adolescent regarding support by the community in aftercare</p>	<p><u>Conduct a family profile assessment through:</u></p> <ul style="list-style-type: none"> <li>• An exercise to depict the adolescent's relationships with the various members of his family</li> </ul> <p><u>Conduct a community profile assessment through:</u></p> <ul style="list-style-type: none"> <li>• Drawing up a social map and compiling an inventory (from the adolescent's perspective) to determine the resources and hindrances present in the community, as well as the support needed from them to develop a recovery lifestyle</li> </ul> <p><u>Concluding the assessment phase through:</u></p> <ul style="list-style-type: none"> <li>• An exercise to identify factors in the family, and personal and social contexts to be included in the aftercare plan to prevent relapses</li> </ul>
<p>Formulation of aftercare goals and developing an aftercare plan</p>	<ul style="list-style-type: none"> <li>• Development of aftercare goals and objectives</li> <li>• Development of an aftercare plan</li> </ul>	<ul style="list-style-type: none"> <li>• The purpose of goal formulation</li> <li>• The focus of planning</li> <li>• Focus areas of an aftercare plan</li> <li>• The use of the aftercare plan as a working agreement</li> </ul>	<p><u>Functional aids: exercises to assist with:</u></p> <ul style="list-style-type: none"> <li>• Step-wise guideline for developing aftercare goals and objectives</li> </ul> <p><u>Functional aids: exercises to assist with:</u></p> <ul style="list-style-type: none"> <li>• Developing an aftercare plan addressing the identified risk factors endangering recovery and the maintenance of a sober lifestyle</li> <li>• Developing a working agreement between the adolescent and any significant other person whose assistance might be needed in recovery, and to develop and maintain a recovery lifestyle</li> </ul>

In order to assess the aftercare needs of the CAA in particular, the social worker needs to have prerequisite knowledge about the **addiction process** and cravings associated with each phase, as well as the **phases of recovery** and the characteristics inherent to each phase. These will be presented in the next two sub-sections of the discussion.

### The phases in the addiction process and the associated craving response

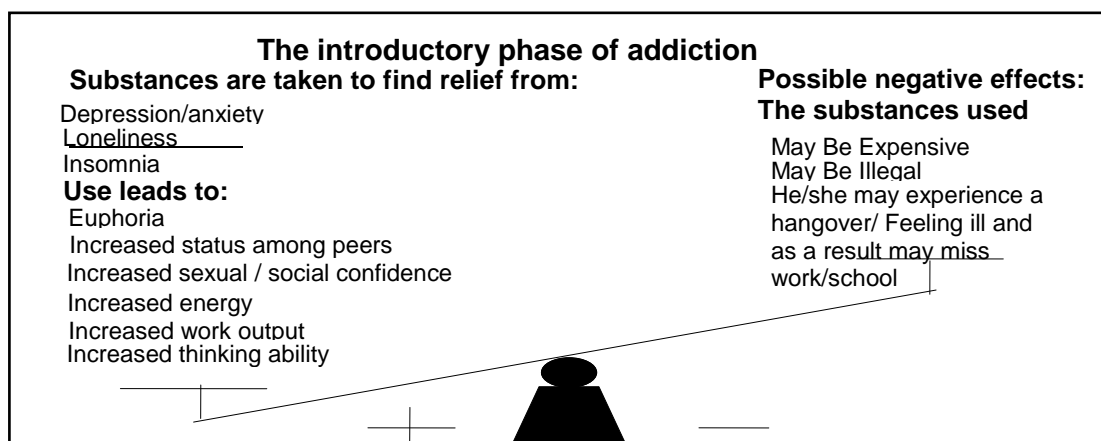


According to the Matrix Institute on Addiction (2008c), the process of **addiction to chemical substances can be divided into the following phases: the introductory, maintenance, disenchantment, and disaster phases. In order to go forward** (i.e. commit to the recovery process) **one has to look back on the impact of the addiction.** Social workers should therefore assist the adolescent to look retrospectively into the phases of addiction in which he/she functioned before entering the treatment process.

- **The introductory phase of addiction and the associated craving response**

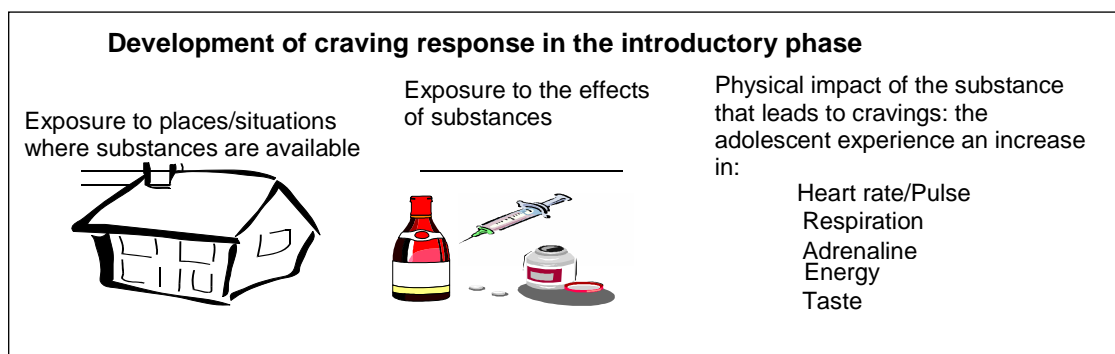
Substance use is relatively infrequent during this phase of addiction, and may be limited to a few times a year, by chance, or on special occasions. In this phase, the person may take substances to deal with depression, anxiety, loneliness or insomnia, and to bring about feelings of euphoria. The substance may also be used to increase popularity amongst peers, sexual and social confidence, energy, and the person's thinking capacities. In this phase of addiction, the positives resulting from the use of substances seem to outweigh the negatives (see the figure below) and awaken the response to start craving the substances. While substance use in this phase is one small component of a person's overall thought process, the user is unknowingly conditioning his/her brain (i.e. the brain becomes used to the effects of the substance, and certain thoughts, events, people and places are associated with the use) every time a dose of his/her substance of choice is ingested.

**Figure 2:** The introductory phase of addiction (Matrix Institute on Addiction, 2008c:11)



The craving response in this phase is that the user begins to associate certain experiences (e.g. being with substance-using friends or certain social events) with substance use. Thoughts about substances result in the beginning of a physical need (craving) to use the substance (Matrix Institute on Addiction, 2008c:14).

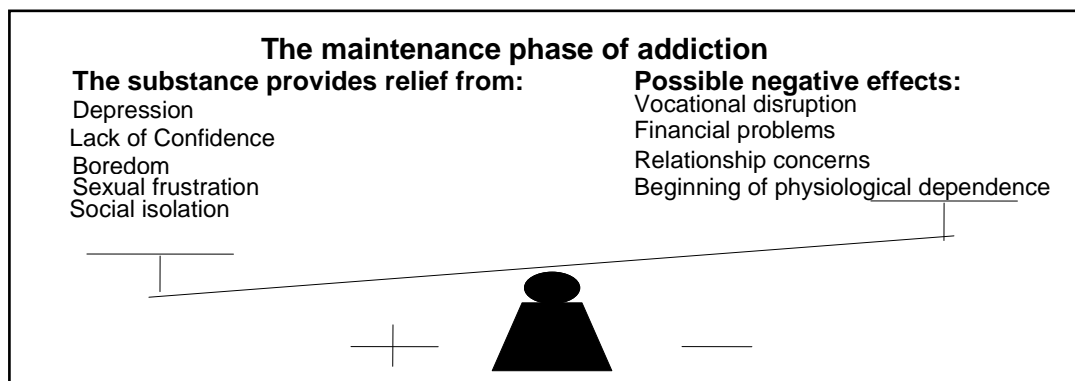
**Figure 3:** Craving during the introductory phase (Matrix Institute on Addiction, 2008c:14)



- **The maintenance phase of addiction and the associated craving response**

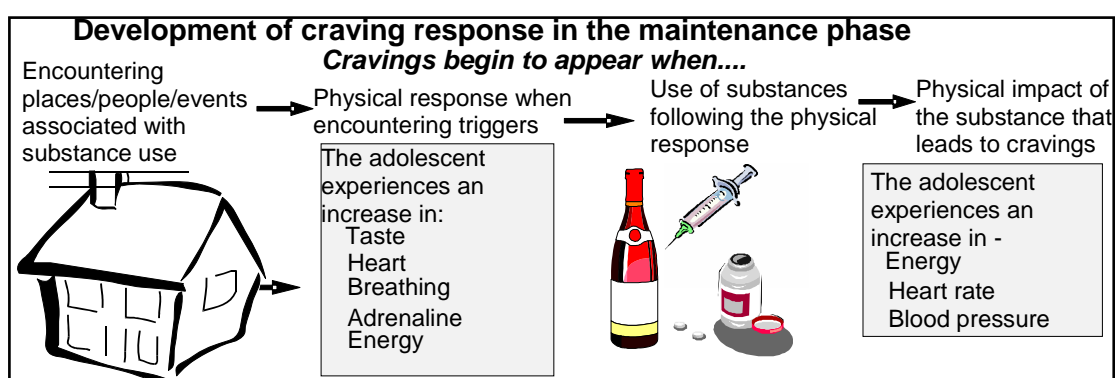
During this phase, the frequency of substance use increases to perhaps monthly or weekly. In terms of the effects and consequences of the substance use, the scales are beginning to lean more in the negative direction as the disadvantages of substance use begin to outweigh the advantages (see Figure 4 below) (Matrix Institute on Addiction, 2008c:15).

**Figure 4:** The maintenance phase of addiction (Matrix Institute on Addiction, 2008c:15)



Regarding the craving response in this phase, conditioning of the brain in terms of the association between the substance and persons, places, and events, has begun. These people, places and events associated with substance use have become triggers that cause a craving for the substance. Thoughts about triggers and the exposure to triggers cause thoughts about substance use. These thoughts awaken mild physiological reactions, producing drives to find and use substances (see Figure 5). Thoughts of substance use begin to occur more frequently (Matrix Institute on Addiction, 2008c:18).

**Figure 5:** Craving during the maintenance phase (Matrix Institute on Addiction, 2008c:18)

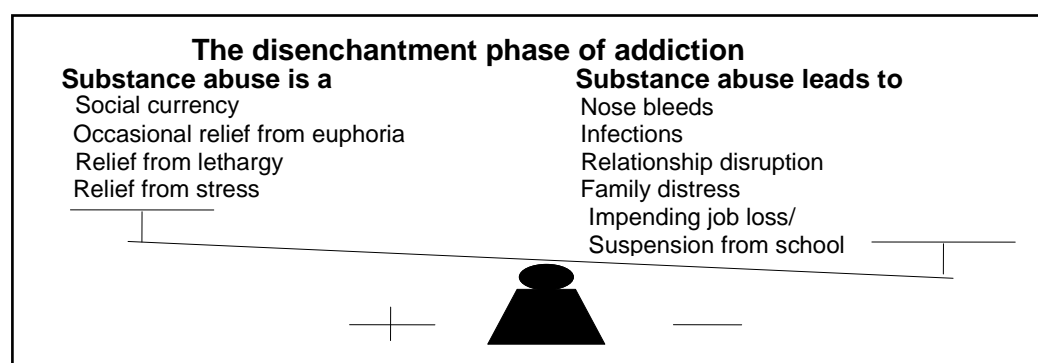


- **The disenchantment phase of addiction and the associated craving response**

During this phase of a developing addiction, the consequences of the substance use are severe, and the user's life begins to become

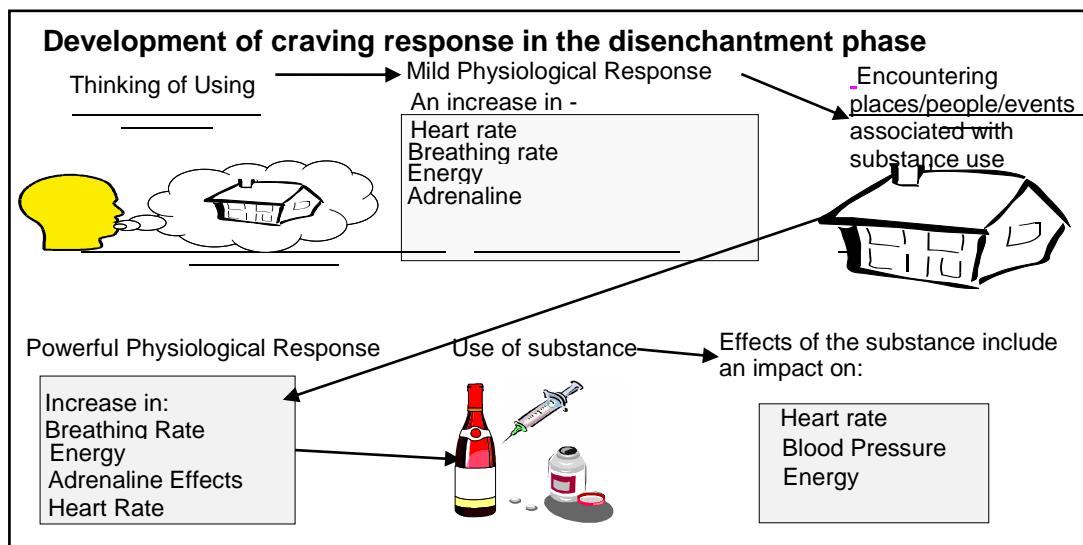
unmanageable resulting in serious consequences (see Figure 6). At this point the user's thoughts and mindset are to stop using the substances, but the mind is no longer in control of actions. Thinking, evaluating, and decision-making appear to be happening, but behaviour is contradictory. The user may sincerely resolve to quit using, and yet may find him/herself out of control at the first thought of substances, the first encounter with a fellow user, or the availability of cash or other potent potential triggers (Matrix Institute on Addiction, 2008c:19). It is usually at this point that a person crosses the line into addiction. Despite the negative consequences of continued substance use, the addiction is evidenced by the loss of control over the decision to use or not to use the substances.

**Figure 6:** The disenchantment phase of addiction (Matrix Institute on Addiction, 2008c:19)



The increasing frequency of thoughts about substances crowds out thoughts of other aspects in life (work, relationships, hobbies, etc.). In this phase, the craving response is a powerful event. The person feels an overpowering physical need (“hunger/thirst”) to use substances in situations further and further removed from the substances themselves (i.e. the availability of the substance or a person/event/place that is remotely associated with the substances is no longer needed to trigger a craving). The craving for the substance of choice becomes a very prominent aspect of the thoughts and actions of the user, regardless of the presence of triggers as is depicted in Figure 7 below (Matrix Institute on Addiction, 2008c:21).

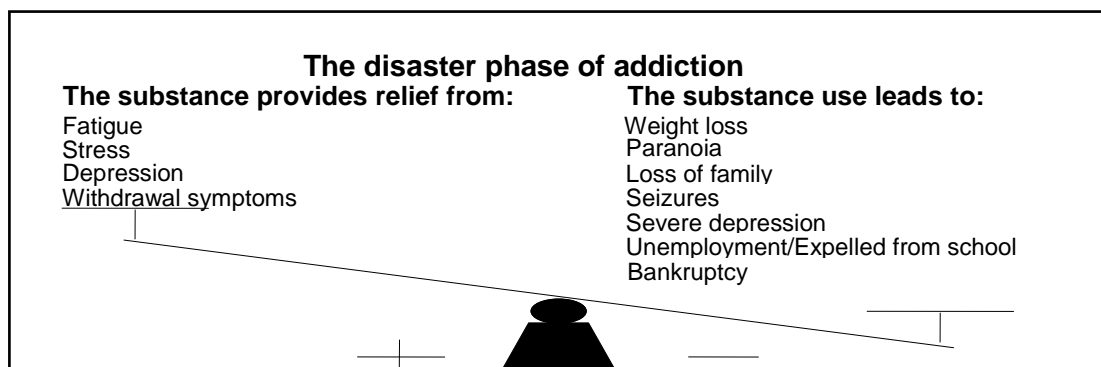
**Figure 7:** Craving during the disenchantment phase (Matrix Institute on Addiction, 2008c:21)



- **The disaster phase of addiction and the associated craving response**

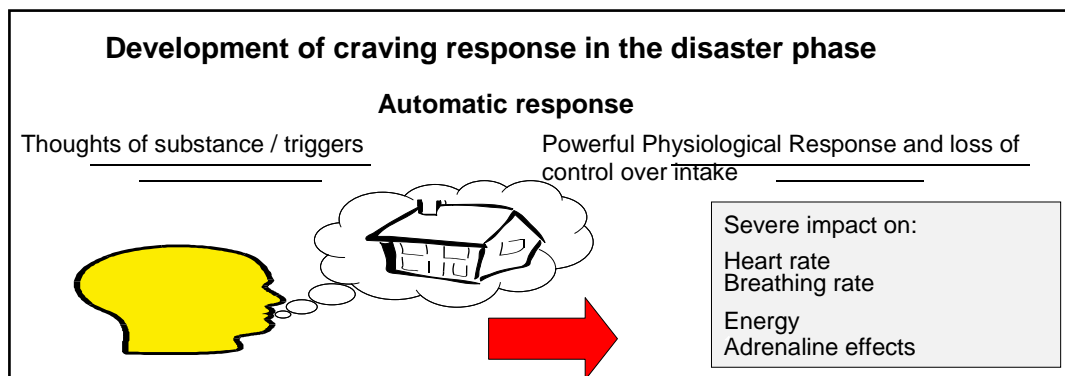
In the disaster phase, the substance use is often automatic. There is no rational restraint upon the substance use; it makes no sense at all. The person is either using daily or in binges, which most likely will be interrupted by physical collapse, hospitalisation, or arrest. Figure 8 below depicts what the substances need to provide relief for and the possible consequences of the substance abuse in the disaster phase of addiction.

**Figure 8:** The disaster phase of addiction (Matrix Institute on Addiction, 2008c:22)



The constant powerful craving is overwhelming, and dominates the user's thoughts and actions. The only motivation is to obtain the substance (see Figure 9 below) (Matrix Institute on Addiction, 2008c:22).

**Figure 9:** Craving during the disaster phase (Matrix Institute on Addiction, 2008c:25)



The discussion above highlights how the craving response changes as the addiction develops. It is important to note that **these craving responses may still be present following treatment, and therefore impact on the recovery potential.** The social worker, through the implementation of the functional aid and strategy provided below, develops an understanding of the **phase of addiction into which the adolescent fitted prior to treatment and the craving responses associated with each phase.**



**Functional aid: A focused discussion and assessment of the phase of addiction into which the adolescent fitted prior to treatment and the craving responses associated with each phase**

The **aim of this activity** is for both the social worker and the adolescent to identify the phase of addiction in which the client was functioning before entering the treatment process, and to develop an understanding of how the associated craving response impacted on his/her thoughts and actions. The identification of impaired thoughts and associated behaviours serves as a foundation for the identification of aspects to include in the aftercare plan that follows the assessment process.



**Strategy on how to implement the knowledge base and functional aid**

The social worker explains that, in order to understand his/her recovery needs, the adolescent needs to identify in what phase of addiction he/she was

functioning before entering treatment, as well as how cravings associated with this particular phase of addiction affected him/her. Emphasis is placed on the fact that the craving responses may still be present. In order to assist the client with this identification, the figures above (Figures 2-9) are enlarged and posted on a flipchart or notice board. The social worker briefly and in user-friendly language, explains the information contained on each of the diagrams and then asks the client to identify the phase he/she fitted into before entering treatment. Once the client provides the information required, the social worker may use the following questions to complement the discussion and assessment of the **phase of addiction**, and in so doing also assess the client's insight into his/her addiction:

- While using the drug, what thoughts did you have about the drug?
- With what did the drug help you? / How did the drug help you in your day-to-day living?
- What advantages did you experience when drugging?
- What were the disadvantages for you when you used drugs?
- What worried you about your drugging?
- How did you feel when you did not use the drug?

With regard to the **craving response** associated with the phase the adolescent fitted into prior to entering treatment, the same functional aid may be used. The social worker initiates a discussion. For example: Looking at the phase of addiction you say you fitted into before treatment, and the craving response that went with it, let me ask you some questions:

- What made you miss or long for the drug?
- When did you usually long for the drug?
- How did you get hold of the drug?
- Where did you usually use drugs? How did your behaviour or thoughts change when you went to these places?
- What was your favourite drug? Why?
- How did this drug make you feel?
- What happened to your body when you took the drug?
- How did you feel when you stopped using the drug?
- How did you feel after using the drug?



Once the adolescent provides this information, the social worker assists him/her to identify areas that need to be included in aftercare services by asking:

- You have given me quite a bit of information about the phase of addiction you were in, and the cravings you had. Thinking about this information, what are the things that you think we should put in your aftercare plan for you to carry on with recovery, and to prevent a relapse?

**The phases of recovery from chemical addiction and the withdrawal symptoms experienced during each phase**



Both becoming addicted to substances and recovering from substance addiction are viewed as “processes” (Matrix Institute on Addiction (2008b; 2008c). In order to assist the addicted adolescent in aftercare, the social worker needs to pinpoint (assess) in which phase of recovery the adolescent finds him/herself. Furthermore, the withdrawal symptoms inherent to the particular phase of recovery must be assessed. The Matrix Institute on Addiction (2008b) identifies the **withdrawal, honeymoon, abstinence and adjustment/resolution phases in the recovery process**, which will be discussed, together with the withdrawal symptoms associated with each phase:

- **The withdrawal phase:** This phase is normally prevalent ***during the treatment process, prior to aftercare***. However, if a treatment period has been shorter than 12 weeks, the characteristics of this phase might still be present at the beginning of the aftercare process. Characteristics of this phase (as further explained in Table 2 below) include physical detoxification, cravings, depression, low energy, irritability, memory problems, disordered thinking, insomnia and exhaustion (Matrix Institute on Addiction, 2008b:4). Should these characteristics surface during the assessment, the social worker should not hesitate to facilitate a process for the adolescent to get appropriate medical (and other professional) help.

**Table 2:** Areas of concern to address in the withdrawal phase of recovery  
(Matrix Institute on Addiction, 2008b:4)

Area to address	Characteristics
Medical problems associated with withdrawal from the substance of choice	E.g. seizure, infections, cardiovascular problems, weight loss, and vitamin deficiencies Excessive sleep and fatigue
Depression	Apathy, low self-esteem, expression of feelings of isolation and suicidal ideation
Concentration problems	Inability to focus on a specific topic/activity for longer than 5 minutes and short-term memory problems
Severe cravings	Inability to control intake during exposure to objects, people, places, or situations, which have been associated with drug and alcohol use, can trigger cravings

- **The honeymoon phase:** This phase normally also forms part of the treatment stage of intervention, but ***characteristics of the honeymoon phase may still be present at the beginning of the aftercare process.*** It is also known as “early abstinence”. Adolescents functioning in this phase are often overconfident that they are now “recovered”, and are convinced that they do not need further assistance. The challenge for the social worker is therefore to assist the adolescent to understand the process of recovery, and to become willing to continue with aftercare, despite the initial feeling of “I’m fine.” Other characteristics typical of this phase include: 1) continued memory problems; 2) feelings which are experienced as intense, as well as mood swings; and 3) secondary substance abuse (i.e. replacing the substance of choice) (Matrix Institute on Addiction, 2008b:9).
- **The abstinence phase:** This phase, ***normally part of the initial period following treatment,*** is viewed as the “main event” of the recovery process, also known as “the wall” (i.e. an obstacle that the adolescent must conquer). Following the honeymoon phase, this phase is characterised by a shift back from the “high” of the previous phase to a point, not as “low” as the withdrawal phase, but still not “normal.” The reason behind this experience in the recovery process is that some feelings related to the after-effects of substance use are still present. In this phase, the social worker needs to assure the adolescent that the “wall” is temporary and that it is a sign of the brain “getting well.” The adolescent may suffer from the following symptoms associated with withdrawal from

substances during this phase: old substance-related behaviours (e.g. lying, associating with substance-using peers and not participating in healthy activities), depression, cravings, irritability and mood swings, unclear thinking, isolation, slips, and family problems (Matrix Institute on Addiction, 2008b:22). Should these characteristics be identified during the assessment, the social worker should introduce the following action plans to address the symptoms of this phase of recovery:

**Table 3:** Action plans to address the symptoms that might surface and are characteristic of the abstinence phase of recovery (Matrix Institute on Addiction, 2008b:22)

Action needed in this stage	Desired outcome
Encourage the adolescent to continue with the behavioural changes that he/she has developed up to this point.	Through continuing with the newly acquired coping skills during treatment, a sequence of inactivity, boredom, loss of recovery, focus, relapse justification, and finally relapse can be prevented.
Inform the adolescent about the manifestation of these symptoms during this phase (and the previous phases) and prepare/empower him/her on how to deal with this.	Ensure treatment continuation and remind the adolescent how far he/she has travelled on the road to recovery since entering treatment.

- The adjustment/resolution phase:** This phase of recovery normally develops during the aftercare process, but characteristics of this phase may already be present following treatment. At this point, the physical withdrawal is substantially resolved, but the recovery is far from complete. The adolescent may experience a feeling of accomplishment at having completed the “wall” phase, but recovery tasks to ensure ongoing recovery from addiction become the main focus of this phase. During this phase, the adolescents are faced with the following problems that may be included in the aftercare plan: problems with relationships (peers and family), boredom, a lack of goals, guilt and shame (stemming from substance-induced behaviour) that were not addressed during treatment/aftercare, as well as career problems.

Adolescents who successfully cope with this phase begin to manage ongoing lifestyle and relationship changes, which began in previous phases. Completion of the aftercare period is only detected once the adolescent becomes able to monitor for relapse signs, maintain a

balanced lifestyle, and develop new areas of interest (Matrix Institute on Addiction, 2008b:34).



### **Functional aid: An exercise to identify the phase of recovery and the withdrawal symptoms associated with the identified phase**

***This exercise is aimed at*** assisting the social worker and the adolescent to identify the phase of recovery in which the adolescent is functioning at present, as well as the withdrawal symptoms inherent to the identified phase. The identified symptoms are then included as areas to be addressed in the aftercare plan that follows the assessment.



### **Strategy on how to implement the knowledge base and functional aid**

The social worker explains that, in order to understand how withdrawal symptoms affect the adolescent's recovery, he/she needs to discover in what phase of recovery he/she is. To assist with this, the adolescent is given the information about the different phases of recovery. The information relating to each phase (i.e. the name of the phase, when it occurs and withdrawal symptoms characteristic of each phase) is written on a flip chart and then read to the adolescent. On completion, the social worker asks the adolescent to pick out which phase of recovery he/she belongs in, and to say why he/she chose that. He/she must also indicate which of the withdrawal symptoms he/she currently experiences. In order to come to a clearer understanding as to how these withdrawal symptoms manifest themselves in the adolescent's life, the social worker can use the questions in Table 4 below for the purpose of a more focused or in-depth exploration and assessment:

**Table 4:** Assessment of the withdrawal symptoms associated with the phases of recovery

Symptoms associated with withdrawal from substances	Questions in relation to the characteristic of the different symptoms
Old substance-related behaviours	<ul style="list-style-type: none"> <li>• What do you do now that reminds you of when you used drugs, or do you behave the same as when you were using drugs?</li> <li>• How does this behaviour you display make you feel?</li> <li>• What of this behaviour would you like to continue with?</li> <li>• What needs to change?</li> <li>• What do you think is needed to change this behaviour?</li> </ul>

	<ul style="list-style-type: none"> <li>• What should you do to change this behaviour and who would you like to help you? How must they help you?</li> </ul>
Depression	<ul style="list-style-type: none"> <li>• How do you feel?</li> <li>• Do you feel down/low?</li> <li>• If yes, explain to me how it is for you to feel down/low?</li> <li>• What do you think when you feel down/low?</li> <li>• When you are feeling down/low, what do you normally do?</li> <li>• When you are feeling down/low, what don't you do?</li> <li>• What help do you need to cope with feeling down?</li> </ul>
Cravings	<ul style="list-style-type: none"> <li>• Do you still have cravings?</li> <li>• Under what circumstances do you experience cravings?</li> <li>• How do you react to these cravings / what do you do, or stop doing?</li> </ul>
Irritability	<ul style="list-style-type: none"> <li>• Do you get irritated/ If so, how often?</li> <li>• What causes these irritations?</li> <li>• What do you do when you get irritated?</li> <li>• How do you feel about the way you reacted when you became irritated?</li> </ul>
Mood swings (either caused by the effect of the mood-altering nature of chemical substances, or mood swings prior to substance use, where the substance was a way of dealing with the mood swing)	<ul style="list-style-type: none"> <li>• Do you sometimes feel very good the one moment, and down the next moment? If so, tell me more?</li> <li>• What do you think causes these mood swings?</li> <li>• How do you react when you have these mood swings?</li> <li>• How do you feel about the way you react when you have mood swings?</li> </ul>
Unclear thinking (substances negatively impact on short-, medium- and long-term memory)	<ul style="list-style-type: none"> <li>• Do you find it hard to concentrate? Explain to me when is it hard to concentrate?</li> <li>• Do you find it hard to remember things? How does this affect your life?</li> <li>• How do you react when you have problems with concentration or memory?</li> </ul>
Isolation	<ul style="list-style-type: none"> <li>• Do you sometimes feel alone? (If the adolescent answered "yes" continue by asking the following questions: <ul style="list-style-type: none"> <li>○ When do you feel alone?</li> <li>○ What do you think when you feel alone?</li> <li>○ What do you do when you feel alone?</li> </ul> </li> </ul>
Slip (one experience of substance use, not followed by continued use)	<ul style="list-style-type: none"> <li>• Have you used drugs recently to see if you can handle it?</li> <li>• How did it make you feel?</li> <li>• Why did you stop again?</li> <li>• What were the advantages of the slip?</li> <li>• What were the disadvantages of the slip?</li> </ul>
Family problems	<ul style="list-style-type: none"> <li>• Do you have any problems with your family members? If so, tell me more?</li> <li>• What do you think causes these problems?</li> <li>• What has been done to solve these problems?</li> <li>• What still can be done to solve these problems?</li> <li>• What can you do to help solve this problem?</li> <li>• What assistance is needed to help you solve these problems?</li> </ul>
Boredom	<ul style="list-style-type: none"> <li>• Take a while and think about when you are bored.</li> <li>• What do you usually do when you are bored?</li> <li>• How do you keep yourself busy?</li> <li>• How does this help or prevent you to remain clean?</li> </ul>
Feelings of guilt and shame associated with substance-related behaviour	<ul style="list-style-type: none"> <li>• What are the things you feel guilty or ashamed about?</li> <li>• How do these feelings affect your relationships?</li> <li>• How do you think you can deal with these feelings?</li> <li>• What makes it hard for you to deal with these feelings?</li> <li>• What help is needed for you to be able to deal with these feelings?</li> </ul>

Once the adolescent provides this information, the social worker assists him/her to identify the nature of assistance needed to deal with the withdrawal

symptoms experienced. The social worker may ask the following question to focus and introduce this discussion:

- Let's look at the withdrawal symptoms you have. What are the things you think we should include in your aftercare plan?

With reference to the areas that the adolescent wants to include, the social worker may ask:

- Why do you think this should be part of your plan?

During the assessment of the adolescent's recovery phase, the social worker might become aware that the adolescent is still resistant to change, despite the completion of formal in/out-patient treatment. **The motivational interviewing technique can be used to motivate the resistant adolescent to commit to aftercare and to enter the recovery process.** This technique in terms of needing a knowledge base, functional aids and strategies on how to implement the motivational technique, will be the focus of the next discussion.

**Implementing the motivational interviewing technique with adolescents who still resist change after formal treatment**



The **motivational interviewing** technique is a technique where resistant chemically addicted clients are encouraged to become ready for change, and is often used to motivate addicted clients to enter formal treatment (Fisher & Harrison, 2005:111). Some adolescents enter the treatment process without being ready to change, and enter recovery when they did not request help themselves (e.g. their parents force them to go for treatment). Resistance at the beginning of aftercare needs to be addressed, for which this technique can be useful. **Motivational interviewing consists of the pre-consideration, consideration, determining, action, maintenance and relapse phases** (Powis, in Becker, 2005:172-173), which will be discussed below.

- **Motivational interviewing in the pre-consideration phase**

CAAs who still show a lack of insight regarding the impact of their addiction following treatment, and who are reluctant to continue with aftercare, can be viewed as clients who are in the pre-consideration phase. The characteristics of the withdrawal phase in the recovery process, as discussed above, are typical of this phase. The social worker working with an adolescent who portrays these characteristics following treatment, makes use of the strategy provided at the end of this discussion, to assist the adolescent to move from the pre-consideration phase towards consideration of committing to aftercare (i.e. the consideration phase).

- **Motivational interviewing in the consideration phase**

The adolescent who enters aftercare, but is still functioning in the consideration phase, is characterised by ambivalence regarding changes and problems caused by his/her addiction. He/she is, however, aware that others (e.g. parents and teachers) identify a problem, and is unsure whether to consider or resist change. Motivational interviewing is aimed at the development of insight regarding the consequences of the addiction (i.e. relapse after treatment), as well as an internal level of motivation to consider and act towards change (i.e. maintaining sobriety after treatment).

- **Motivational interviewing in the determining phase**

During this phase the adolescent acknowledges the addiction, and shows an awareness of the need to change. He/she becomes willing to investigate possible solutions to address the problem of addiction, and is therefore ready and willing to commit to an aftercare plan. Once the adolescent in aftercare is ready to enter this phase, the social worker can start with the assessment of aftercare needs. The activities associated with the assessment (as discussed in the next sub-section) also assist the adolescent to become aware of his/her strengths, aftercare needs and resources needed to enter a recovery lifestyle.

- **Motivational interviewing in the action phase**

During the action phase, the adolescent becomes ready to develop aftercare goals, objectives and plans. He/she will act deliberately towards change, because ambivalence and resistance have made place for readiness. The social worker will be aware of the readiness when the adolescent stops arguing, denying and protesting, when he/she is calm and asks questions regarding change, talks about the future after change, and starts to experiment with change. During this phase, the social worker and adolescent develop an aftercare plan based on the strengths, aftercare needs and resources identified during the determining phase.

- **Motivational interviewing in the maintenance phase**

The adolescent attempts to act on the decision to change. In aftercare, motivational interviewing during the maintenance phase focuses on the development of specific techniques to continue with, and to maintain, cognitive and behavioural changes made during treatment. Activities associated with this phase in aftercare include addressing intrapersonal-, interpersonal and environmental needs to prevent relapses, and to contribute to a recovery lifestyle.

- **Motivational interviewing in the relapse phase**

An important issue during the maintenance and relapse phases is to create an environment and therapeutic relationship where the adolescent feels safe to discuss problems, maintain behavioural change, report relapses, and deal with relapses. During this phase, the adolescent is encouraged to implement and maintain the changes, while becoming able to use resources when assistance is needed. Once the adolescent is able to do this, the social worker can start to prepare him/her for termination of formal aftercare.

In the discussion to follow, a functional aid and strategy are provided which the social worker may use to aid the process of motivational interviewing during the **pre-consideration phase** to help the adolescent to become ready to participate in the aftercare process.

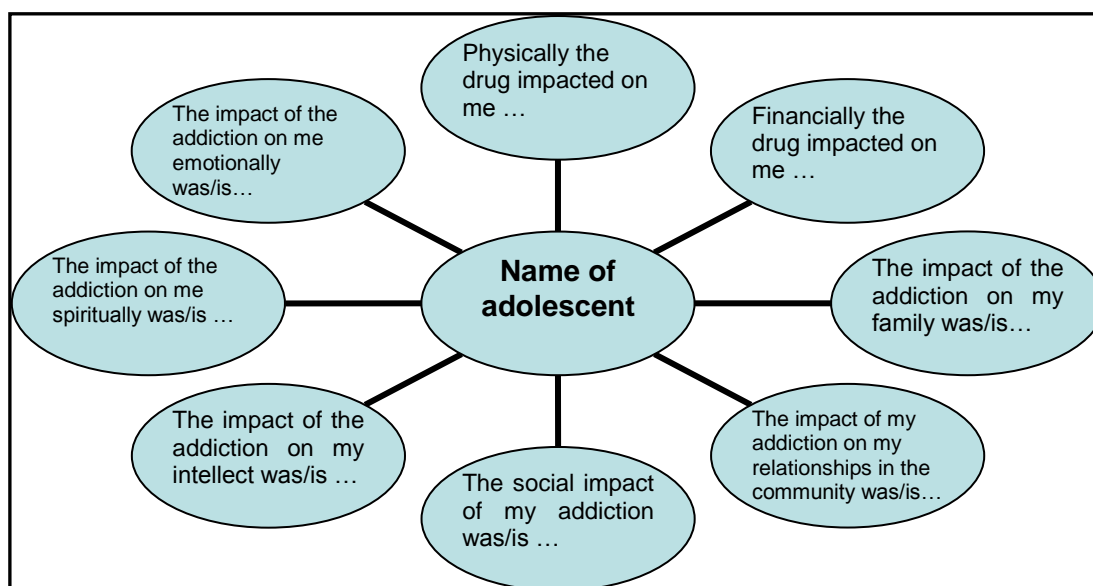




### Functional aid: Drawing an eco-diagram to assess the impact of addiction as displayed at the beginning of the treatment process

**The aim of this exercise** is to revisit the physical, mental, social and spiritual impact caused by the addiction and its current aftermath. Figure 10 below is used together with subtle confrontation to motivate the adolescent towards committing to aftercare services.

**Figure 10:** An eco-diagram to assess the impact of the addiction (adapted from the eco-map proposed by Sheafor & Horejsi, 2006:257)



### Strategy on how to implement the knowledge base and functional aid

The social worker explains to the adolescent the concept of an “eco-diagram”. It is a diagram on which he/she places him/herself in the middle of a circle and then in a spiral formation indicates how the addiction impacts on the various spheres of his/her life. The adolescent is then provided with an example, as provided in the figure above, and instructed to draw an eco-diagram to indicate how the substance use affected him/her. The social worker facilitates the process by posing the following questions:

- **In relation to the physical aspect:** How do/did the drugs affect your health? How do/did the drugs affect your body? How does/did your addiction affect your eating habits? How does/did drugging affect your involvement in sport/exercises?

- **In relation to the financial aspect:** How does/did drugging affect you financially? How much does/did your addiction cost you? How do/did you get money for clothes, food, personal items? How do/did you manage to get money for drugs? How do/did you spend your money while drugging?
- **In relation to the family:** How does/did the addiction affect your family relationships? How does/did your family life affect your addiction?
- **In relation to the community:** How does/did the community affect your addiction? How does/did your addiction affect the community? How do/did you feel about the community labelling you as a drug addict? Where are drugs readily available in your community? What is/was the attitude of the community towards you?
- **In relation to the social aspect:** How does/did the addiction affect your social life and relationships with friends? How do/did your social life and relationships with friends affect your chemical addiction? Who are your friends who still use drugs? Who are your sober friends? How does/did your addiction affect your relationship with them?
- **In relation to the emotional aspect:** How are/were you affected emotionally by the addiction? How does/did your addiction impact on your feelings about yourself?
- **In relation to the intellectual aspect:** How do/did the drugs affect your memory/concentration? How do/did the drugs affect your school work/work?
- **In relation to the spiritual aspect:** How does/did your addiction impact on your spiritual life? Did drugging change your involvement with church activities? How do you feel about this?

In order to strengthen the use of this functional aid as a motivational force to move the client towards considering a commitment to aftercare, the adolescent is asked to look at his/her responses, and to say how he/she would like to change the impact of the addiction and its aftermath. If a resistance to commitment to aftercare becomes apparent, a scenario can be sketched using the information provided by the adolescent, dramatising the consequences should a sober lifestyle following treatment not be pursued.

In the discussion to follow, a functional aid and strategy are provided which the social worker may use to aid the process of motivational interviewing during the **consideration phase**, for the purpose of helping the adolescent to become ready to commit to aftercare.



### **Functional aid: Compiling an inventory on previous efforts to deal with the addiction and the outcome of these efforts**

**The aim of the functional aid** is to assist the adolescent to identify, examine and assess the previous efforts made by him/her to deal with the addiction, as well as the outcome of these, in order to create insight that professional help is needed to help in the recovery process (i.e. aftercare).

**Table 5:** My previous efforts to deal with the consequences of my addiction

	Description of my effort	The outcome of my effort
Efforts to stop abusing drugs		
Efforts to change my drug of choice to have more control		
Efforts to hide the addiction and the damage caused by drug addiction		



### **Strategy on how to implement the knowledge base and functional aid**

The social worker gives the client a handout with the information on it provided in Table 5 above, and then asks the following questions to help the adolescent to complete this handout.

- What efforts did you make to stop using drugs? What or who caused you to make these efforts?
- Have you ever changed your drug of choice to have more control over the addiction? If so, what efforts did you make?
- What efforts did you make to hide your addiction and the damage caused by the addiction?

The adolescent is then requested to give the outcome of each of these efforts. Once the list is completed, the adolescent is encouraged to talk about the efforts and results, in order to develop insight into the fact that he/she needs to consider other alternatives (i.e. to commit to aftercare treatment) and/or to articulate efforts where aftercare treatment might be needed.

In the discussion to follow, a functional aid and strategy are provided which the social worker may use to aid the process of motivational interviewing during the **determining phase** and assist the adolescent to commit to the aftercare process.



### Functional aid: Developing a “pros and cons list’ associated with being addicted versus being sober

**The aim of this activity** is to help the adolescent to identify the pros and cons associated with being addicted versus the pros and cons of being sober, in an attempt to confirm the insight that the pros of sobriety outweigh the pros of addiction, and to motivate the adolescent to commit to aftercare.

**Table 6:** Dealing with the pros and cons of chemical addiction

Think back for a moment and compile a list of <b>all the pros</b> that you have <b>associated</b> and can associate <b>with your addiction</b> :	Think back for a moment and compile a list of <b>all the cons</b> that you have <b>associated</b> and can associate <b>with your addiction</b> :
Take a moment and think of all the <b>pros that you can associate with being sober</b> (List them)	Take a moment and think of all the <b>cons that you can associate with being sober</b> (List them)



### Strategy on how to implement the knowledge base and functional aid

The adolescent is given a handout depicting the information provided in the table above, and asked to complete it. Upon completion, the social worker starts a discussion in which the adolescent can develop insight into the fact that the pros of being sober outweigh the pros of continuing with substance abuse (relapse). The adolescent is encouraged to make use of the content of the pros and content list, and to make a list of “reasons why I want to stay sober” to carry with him/her as a reminder of the outcome of this discussion.

The activity to follow, related to motivational interviewing in the **action phase**, can be implemented once the adolescent shows an interest in committing to aftercare services.



### **Functional aid: A discussion to identify the focus areas for recovery**

**The aim of this exercise** is to provide the adolescent with a “bridge” between resistance to change and commitment to recovery. Once the resistance gives way to readiness for change, this discussion aims to assist the adolescent to identify goals and objectives for aftercare.



### **Strategy on how to implement the knowledge base and functional aid**

The social worker helps the adolescent to obtain a focus for aftercare through the following questions that can lead to the development of aftercare goals, objectives and plans.

- Why do we want to develop a plan? What do you want to achieve at the end of the aftercare process? What must be the outcome?
- How can you achieve this? What are the steps you must take to achieve the goal?
- Who must be involved with each of the steps? Who must do what, when must they do it, and how must they do it? What must you do? When must it be done?

The social worker can continue with the assessment of the adolescent’s aftercare needs and the planning of aftercare services once the adolescent moves from the action phase into the maintenance and relapse phases of motivational interviewing.

**The development of an individual, family and community profile, as part of assessment to identify aftercare needs**

### **The individual profile**



An individual profile must be drawn up to identify the following:

- The adolescent's existing skills/strengths that can contribute to the development of a recovery lifestyle (i.e. a lifestyle that will lead to continued sobriety and assist in the prevention of relapses);
- Needs (weaknesses/challenges/obstacles) experienced by the adolescent, and resources required to support him/her to develop a recovery lifestyle;
- The potential to be reintegrated into family and community (Western Cape Department of Social development Western Cape, 2008:16-17).

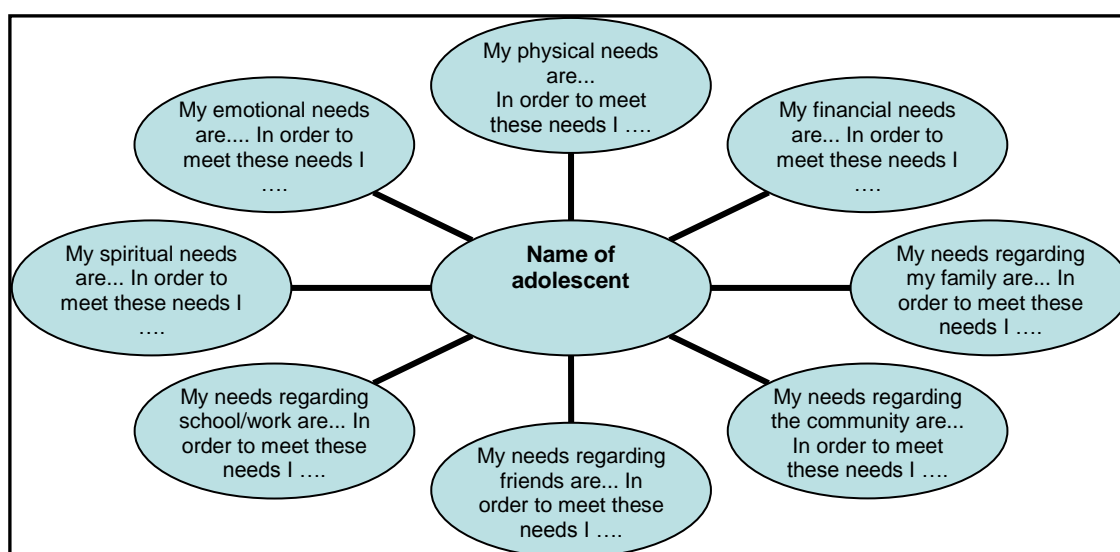
In the discussion to follow, a functional aid is suggested that may be used to aid the social worker when drawing up an individual profile of the adolescent to inform the process of developing an aftercare treatment plan.



### **Functional aid: Drawing an eco-diagram of the individual needs and efforts to address these needs**

**The aim of this activity** is to help the adolescent identify and describe his/her individual needs while developing a recovery lifestyle, and attempts to address these needs, while including resources such as the family, the community, the school and friends.

**Figure 11:** Eco-diagram to identify individual needs (adapted and adopted Sheafor & Horejsi, 2006:257)





## Strategy on how to implement the knowledge base and functional aid

The social worker explains that, in an eco-diagram, the adolescent places him/herself in the middle of a circle, and then all round it, indicates his/her individual needs while developing a recovery lifestyle, and attempts to address these needs, while including resources such as the family, the community, the school and friends. The adolescent is given an example of the figure above, and asked to draw an eco-diagram to identify his/her needs in order to carry on with a recovery lifestyle. Questions that can assist the adolescent in completing the diagram include the following:

- **Physical needs:** What physical needs do you experience while you are developing a recovery lifestyle? What do you need to eat to stay healthy? How often do you need to eat? What type of exercises can you do to improve your physical health? What activities can help you to relax when you feel stressed? How do you try to address these needs? Who can help you to address these needs?
- **Financial needs:** What financial needs do you experience while you are developing a recovery lifestyle? What do you need in terms of clothing, personal items, etc.? How will you get money for this? How will you make sure that you use the money wisely?
- **Family needs:** What needs do you have regarding your family life and your relationships with your family members? What do you need from each family member? How are you trying to address these needs?
- **Community needs:** What needs do you experience in relation to your community? What are the resources in your community that you can/will use? How will you deal with the availability of drugs? How would you like the community's attitude towards you to change? What can you do to change it?
- **Social needs:** What needs do you experience in relation to your friends and social life? Who are your friends who still use drugs? How will you relate to them to ensure that you are not tempted? Who are your sober friends? What can you do to improve your relationship with them? What social activities can help you to socialise without drugs?

- **Emotional needs:** What needs do you experience in relation to your emotions? What can you do to feel happy and relaxed? What can you do when you experience painful emotions/stress? Who can help you to address these needs?
- **Intellectual needs:** What needs do you experience in relation to your schoolwork? What needs do you experience in relation to work? What are your plans regarding school/a job? What skills do you need to develop to obtain a job? What do you struggle with at school/work? What and who can help you to address these needs?
- **Spiritual needs:** What needs do you experience in relation to your spiritual life? How can you make sure that you attend to your spiritual needs (i.e. meditation or prayer)? Do you want to become involved in church activities? How can you become involved? Who can help you to address these needs?

Once the diagram is completed, the adolescent is asked to indicate in which areas and with what he/she would like the social worker to assist him/her.

## A family profile



The family should be viewed as an integral part of aftercare services, considering the following: the addiction occurred in the family; it harmed the family; the family could have participated and perpetuated the addiction; and the family is an important potential resource for treatment and recovery (Gruber & Taylor, in Straussner & Fewell, 2006:3). A family profile must be drawn up by the adolescent to identify his/her needs regarding what he/she needs from the family in the recovery process in terms of: 1) the relationship between the family and the adolescent and 2) family resources that are available and needed. The following functional aid and strategy are provided to aid the social worker when drawing up a family profile before planning aftercare services.

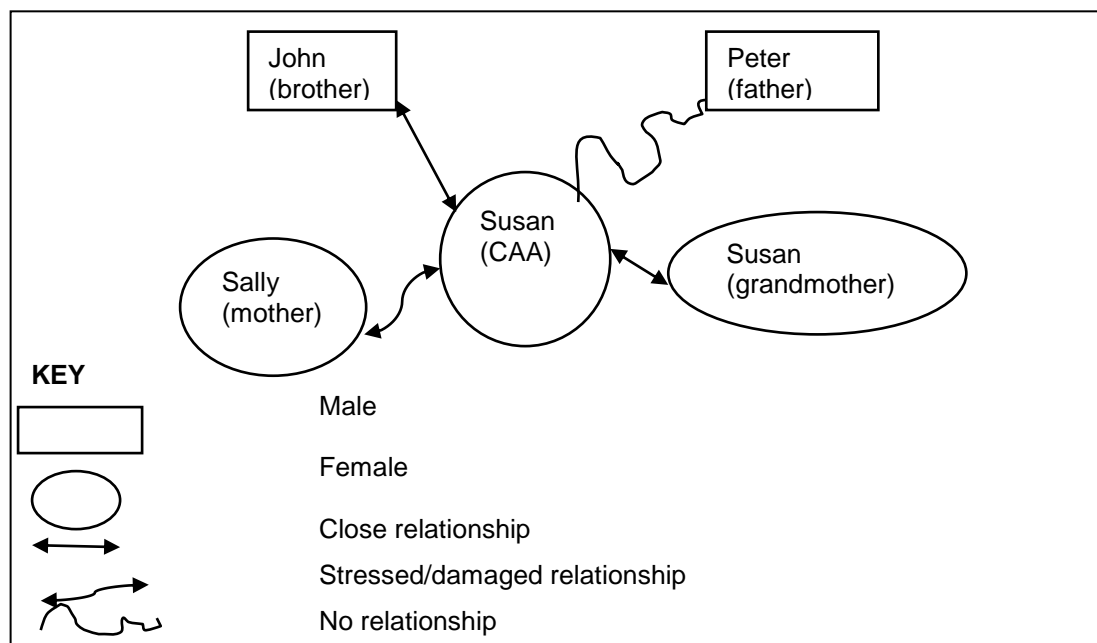




**Functional aid: An exercise to depict the adolescent's relationships with the various members of his family**

**The aim of this functional aid** is to assist the adolescent to develop insight into his/her family relations, by drawing a family relationship map, as well as by identifying needs relating to family support in aftercare.

**Figure 12:** A family relationship map to depict the adolescent's relationships with the various members of his/her family (adapted from Alpaslan, 2005)



**Table 7:** An inventory (from the adolescent's perspective) to determine the support and hindrances present in the family, as well as the support needed from them to develop a recovery lifestyle

In my family the following things are present to help me to develop a recovery lifestyle after treatment	In my family the following things will make it difficult for me to develop a recovery lifestyle after treatment	In supporting me in the development of a recovery life style, my family should support me in ...



**Strategy on how to implement the functional aid**

The social worker assists the adolescent to complete the family relationship map by giving the following instructions: Take a clean sheet of paper and put your name in the middle of the page. (If the adolescent is a male, he can indicate himself and the other males in the family as squares. In the case of a

female client, she can indicate herself and all the other females in the family as circles.) Put all the family members in the squares or circles according to gender. Link yourself to each of the other members of your family, using straight lines to show a close relationship between a family member(s) and yourself. Use a zigzag line to show a stressed or damaged relationship between a family member(s) and yourself. A scribble line can be used to show a non-existing or very poor relationship. The adolescent is provided with an example of a relationship map as depicted in Figure 12 above.

When the diagram is finished, the social worker can ask the following questions (adapted from Alpaslan, 2005) to the adolescent to assess the nature of the relationships with his/her respective family members. The following questions may be used to further explore these relationships:

- What reasons can you give for the close/damaged/stressed relationships that you experience with \_\_\_\_\_ (include the name of the particular member of your family? Were there times when you were closer to each other? Tell me more about it...
- I notice that the present relationships between you and \_\_\_\_\_ (include the name of the family member) are good. Was this always the case? If not, what has helped to make the relationship better? What do you think you could do to keep the relationship good?
- I see that the relationship between you and \_\_\_\_\_ (include the name of the family member) is stressed. What would you say are the reasons for this? Since when has the relationship been like this? What do you think should happen to improve the relationships? How could you try to improve the poor relationships between some members of your family and yourself? What should he/she do to improve their relationships?
- When looking at the relationships with these members of your family, how did some contribute to your addiction? How did your addiction impact on these relationships?
- How have the relationships between the different members of your family and yourself changed since you went into treatment? How will the relationships you have with members of your family help/hinder you in the development of a recovery lifestyle?

- How would you like your family to support you in developing a recovery lifestyle? Be specific, and say what you want them to do, or not to do.

Concluding the assessment of the family, and based on the insight developed through the completion of the family relationship map, the social worker gives the adolescent a handout containing the information provided in the Table 7 above. The adolescent is requested to complete the handout. In a focused discussion, each of the aspects requested is then discussed. When this has been done, the following questions may be used to further explore and assess the information provided by the adolescent:

- How has your family supported you since you went for treatment?
- In what way does their support help you to develop a recovery lifestyle following treatment?
- What should be changed in your family to increase the support you need, to develop and maintain a recovery lifestyle?
- How do you think should this change be brought about?

## **A community profile**



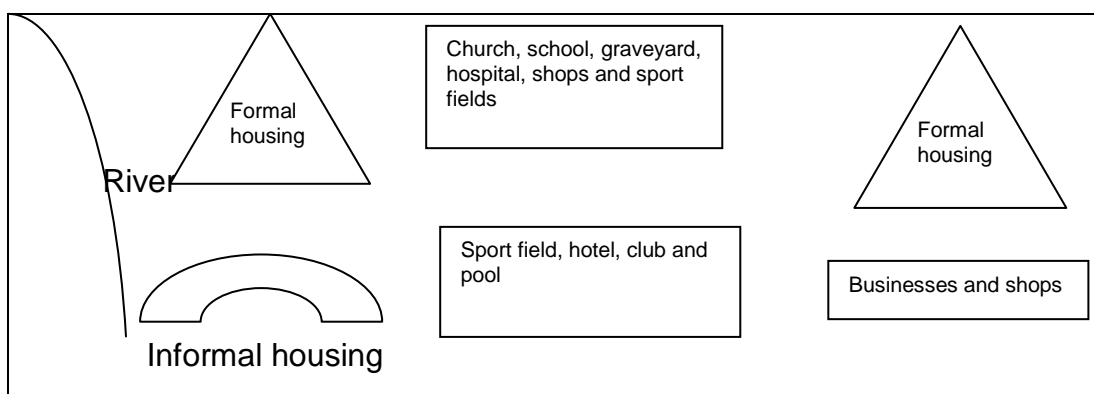
Both the lack of resources (providing support and assistance following treatment) in the community and the negative attitudes of community members towards addicts are viewed as factors that harm the adolescent's ability to reintegrate into the community (Pienaar, 2005:13). "Social reintegration" refers to assistance from community members and institutions to CAAs to re-establish themselves in the community (United Nations, 2003:15). Based on this, a community profile must be drawn up to identify the resources available to the adolescent in terms of: 1) available resources, 2) public services (clinics, schools, etc.), 3) service providers, and 4) religious systems in the community (Western Cape Department of Social development Western Cape, 2008:16-17). The following functional aid and strategy are provided to help the social worker when drawing up a community profile before planning aftercare services.



**Functional aid: Drawing up a social map and compiling an inventory (from the adolescent's perspective) to determine the resources and hindrances present in the community, as well as the support needed from them to develop a recovery lifestyle**

**This exercise aims** to assist the adolescent to become aware of, and to develop insight into, the obstacles he/she faces in his/her community following treatment, as well as thinking about resources needed and available in the community to assist him/her in developing a recovery lifestyle.

**Figure 13:** Social map (adapted from Weyers, 2001:136)



**Table 8:** An inventory to aid the drawing up of a community profile

The following resources are available in my community to help me to develop a recovery lifestyle after treatment	The following resources are needed in my community to help me to develop a recovery lifestyle after treatment



### **Strategy on how to implement the functional aid**

The social worker assists the adolescent to draw a map of his/her neighbourhood (using Figure 13 as an example) or to use an existing map, indicating where chemical substances are available and tolerated, as well as where substances are not available or tolerated (i.e. safe places). The adolescent chooses a colour that represents a safe place, and then marks the safe places with this colour on the map. Another colour is chosen to indicate

places where substances are available or tolerated. The tolerance and availability of chemical substances is assessed through questions such as:

- Who uses drugs in your community? / Where do they use or buy the drugs? / Who does not use drugs in your community? / Where do they normally go? / Where can one find drugs in your neighbourhood? / Where are drugs not available? / Where are drugs sold? *Choose a colour and indicate these places with the colour on the map.*
- Who does not use drugs in your community? / Where do these people live or spend time? / Where in your community are there no drugs? / Where are drugs not tolerated in your community? *Choose a colour and indicate these places with the colour on the map.*

Upon completion, the social worker gives the adolescent a handout of Table 8 above, and explains that, in order to deal with challenges in the community, the adolescent needs to become aware of resources that are either available or needed. The adolescent is asked to complete the handout. In a focused discussion, each of the aspects covered in the table is discussed. The following questions may be used to further explore and assess the information provided by the adolescent:

- What resources to help you in the development of a recovery lifestyle in your community are you aware of?
- How can these resources help you?
- What other resources do you think you will need? Why?

Once the profiling activities are concluded, the social worker concludes the assessment in order to prepare the adolescent to draw up an aftercare plan.

### Concluding the assessment



The outcome of the assessment of aftercare needs should be the identification of: 1) the specific needs of the adolescent, 2) strengths that could assist with the development of a recovery lifestyle, and 3) resources to support the adolescent's efforts. The social worker makes use of the information obtained in the activities described above, and concludes the

assessment with a summary of the identified needs, strengths and resources to be included in the aftercare plan. The identified areas to be addressed in aftercare should contribute to becoming comfortable with the recovery lifestyle, and to prevent relapses (Sheafor & Horejsi, 2006:298-299; Timberlake et al., 2008:243). The following functional aid and strategy can be used to summarise the information obtained from the profiling activities.



**Functional aid: An exercise to identify factors in the family, and personal and social contexts to be included in the aftercare plan to prevent relapses**

*The aim of this functional aid* is to make use of the information obtained during the previous assessment exercises, and to identify and summarise those areas that need to be included in the aftercare plan that would lead to preventative measures to curb possible relapses from occurring. The table below can be used as a guide to distinguish between needs related to the family, the community, and the adolescent's personal traits.

**Table 9:** Contributing factors in relapses among chemically addicted adolescents (adopted and adapted from Galambos & Leadbeater, 2000:292; Pires & Jenkin, 2007:169)

The following <b>factors in my family</b> might contribute to a relapse...	The following <b>factors in my social environment</b> (i.e. amongst my peers, friends) might contribute to a relapse...	The following <b>personal traits</b> might contribute to a relapse...
In order to prevent the mentioned family factors from contributing to a relapse, the following preventative measures (action plan) are suggested...	In order to prevent the mentioned factors in my social environment from contributing to a relapse, the following preventative measures (action plan) are suggested...	In order to prevent the mentioned personal traits from contributing to a relapse, the following preventative measures (action plan) are suggested...



**Strategy on how to implement the knowledge base and functional aid**

The social worker gives the adolescent an activity sheet, using the table above, and instructs him/her to indicate what factors in his/her family, social environment and personal traits might contribute to a relapse. On completion, the information provided by the adolescent is discussed (and where necessary, further explored), and an action plan with preventative measures

is drawn up as a means to curb relapses in the aftercare phase, where the adolescent is working towards establishing and maintaining a recovery lifestyle.

### Formulation of aftercare goals and development of an aftercare plan

#### The development of aftercare goals and objectives



Once the social worker sees that the adolescent has a clear focus and vision for aftercare (i.e. to develop and maintain a recovery lifestyle), the aftercare goals and objectives are developed. The *purpose* of goal formulation is to: 1) provide direction and continuity for services; 2) provide a means to come to an agreement regarding the content and structure of services; 3) facilitate selection of intervention strategies; and 4) serve the outcome criteria, in this case relapse prevention. Aftercare goals serve as the focus of intervention. The client is involved in the choice of an intervention strategy as well as in co-constructing the aftercare goals, and the strategy is used as a measurement tool. The goals and objectives of aftercare plans must be user-friendly, and ensure that success is possible (Epstein & Brown, 2002:168-169; Hepworth et al., 2006:341-344; Timberlake et al., 2008:250). The functional aid and strategy below may be used in this regard.



#### Functional aid: Step-wise guideline for developing aftercare goals and objectives

Based on the needs identified in the previous section, ***this functional aid aims to*** assist the social worker to support the adolescent to develop achievable aftercare goals and objectives.

**Table 10:** An example of identified needs to be addressed through aftercare

Functional aid	Examples of needs identified in relation to these functional aids:
Family relationship diagram of the significant others in his/her life	I need my parents to trust me again
An "eco-diagram" to identify individual needs	I need new sober friends
A resource list to be utilised in the recovery process	I need to have access to a support group
A social map	I need to become aware of, and deal with, places in my community where drugs are available



### Strategy on how to implement the functional aid

By way of summarising, the social worker and adolescent engage in a discussion during which they look at all the needs identified (through the various functional aids used for assessment purposes) and formulate for each of the identified needs a **goal** to address the needs. The table above can be used as an information sheet for this purpose. Based on the needs identified, the social worker assists the adolescent to identify specific desired goals for each of these identified needs, using the step-wise guideline for the development of achievable, specific and flexible goals by Gosling (2003:76-79): Who must do what, how, and for what purpose?.

- **Who:** This refers to the target system (e.g. the adolescent/the family/the community)
- **What:** This refers to the problem/need that must be addressed (e.g. aftercare on an intrapersonal/interpersonal/environmental level of functioning)
- **How:** This refers to the level of intervention, techniques and aids (e.g. the development of intrapersonal skills/interpersonal skills/addressing environmental challenges)
- **Why:** This refers to the preferable outcome (e.g. relapse prevention as well as successful reintegration into families and communities)

These goals are described in sentences such as:

- “I (**who**) want to become able to build friendships with sober friends (**what**), through decision-making, communication and assertiveness skills (**how**), to make sure that I do not spend time with people who could trigger a craving (**why**).

**Objectives** are now added to each goal. The objectives relate to the goal of the aftercare plan, and are formulated in a similar way to the goal. This can be viewed as the *steps that need to be taken* in order to achieve the goal (Gosling, 2003:78). For example (using the example of a goal above):

- **Who:** target system (The adolescent and sober peers)
- **What:** the problem/need that will be addressed (The need to make new sober friends)



- **How:** level of intervention, techniques and aids (inter- and intrapersonal levels of intervention, list of desired quality of friends, practical exercise to engage with sober peers, practical exercise to become able to say “No” to drug-using friends)
- **Why:** the preferred outcome (replacing drug-using friends with sober friends)

Using the example of a goal provided above, these objectives are described in sentences (steps) such as:

- 1) “When spending time with friends, I (**who**) want to learn how to choose friends (**what**), through making a list of what I want in a friend (**how**), to be able to identify who my friends should be (**why**)”;
- 2) “When spending time with friends, I (**who**) want to learn how to talk to sober peers (**what**), through a group activity where I practise new communication skills (**how**), to become able to make new friends (**why**)”;
- 3) “When spending time with friends, I (**who**) want to learn how to say ‘No’ when my drug-using friends approach me (**what**), through a group activity where I practise saying ‘No’ (**how**), to become able to avoid people who might trigger a craving to use drugs (**why**)”.

## The development of an aftercare plan



In providing an aftercare service to the CAA, the social worker should ensure that the adolescent is involved in the construction of the service, and that it is based on the goal and objectives described above. Weyers (2001:139) endorses this and states that the focus of planning should be based on: 1) collective action (involving the adolescent and social worker); 2) the needs as identified during assessment; and 3) the goals and objectives emanating from the assessment. Focusing specifically on providing aftercare services, Arterburn and Burns (2007:169-180) note that the focus of intervention should be on the adolescent’s continued physical, mental, emotional, social and spiritual recovery and the maintenance thereof. In the table below an exposition is provided of ways to pursue this.

**Table 11:** Focus areas for an aftercare plan (Arterburn & Burns, 2007:169)

Physical recovery and maintenance can be obtained by following	Psychological recovery and maintenance can be obtained by	Emotional recovery and maintenance can be obtained by	Social recovery and maintenance can be obtained by	Spiritual recovery and maintenance can be obtained by
A proper - <ul style="list-style-type: none"> <li>Nutritional plan</li> <li>Exercise routine</li> </ul> By <ul style="list-style-type: none"> <li>resting properly,</li> <li>seeking concerted efforts for relaxation and</li> <li>engaging in intellectual stimulating activities</li> </ul>	<ul style="list-style-type: none"> <li>Joining a supportive community/ support groups for peers in recovery</li> <li>Developing self-efficacy , a realistic self-image and a balanced self-esteem</li> </ul>	<ul style="list-style-type: none"> <li>Identifying emotions</li> <li>Sharing the emotions</li> <li>Letting go of the emotion</li> </ul>	<ul style="list-style-type: none"> <li>Identifying traits in good friends</li> <li>Choosing friends according to these traits</li> </ul>	<ul style="list-style-type: none"> <li>Hope to be able remain sober</li> <li>Learning to forgive oneself and others and exercising this forgiveness</li> <li>Finding a purpose for one's life and exercising this purpose</li> </ul>

The value of joint activities during assessment, goal formulation and the development of the aftercare plan is that the adolescent can identify with the aftercare plan as his/her own. The aftercare plan can thus serve as a working agreement (contract) in clear language between the social worker, the adolescent, and the family (Epstein & Brown, 2002:168-169). These agreements represent a degree of commitment and goodwill from all the parties concerned, but must not be rigid. The following functional aids and strategies provide an illustration of how aftercare plans and working agreements can be structured, as well as the possible contents (based on the findings of this research study).



**Functional aid: An exercise for developing an aftercare plan addressing the identified risk factors endangering recovery and the maintenance of a sober lifestyle**

**The aim of this functional aid** is to assist the adolescent to draw up an aftercare plan addressing the identified risk factors endangering recovery and the maintenance of a sober lifestyle, as well as stipulating how these risk factors will be prevented through aftercare. The table below may be used as a guide, while the social worker adds more goals to include aspects identified during the assessment that are not displayed in this table.

**Table 12:** Worksheet for identifying risk factors that will endanger the adolescent's recovery process and the maintenance of a sober lifestyle, as well as a plan for preventing these risk factors

Risk factors (as adapted and adopted from Perkinson, 2008:146)	Tick (✓) if this risk factor is applicable to you	In order to prevent this risk factor, I plan to do ...	In order to prevent this risk factor, I will involve the following person/people to help me...	When will I do this?	How will I benefit from this?
<b>Goal:</b> To address risk factors that can endanger my recovery, and to develop and maintain a sober lifestyle					
The availability of drugs in my environment is a risk factor endangering my recovery and the maintenance of a sober lifestyle					
The affordability of drugs is a risk factor endangering my recovery and the maintenance of a sober lifestyle					
My previous habit of using drugs as a pain reliever, is a risk factor endangering my recovery and the maintenance of a sober lifestyle					
Friends in my peer group who still use drugs are a risk factor endangering my recovery and the maintenance of a sober lifestyle					
The lack of alternative "fun" to replace the use of drugs is a risk factor endangering my recovery and the maintenance of a sober lifestyle					
Problems in my family are a risk factor endangering my recovery and the maintenance of a sober lifestyle					
Painful emotions and an inability to deal with them are a risk factor endangering my recovery and the maintenance of a sober lifestyle					
Emotions that lead to a de-focus from my recovery plan are a risk factor endangering my recovery and the maintenance of a sober lifestyle					
Social pressure, such as poverty, unemployment, and association with gangs, is a risk factor endangering my recovery and the maintenance of a sober lifestyle					
Conflict with friends and family members and the inability to resolve it, is a risk factor endangering my recovery and the maintenance of a sober lifestyle					

A need to test personal control (just wanting to make sure that I am truly free of addiction) is a risk factor endangering my recovery and the maintenance of a sober lifestyle					
Other: (specify)...					



### Strategy on how to implement the functional aid

The social worker gives the adolescent a clean copy of the worksheet above, and, in a focused discussion, assists him/her to identify risk factors that will endanger his/her recovery process and the maintenance of a sober lifestyle, and to draw up a plan for preventing these risk factors. The social worker must facilitate the discussion in such a way that the adolescent will be able to say exactly who will do what under what circumstances to help prevent this risk factor from occurring. Where the assistance of another person/people is needed, the social worker assists the client to say who this person/people will be, exactly what they must do, and how the adolescent will approach them. Where the adolescent lacks the confidence to approach this person/these people, role-plays may be used to show the adolescent how to approach this person/these people for help, and how to clearly express the need of help requested. The social worker assists the adolescent to assess if the nature of the request for help is realistic and feasible. The development of this skill forms part of intervention services aimed at the intra- and interpersonal needs of the adolescent, but is presented here as the adolescent is at this stage preparing an aftercare plan that might include the assistance of other persons. The social worker should also allocate time in the aftercare programme for the adolescent to give feedback on the management of risk factors and his/her experiences in this regard. In order to be able to measure progress, and to identify obstacles during the implementation phase, the adolescent is also required to include a timeframe during which the activity will take place. Additionally, in an effort to increase the internal level of motivation to commit to the aftercare plan, the adolescent is assisted and encouraged to identify how he/she will benefit from the steps to address the risk factor, and to develop and maintain a recovery lifestyle.

The next functional aid is provided to solidify the working arrangement through an agreement between the adolescent and any other person/people he/she would like to assist him/her with developing a sober lifestyle.



**Functional aid: An activity to develop a working agreement between the adolescent and any significant other person whose assistance might be needed in recovery and to develop and maintain a recovery lifestyle**

The *aim of this functional aid* is to assist the adolescent and any significant other person/people whose assistance is needed in recovery and to develop and maintain a recovery lifestyle, to draw up a working agreement (see example in the table below) indicating clear boundaries and expectations between the parties concerned.

**Table 13:** A sample of a working agreement between chemically addicted adolescents and their parents (as adopted and adapted from Perkinson, 2008:239)

Arrangement	between _____ (parents)	and _____ (chemically addicted adolescent)
Purpose		
<b>Parents</b> We want to support _____ in his/her effort to stay sober and want to participate in actions that will lead to our household's recovery from the consequences of the addiction	<b>Chemically addicted adolescent</b> I would like to become a healthy member of my family, gain their trust back and learn to live a sober life	
<b>Parents</b>		
Action (what)	Time-frame (when)	
We will take _____ to support meetings	Twice weekly	
We will provide him/her with the opportunity to continue his/her school work	For two years	
We will participate in family therapy	Every second week	
We will attend family support groups	Twice weekly	
<b>Chemically addicted adolescent</b>		
Action (what)	Time-frame (when)	
I will attend support meetings	Twice weekly	
I will return to school	Daily for two years	
I will participate in family therapy	Every second week	
I will join the youth group at my church	Twice weekly	
<b>Agreement period</b>		
<b>Signed</b>		
Parents		
Chemically addicted adolescent		
Social worker		
Date		



### **Strategy on how to implement the knowledge base and functional aid**

The above table is an example of a working agreement between the adolescent and his/her parents (adopted and adapted from the work of Perkinson, 2008:239). The social worker uses the information obtained from the previous functional aid (Table 12) and then identifies the significant others the adolescent needs to develop working agreements with, to assist him/her in recovery and to develop and maintain a recovery lifestyle. With the assistance of the social worker, working agreements are drawn up for each of these significant other people. With the consent of the adolescent, the social worker invites these people to a meeting where the respective contracts are discussed and finalised in terms of what they seem fit and willing to do.

The aftercare plan and working agreement form the foundation of the **goal attainment stage in the intervention process**, and will be discussed in the following sub-section. Table 14 below provides a visual illustration of the goals and objectives for goal attainment and interventions addressing the intrapersonal aftercare needs of CAAs, and the knowledge, functional aids and strategies required by social workers to realise the goals and objectives.

**Table 14:** The goals and objectives for interventions addressing the intrapersonal aftercare needs of chemically addicted adolescents, and the knowledge and strategies required by social workers to realise the goals and objectives

Goals	Objectives	Knowledge base prerequisite	Functional aid and strategy to realize the goals and objectives
Implementing the aftercare plan through intervention	Attaining the aftercare goals through the implementation of the aftercare plan	<ul style="list-style-type: none"> <li>The task of the social worker in goal attainment</li> <li>Focus areas in case-management</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>A tick list for case-management and monitoring the implementation of the aftercare plan</li> </ul>
Interventions addressing the intrapersonal needs of chemically addicted adolescents in aftercare	Case work aimed at increasing internal levels of motivation to pursue and maintain a sober lifestyle	<ul style="list-style-type: none"> <li>Areas to address to increase internal levels of motivation</li> <li>The difference between a lapse and a relapse and the impact thereof on the adolescent's intrinsic level of motivation</li> </ul>	<u>Functional aids: exercises to assist with:</u> <ul style="list-style-type: none"> <li>Increasing internal levels of motivation</li> <li>Rebuilding intrinsic levels of motivation following a lapse</li> </ul>
	Case work aimed at breaking down defence mechanisms that maintain old habits and changing substance-related behaviour	<ul style="list-style-type: none"> <li>Why chemically addicted adolescents use defence mechanisms</li> <li>Dishonesty that underlies defence mechanisms</li> <li>Focus areas when learning positive behaviours</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>Breaking down dishonesty and building honesty through developing alternative behaviours</li> </ul>
	Case work aimed at developing and maintaining lifestyle changes	<ul style="list-style-type: none"> <li>The purpose of a recovery lifestyle</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>Identifying pit-stops on the recovery road and identifying and implementing activities to be included in the recovery lifestyle</li> </ul>
	Case work aimed at identifying and dealing with feelings	<ul style="list-style-type: none"> <li>Types of feelings that impact on the recovery potential</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>Illustrating that feelings experienced cannot be denied, identifying feelings that are experienced following treatment, and identifying ways to constructively deal with feelings</li> </ul>
	Case work aimed at the development and maintenance of a realistic self-image	<ul style="list-style-type: none"> <li>Characteristics of a low self-image</li> <li>Characteristics of a positive self-image</li> <li>The importance of self-awareness</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>Becoming self-aware, developing realistic expectations of oneself and making positive changes that contribute to a realistic self-image</li> </ul>

## AFTERCARE INTERVENTION

### Attaining the aftercare goals through the implementation of the aftercare plan



When an aftercare plan has been completed to assist the adolescent in recovery and to develop and maintain a sober lifestyle, the social worker acts as a case manager. In this context, the *tasks* of the social worker are to: 1) monitor goal accomplishment, 2) adjust plans and 3) re-negotiate the working agreement when/if needed (Timberlake et al., 2008:79). The *focus of activities* in the goal attainment stage of the intervention process is described by the Western Cape Department of Social Development Western Cape (2008:20) as: 1) the client is implementing the contracted action steps of his/her aftercare plan; 2) the client is attending structured substance-abuse programmes (in this case aftercare programmes); 3) feedback is given to the client on behavioural changes and areas of development; 4) strategies for positive behavioural reinforcement are practised and maintained; 5) sessions could be held with significant others e.g. families, friends, etc in order for them to offer ongoing support; and 6) the client is prepared for termination/referral to experts, support groups, or other stakeholders in the field of substance abuse, depending on the client's state of readiness.

Rapp (in Saleeby, 2006:137) advises that the social worker manages the aftercare plan by means of a tick list for case-management. The discussion below provides a functional aid, together with a strategy to use in this regard.



#### **Functional aid: A tick list for case-management and monitoring the implementation of the aftercare plan**

**The aim** of this tick list is to assist the social worker to monitor the implementation of the aftercare plan, to identify obstacles experienced during the implementation, and to adjust the aftercare plan if needed. The table below is an example of such a tick list.



**Table 15:** An example of a tick list for case-management when dealing with aftercare (adopted and adapted from Rapp, in Saleebey, 2006:137)

Focus area	Steps/activities to address the focus area and people/persons involved	Monitoring tool (proof of progress/completion)	Arranged	Progress
Life skills				
Finances				
Leisure and time management				
Relationships				
Living arrangements				
Education/occupation				
Health: mental and physical				
Recovery plan				



### **Strategy on how to implement the knowledge base and functional aid**

In the table above, an example is provided of a tick list that the social worker can use for the purpose of case management and for monitoring the aftercare plan. Using this example, the social worker, together with the adolescent, develops an individualised tick list that will aid the social worker in managing the aftercare case of the particular client, as well as the progress he/she is making towards realising the formulated aftercare goal. The social worker lists all the focus areas included in the aftercare plan under the first heading, as illustrated in the figure. The activities involved in each service area, as well as the resources to be utilised in each specific service area, are then listed next to each area under the second heading.

The next step is to identify ways in which the social worker will monitor the implementation of each service area (e.g. attendance register, changes in behaviour, changes in relationships, etc.) under the third heading and next to the service area relevant to each monitoring tool. The social worker, together with the client, then ticks off the completed activities in each service area. Apart from monitoring progress, this activity also serves as motivation for the client (seeing the progress made), as well as a visual picture of aspects that still need to be attended to.

During the assessment and planning stages, the social worker and the adolescent identify the needs of the adolescent with regard to the development and maintenance of a recovery lifestyle. The goal- attainment stage<sup>18</sup> will be presented in terms of guidelines for intervention addressing 1) intrapersonal needs of adolescents in aftercare (i.e. case work); 2) interpersonal needs of adolescents in aftercare (i.e. group work); and 3) environmental challenges and needs of adolescents in aftercare (i.e. community work).

The social worker includes those topics/interventions that relate to the needs identified by the adolescent during the assessment of aftercare needs. In addition, he/she may choose to implement the functional aids provided under interventions addressing intrapersonal needs in group work (addressing interpersonal needs) or the functional aids provided under interventions addressing interpersonal needs in case work (addressing intrapersonal needs). The case and group-work methods can also be used in combination. For example, while the adolescent develops problem-solving skills during group sessions, these skills can be referred to and used during case work when identifying and dealing with feelings. In order to ensure sustainable change following treatment through aftercare, the activities that are included in the discussion below should be conducted over a period of time and repeated a number of times. This should lead to the internalisation of new information, perceptions, and behaviours; and assists in monitoring progress.

### **Interventions addressing the intrapersonal needs of chemically addicted adolescents in aftercare**



“Intervention on an intrapersonal level” refers to services that aim to address thoughts, feelings and perceptions that are harmful to the individual client’s functioning (Toseland & Rivas, 2005:286). Case work, as a primary method in Social Work, is used to facilitate interventions on an intrapersonal level (Timberlake et al., 2008:23).

<sup>18</sup> Based on the responses of the participants to this study (Chapters 3 and 4)

The focus areas to be included in case work as part of aftercare to CAAs will be presented under the following headings: increasing levels of motivation to pursue and maintain a sober lifestyle; breaking down defence mechanisms that maintain old habits; developing and maintaining lifestyle changes; identifying and dealing with feelings; and developing and maintaining a realistic self-image.

**Increasing internal levels of motivation to pursue and maintain a sober lifestyle**



Intrinsic motivation (or motivation from within) leads to the “will to make an effort” to change, or in the case of aftercare to maintain and continue with changes made during treatment (Bezuidenhouit & Joubert, 2003:165-167). Once formal treatment is completed, the adolescent needs assistance on an intrapersonal level to continue to develop internal levels of motivation to ensure the internalisation of change. Through aftercare services, the social worker assists the adolescent: 1) to develop a need to enrich him/herself; 2) to persevere with efforts to remain sober, to become comfortable with the recovery lifestyle, and practise new skills; 3) to develop a need to achieve success; 4) to become positive regarding learning through mistakes; and 5) to make an effort to change or to maintain change (Goodwin, 2000:144).

Also, when/if the adolescent interrupts a sober period with a drinking/drugging episode, and then returns to abstinence, it is viewed as a “lapse”. When/if a lapse or relapse occurs, it is important to take cognisance of its impact on the level of motivation, and to continue with efforts to remain sober through the focus areas described above. Although it often is the beginning of a relapse, a lapse does not imply that it will necessarily lead to a relapse. It could be viewed as learning and confirming experiences, thus becoming a breakthrough instead of a breakdown in the recovery process (Marlatt, Parks & Witkiewitz, 2002:5; Fisher & Harrison, 2005:156). The value of aftercare is that it could prevent a lapse from becoming a relapse. On the other hand, a relapse is a process that occurs within the addict in recovery, which manifests itself in a progressive deterioration in the pattern of behaviour, and symptoms

leading to the use of addictive substances (Barber, 2002:133). The relapsed adolescent has to enter the treatment process again, while the lapsed adolescent can be assisted, through aftercare, to understand what has happened, and to learn from the experience. A lapse, however, is a painful experience, during which the adolescent becomes de-motivated, and self-doubt occurs. The aftercare worker should assist the lapsed adolescent to rebuild his/her intrinsic levels of motivation, in order to move back into the recovery process.

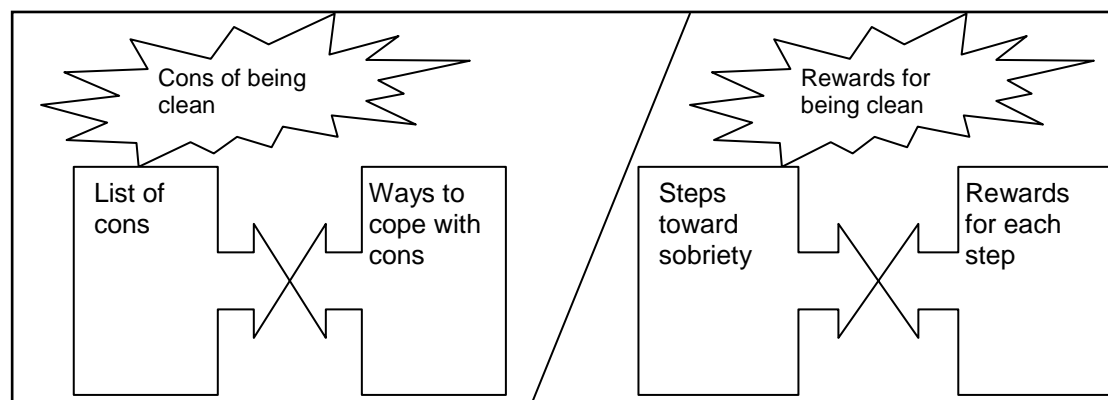
The following functional aids and strategies therefore focus on: 1) the increase of internal levels of motivation to maintain the recovery lifestyle following treatment, and 2) addressing the decrease of levels of motivation to continue with recovery following a lapse.



**Functional aid: An activity to increase internal levels of motivation**

The *aim of this activity* is to increase internal levels of motivation by assisting the adolescent in developing insight into the consequences, as well as the advantages, of a recovery lifestyle. The adolescent is also assisted to identify steps to cope with the consequences, and to identify rewards related to the recovery lifestyle. This functional aid relates to the identification of the pros and cons of chemical addiction, as discussed under the determining phase in motivational interviewing (see p. 300).

**Figure 14:** Increasing internal levels of motivation (adapted and adopted from Perkinson, 2008:16)





### Strategy on how to implement the knowledge base and the functional aid

The social worker writes the following topic on a flipchart: “Cons of being sober”, and brainstorms with the adolescent the cons by asking the following question: “*What are the things you do not like about being sober?*” Once the adolescent has exhausted this topic, the adolescent is encouraged to explore other ways of addressing these consequences, apart from using substances.

On completion of this exercise, the social worker writes the following topic on a flipchart: “Rewards of being sober” on a clean paper. The adolescent is given an opportunity to explore the rewards of being sober. In order to enhance the adolescent’s intrinsic motivation to pursue sobriety, the social worker must focus next on how he/she rewards him/herself for staying sober. If rewarding him/herself does not produce many ideas, a discussion must be initiated on ways the adolescent can reward him/herself. The figure above can be used to summarise the outcome of the discussion. The adolescent is encouraged to put this summary in a special place, and to revisit his/her decisions on a regular basis.

The following activity is specifically aimed at increasing levels of motivation after a lapse.



### Functional aid: An activity to rebuild intrinsic levels of motivation following a lapse

The ***aim of the functional aid*** is to assist the lapsed adolescent to rebuild intrinsic levels of motivation in order to move towards thoughts and actions to return to the recovery process, and thereby to prevent the lapse to escalate into a relapse.



### Strategy on how to implement the knowledge base and the functional aid

The social worker engages in a non-threatening and non-judgemental discussion with the adolescent following a lapse. Instead of focusing only on

the lapse, the social worker assists the adolescent to move towards thoughts about the process of returning to recovery. The social worker explains the difference between a lapse and a relapse, and explains that the adolescent can prevent the lapse from escalating into a relapse. The following questions are aimed at stimulating the exploration of the nature of the lapse, in order to understand what happened, and to identify its consequences:

- What happened when the lapse occurred?
- Think about the period before the lapse occurred. What do you think happened that contributed to the lapse? If you can go back, what would you have done differently?
- Who could have supported you during that time to help you to prevent the lapse? How could this person/these people have supported you?

The adolescent is asked to list the factors contributing to the lapse, own reactions to the contributing factors, and the consequences of the lapse. Questions that could assist the adolescent to identify actions that could assist him/her to return to the recovery process, according to pointers provided by De Jong and Insoo (2002:86), and adapted, are the following:

- The miracle question: Let's use the list you made about your lapse. How will you know your lapse is over with regard to your actions and the consequences of your lapse? In order to make sure that your lapse is over, what must you do to know that your lapse is over? What needs to happen for the lapse to be over? How would you feel if you knew you were back in recovery and not lapsing anymore?
- Now after the lapse experience, what will be different in your continued recovery plan and lifestyle? What did you learn from this experience? Looking at your list of the factors contributing to your lapse, how can you prevent this in future?
- Your experience was a lapse. What happened that led to the return to recovery, instead of a relapse? What are the advantages of returning to your recovery programme? What are the steps you can take to ensure that you become actively involved in your recovery plan again?

The social worker and the adolescent then adjust the goals and objectives of the recovery plan to include the aspects identified during this activity. Related to increasing the adolescent's levels of motivation, he/she needs to be assisted to break down defence mechanisms that maintain old habits.

### **Breaking down defence mechanisms that maintain old habits and changing substance-related behaviour**



Even though adolescents in aftercare have already received treatment, the use of defence mechanisms such as blaming, projecting and rationalising may still be present as part of old internalised behaviour. *Dishonesty* often underlies the use of defence mechanisms, such as denial and blaming (Caroufek, 2007:4-6). These defence mechanisms are used to enable the adolescent to continue with old substance-related behaviours without regard for the consequences, which result in thinking patterns that hamper the ability to change old habits, and also the recovery process (Perkinson, 2008:98-107). Aftercare service aims to change thinking patterns, deal with defence mechanisms (e.g. dishonesty), and assist the adolescent to engage in new behavioural patterns conducive to the recovery process. "Changing addictive behaviours" means to "unlearn" negative behaviours associated with the substance abuse and replace them by learning positive behaviours (Marlatt et al., 2002:3). The social worker focuses on the following when assisting the adolescent in this regard: 1) identifying rewards for change in behaviour; 2) developing task-orientated activities that are manageable; 3) rehearsing new behaviours to internalise it; 4) developing stimulus control through the avoidance of trigger situations and learning to participate in new activities; and 5) developing urge control by recognising and changing thoughts and feelings (NIDA, 2008:8-9). A Functional aid and strategy to address old behaviours and defence mechanisms are provided below.



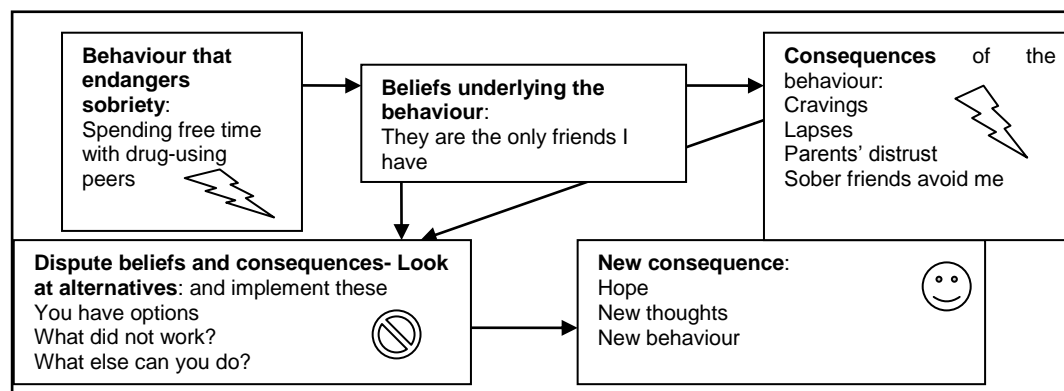
### Functional aid: An activity to break down dishonesty and to build honesty through developing alternative behaviours

The **following activity aims** to assist the adolescent in breaking down the need to use dishonesty as a form of defence mechanism, and becoming ready to change behaviour through honesty. The adolescent is provided with steps through which he/she can: 1) identify old substance-related behaviours and thoughts related to the behaviour, 2) admit the consequences of the behaviour, 3) identify alternative behaviours, and 4) implement alternative behaviours while identifying their outcomes.

**Figure 15:** Breaking down defences and building honesty (adopted and adapted from Perkinson, 2008:299)

1. Five lies I told someone close to me about my drugging:	2. Five lies I told myself:	3. Five people I lied to:
4. Five reasons why I needed to lie about my drugging:	5. Five examples of how lying hindered me in recovery and the development and maintenance of a sober lifestyle:	6. The consequence - five advantages of being honest:

**Figure 16:** The process of developing new behaviour (adopted and adapted from Van Niekerk & Prins, 2001:168)







### **Strategy on how to implement the knowledge base and the functional aid**

The social worker gives the adolescent a worksheet on which Figure 15 above is depicted, asking him/her to complete it honestly as a homework assignment. In a follow-up session, the focus of the discussion is on the answers in the first three blocks, in order to explore the use of lying as a defence mechanism. The focus of the discussion then shifts to the encouragement of honesty. The social worker refers to Block 4 and asks: “*Why did you feel a need to lie about your addiction?*” The adolescent’s answers are then related to Block 5. The social worker encourages the adolescent to explore how dishonesty hindered his/her recovery towards developing and maintaining a sober lifestyle. The focus of the discussion is shifted once again, by looking at what the consequences of honesty are (block 6).

Moving on to encouraging new behaviour to build honesty, he/she and the social worker engage in a brainstorm to identify behaviours that need to change in order to live honestly, and to assist him/her to create a recovery lifestyle. Figure 16 above may be used as a visual illustration of how this activity is used. The following five steps are followed over a number of sessions:

1. **Identify the behaviour that endangers sobriety and the development and maintenance of a recovery lifestyle following treatment:** This step may be introduced with the following question: *What behaviour that was previously part of your substance-related lifestyle is still present?* This discussion entails the identification of behaviour that needs to change and the identification of events/situations where this behaviour occurs.
2. **Identify the belief underlying this behaviour:** The social worker asks the following questions to encourage the adolescent to identify thoughts related to this behaviour (e.g. I’m a loser/I always fight back): *Why do you think you still behave in this way? How does the fact that you did not change this behaviour following treatment make you feel?*

3. **Consequence of the behaviour:** The adolescent then receives homework in which he/she has to monitor the behaviour and consequences until the next session. The next session is dedicated to a discussion of the incidents that took place during the monitoring period. The social worker encourages the adolescent to become aware of the consequences through the following question: *What is the result of this behaviour?*
4. **Brainstorm alternative behaviour:** The old behaviour is then disputed, based on the identified results. The adolescent is encouraged to look at other options, and to identify the possible benefits of each option.
5. **Action plans to execute this behaviour:** A decision is made on new behaviour that the adolescent believes he/she can manage. The adolescent then receives homework in which he/she has to monitor the new behaviour and consequences until the next session. The experience of implementing new behaviour and its consequences are the focus of the next session. Obstacles in implementing new behaviour are discussed, as well as ways to deal with these obstacles. The social worker and the adolescent continue with this process until both parties are satisfied that the new behaviour is internalised.

New behaviour also assists the adolescent to develop and maintain a recovery lifestyle, as discussed below.

### Developing and maintaining lifestyle changes



The purpose of developing and maintaining a recovery lifestyle in aftercare is to prevent relapses (Lessa & Scanlon, 2006:275). This subsection is related to the previous discussion, as the change in lifestyle is a result of behavioural change on the one hand, and leads to behavioural change on the other hand. When addressing intrapersonal needs through case work, the adolescent is encouraged to develop a balanced lifestyle. The

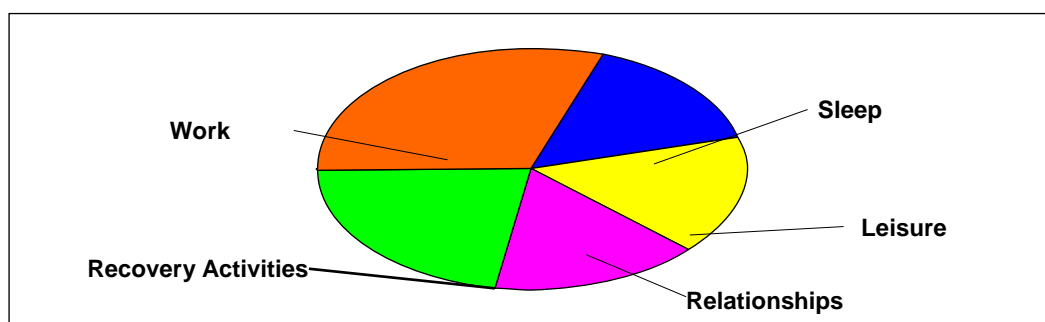
functional aid below illustrates focus areas that can assist the adolescent when developing a balanced lifestyle in recovery from chemical addiction.



**Functional aid: An exercise to identify pit-stops on the recovery road, and to identify and implement activities to be included in the recovery lifestyle**

The *aim of this functional aid* is to identify pit-stops that will guide the recovery lifestyle. Furthermore, the adolescent is assisted to identify activities that relate to a healthy, balanced lifestyle to be mastered in aftercare, to prevent relapses.

**Figure 17:** Pit-stops on the recovery road (as adopted and adapted from Matrix Institute on Addiction, 2008b:34):



**Table 16:** Developing and maintaining a recovery lifestyle (adopted and adapted from Fisher & Harrison, 2005:166-169)

Using my support systems	Doing sport and hobbies	Spending time with friends	Looking after my body	School/work activities	Working with money	Spending time with my family



**Strategy on how to implement the knowledge base and functional aid**

Figure 17 above is used to illustrate the different areas (pit-stops) that should be attended to in order to develop a healthy lifestyle during the period following treatment. The activity is introduced through a discussion based on the following questions:

- Describe your recovery lifestyle in terms of the following: your situation at school or work, your relationships, how you relax, and your sleeping pattern to me.
- What do you do to ensure that you work towards a recovery lifestyle/make progress in terms of the following: your situation at school or work, your relationships, how you relax, and your sleeping pattern?
- Which of these areas need more attention? Why?

A copy of the figure above is given to the adolescent, together with paint, magazines, scissors, crayons, etc. The social worker then asks the following question:

- In order to identify pit-stops that you can use to ensure that your lifestyle is healthy, what do you think should be included in each area of your life, as illustrated in the figure?

He/she is then encouraged to make a collage of the pit-stops he/she would like to include in each area. The adolescent identifies how these areas are attended to, and what aspects need to be addressed. He/she is encouraged to put this collage in a special place, and to look at it regularly to ensure that he/she remains aware of the pit-stops to be visited to ensure a healthy lifestyle.

Next, the social worker assists the adolescent to choose activities and tasks related to the pit-stops identified above. The adolescent is allowed to choose activities and tasks that he/she feels comfortable with. Table 16 above is used to write down those activities to be included in the recovery lifestyle. The adolescent is then encouraged to implement these activities in his/her day-to-day life. Feedback on progress is provided during follow-up sessions, obstacles are identified, and ways to deal with these obstacles are identified. Once he/she has succeeded in these activities and tasks, he/she is encouraged to choose other activities and tasks to add to the list. The initial success should lead to a feeling of “I can do it”, thereby increasing intrinsic levels of motivation. In order to sustain change, activities and tasks that were completed successfully, remain on the list. The social worker and adolescent

discuss the implementation of the list on a weekly/bi-weekly basis to encourage continued efforts in this regard.

While old behaviours are changed and a new lifestyle is developed, the CAA needs to address feelings that could lead to relapses, as described below.

### Assisting the adolescent to identify and deal with feelings



Adolescents in general tend to have extreme and intense emotional reactions (Geldard & Geldard, 2004:10). Fear of failure, grief about losses due to the addiction, resentment of persons/situations that harmed the adolescent, and self-pity, are feelings that impact negatively on the recovery potential of CAAs (Neuland, 2006:57). These feelings are common in everyday life, but for the adolescent in recovery, the inability to deal adequately with these feelings becomes a threat to ongoing sobriety. Therefore, in aftercare, the social worker needs to focus on the following activities related to feelings in order to prevent relapses.



**Functional aid: An exercise to illustrate that feelings which are experienced cannot be denied, to identify feelings that are experienced following treatment, and to identify ways to deal constructively with feelings**

This **functional aid aims** to assist the adolescent to develop insight regarding the importance of identifying and admitting to feelings that are experienced, and to become willing to express these feelings in a way that does not damage or harm him/her or others. Additionally, the adolescent is assisted to become aware of feelings, to develop the ability to identify the origin of the feelings as well as thoughts about them and, his/her reaction to the feelings, and to learn skills about how to deal with these feelings.

**Table 17:** Dealing with feelings in a constructive manner (as adapted from Dummett & Williams, 2008:52-53)

<b>First experience</b>	
The emotion (e.g. anger) What triggered this emotion?	
How did I react?	
What was the result of my reaction?	
How else could I have reacted?	
<b>Second experience</b>	
The emotion (e.g. anger) What triggered this emotion?	
How did I react?	
What was the result of my reaction?	
How else could I have reacted?	
<b>Result</b>	
What is the difference between the first and the second experience?	



### **Strategy on how to implement the functional aid**

The social worker provides the adolescent with a clean sheet of paper and a non-erasable black marker, and instructs him/her to make a list of all the feelings currently experienced. Next, the adolescent is given an eraser and instructed to erase the feelings (to demonstrate that feelings cannot be erased). The social worker then explains that feelings cannot be denied, but must be experienced and processed in a constructive way. It must be emphasised that the adolescent him/herself is responsible for identifying and dealing with his/her feelings constructively (adopted and adapted from Alpaslan, 2005:4, 8).

Next, the adolescent is provided with a sample of Table 17 above, and requested to compile, on a separate piece of paper, a list of situations that caused painful feelings while journeying on the road of recovery (i.e. a situation that causes anger, disappointment, etc.) The social worker assists the adolescent to complete the table by using the following questions to guide this activity:

- Let's focus on each of the feelings one at a time. Once the adolescent chooses which feeling to focus on, the social worker asks: What do you think caused the particular feeling? / When do you experience this feeling?
- How do you normally react when you experience this feeling?
- How do you feel about the way you normally react?

Then he/she is advised to take a moment and think how it could have been expressed differently. In other words, the reaction is disputed. The adolescent is encouraged to look at other possible reactions. A decision is made on a new reaction that the adolescent believes he/she can manage. The adolescent then receives homework in which he/she has to monitor the new reaction and its results, until the next session. The experience of implementing a new reaction and seeing its results is the focus of the next session. Obstacles in implementing new reactions, as well as ways to deal with these obstacles, are discussed. The social worker and the adolescent continue with this process until both parties are satisfied that reactions to painful emotions are internalised.

Concluding this activity, the social worker provides the adolescent with guidelines (adopted from De Klerk & Le Roux, 2003:63) that allow him/her to express him/herself, while gently guiding him/her towards appropriate responses when confronted with painful emotions. The social worker asks the adolescent to identify a situation where he/she is currently experiencing a painful feeling. The adolescent is then guided through the natural breathing exercise to become calm and in control while experiencing this feeling. The next part of the activity is played out during the session, while the social worker gives the pointers provided below.

- Find a place in this room where you will feel comfortable.
- Stand up or sit up straight in a comfortable chair.
- Breathe slowly and deeply through your mouth.
- Close your eyes and start breathing slowly through your nose.
- Take deep breaths and hold each one for a few seconds.
- Expel the air slowly.
  - Continue for 5 minutes.

The adolescent is encouraged to implement this exercise where possible when he/she experiences painful feelings that impact on his/her ability to solve difficult situations.

In addition to dealing with emotions, the adolescent will need assistance with the development of a realistic self-image.

## Developing and maintaining a realistic self-image



McTavish (2004:105) notes that the use of substances is seen as a way to deal with a low self-image, but that in actual fact in most cases have a distorting and/or negative influence on the self-image of addicts (cf. Alpaslan, 2005). *Characteristics of a low self-image* include: the fear of trying new things; the inability to take responsibility for mistakes; a lack of awareness of strengths; and accepting blame inappropriately (McTavish, 2004:105). A *realistic self-image*, on the other hand, leads to: “resilience”, meaning the ability to do one thing well to the advantage of themselves and others; a helpful attitude; the ability to ask for help; distancing the self from events and circumstances that threaten sobriety; and the existence of a strong social network (Page & Page, 2003:59-62). For this reason, aftercare should focus on restoring the self-image that was damaged by the addiction. In order to guide the adolescent in the process of building a realistic self-image, he/she must become aware of him/herself. The awareness of, among other things, likes and dislikes; losses experienced; emotions experienced; labels; and family membership assists him/her to understand him/herself better, and therefore contributes to the development of a realistic self-image (Sheafor & Horejsi, 2006:278-280).

The functional aid and strategy below may be used to assist the adolescent to become self-aware, to develop realistic expectations, and to make positive changes that will contribute to a realistic self-image.



**Functional aid: An activity that assists the adolescent to become self-aware, develop realistic expectations of him/herself and to make positive changes that will contribute to a realistic self-image**

The *aim of this activity* is to enable the adolescent to become self-aware through reflection on perceptions and feelings that may impact on the self-image. In addition, the adolescent is assisted to develop a realistic expectation of him/herself, based on this self-awareness. Realistic expectations ensure that the adolescent does not “set him/herself up for



failure”, as he/she learns to act towards realistic outcomes, based on the awareness of what is achievable (realistic) and what is not. Based on the newly developed self-awareness and realistic expectations, the adolescent is assisted to identify and maintain positive changes aimed at developing behaviour that will contribute to a realistic self-image.

**Table 6.18:** Unfinished sentences that stimulate the development of self-awareness (as adapted from Page & Page, 2003:42)

I hate
I wish
I fear
I love
I hope
I am embarrassed when
The thing that bothers me most
The thing I am most afraid of
The thing I want most
Regarding myself, I feel
I am most cheerful when
My greatest interest is
The person who means most to me is
The person I would most like to be
I have the greatest respect for
When bullied, I
When I am the centre of attention, I
When I am late, I
When I am given responsibility, I
When embarrassed, I
When I want to show I like someone, I
When I am angry, I
When others put me down, I

**Table 19:** Developing awareness of strengths and weaknesses in an effort to develop realistic expectations of oneself (as adapted from Page & Page, 2003:43)

I am	I am not	I can	I cannot	I have	I do not have



### Strategy on how to implement the knowledge base and functional aid

The adolescent is requested to complete a worksheet as depicted in Table 18 above as part of a homework exercise and bring it to the next contact with the social worker. The discussion that follows in the next session is aimed at developing self-awareness, as well as identifying areas that need to be addressed in order to improve the adolescent’s self-image.

- What was interesting about completing this list?
- What did you learn about yourself?
- What did you like about what you discovered about yourself?
- What did you not like about what you discovered about yourself?
- How do you think you can change the things you did not like?

In addition to becoming self-aware, the adolescent in aftercare must develop realistic expectations of him/herself. The social worker explains that, in order to develop a realistic self-image, the adolescent must become able to differentiate between what type of person he/she is and what type of person he/she is not, what he/she can do and cannot do, and what he/she has and does not have. The adolescent is given a worksheet containing Table 19 depicted above. The social worker makes use of the following strategies to encourage self-awareness and realistic expectations and also to aid him/her to complete the worksheet:

- Name three things to describe yourself in terms of what type of person you are (for example, I am friendly).
- Name three things to describe yourself in terms of what type of person you are not (for example, I am not patient).
- Name three things to describe yourself in terms of what you can do (for example, I can play soccer).
- Name three things to describe yourself in terms of what you cannot do (for example, I cannot run fast).
- Name three things to describe yourself in terms of what you have (for example, I have a friend who wants me to stay sober).
- Name three things to describe yourself in terms of what you do not have (for example, I do not have sober friends).

In order to continue to develop a self-awareness that can contribute to a realistic self-image, the questions pertaining to the previous activity (related to Table 18) are then repeated.

Following the activities related to becoming self-aware, and to develop realistic expectations, the adolescent is now assisted to make positive changes that would contribute to a realistic self-image. The social worker

writes down the characteristics of a poor self-image, as well as of a realistic self-image, described at the beginning of this sub-section, on a flipchart. The adolescent is encouraged to take down the information, and to choose two different colour crayons. One colour represents those aspects that he/she wants to include in his/her own list of positive changes that would contribute to a more realistic self-image, while the other colour represents those aspects he/she chooses not to include. Next, the adolescent is encouraged to make a collage to indicate the changes he/she wants to make, using pictures from magazines and drawings. The adolescent is encouraged to take the collage home and to place it where he/she will be able to see it often, in order to be reminded of the choices made. He/she is then asked to monitor the changes he/she was able to make, as well as the outcomes, until the next session. At the beginning of each of the following sessions, the adolescent reports on progress made and obstacles encountered. Insight is developed through questions such as:

- How do these changes make you feel?
- How do other people react to the changes you have made?
- How does this help you to develop a realistic self-image?
- How do you feel about the progress you have made?
- What/who made it difficult for you to implement the changes?
- What do you think you should do about the obstacles you encountered?

The social worker encourages the adolescent to continue with efforts to live according to the identified changes, until both parties are satisfied that the adolescent is able to implement this. The activities as discussed under the heading “changing old habits” (in the section addressing interventions aimed at interpersonal needs) may be used to assist the adolescent.

Focus areas of the case work method, provided in this section (above), assist the social worker to develop a trusting relationship with the CAA, develop the level of motivation, address sensitive issues such as feelings, and assist the CAA to become involved in interventions that address interpersonal and environmental needs, which will be discussed in the sections that follow.

**Table 20:** The goals and objectives for interventions addressing the interpersonal aftercare needs of chemically addicted adolescents, and the knowledge and strategies required by social workers to realise the goals and objectives

Goals	Objectives	Knowledge base prerequisite	Functional aid and strategy to realize the goals and objectives
Interventions addressing the interpersonal needs of chemically addicted adolescents in aftercare	Group work aimed at mobilising the family to become supportive of the adolescent in aftercare	<ul style="list-style-type: none"> <li>• Characteristics of poor family management</li> <li>• Characteristics of family support</li> </ul>	<p><u>Functional aids: exercises to assist with:</u></p> <ul style="list-style-type: none"> <li>• Mobilising the family to become supportive of the adolescent in recovery, through knowledge about the addiction and recovery processes</li> <li>• A focused discussion on identifying dysfunctional family dynamics; their impact on the recovery of the adolescent; and interventions to address dynamics that harm the recovery process</li> <li>• A focused discussion for motivating the family to become part of the adolescent's recovery process and to develop a family activity plan to assist the adolescent with his/her reintegration into the family during aftercare</li> </ul>
	Group work aimed at developing the ability to make new friends as a means to disengage from substance-using peers who endanger the recovery process	<ul style="list-style-type: none"> <li>• The value of acceptance from peers</li> </ul>	<p><u>Functional aid: exercise to assist with:</u></p> <ul style="list-style-type: none"> <li>• An exercise to assist adolescents in identifying qualities to look for in friends to help them fulfill their recovery needs, as well as to develop skills to act in a "relationship-friendly" manner</li> </ul>
	Group work aimed at acquiring constructive communication skills and skills to act assertively in interpersonal contexts	<p>Knowledge/understanding of:</p> <ul style="list-style-type: none"> <li>• the communication process awareness wheel</li> <li>• levels and styles of communication</li> <li>• rules for constructive communication</li> <li>• communication stumbling-blocks</li> <li>• tips for active listening</li> </ul>	<p><u>Functional aids: exercises to assist with:</u></p> <ul style="list-style-type: none"> <li>• A mini-lecture on the building-blocks of constructive communication and exercises to develop skills in this regard</li> <li>• Developing the skill to assertively say "No" to triggers that endanger the development and maintenance of a sober lifestyle</li> </ul>
	Group work aimed at identifying the adolescent's conflict-management styles, and guidelines for constructive-management- and	<ul style="list-style-type: none"> <li>• Conflict as a high risk for relapsing</li> <li>• The value of constructive conflict-management skills</li> <li>• Alternative anger-management styles</li> </ul>	<p><u>Functional aid: an exercise to assist with:</u></p> <ul style="list-style-type: none"> <li>• An activity to identify the conflict-management style used by the adolescent and to provide guidelines for constructive conflict-management</li> <li>• A focused discussion on alternative anger-management styles</li> </ul>

	alternative anger-management styles		
	Group work aimed at developing constructive stress-management skills	<ul style="list-style-type: none"> <li>Positive and negative outcomes of stress</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>A focused discussion and an exercise to identify the sources of stress that the adolescent experiences in recovery and ways to deal with this stress constructively</li> </ul>
	Group work aimed at developing constructive problem-solving and decision-making skills	<ul style="list-style-type: none"> <li>The process of solving problems and making decisions on how to address these problems</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>An activity to assist adolescents to identify a problem, explore different solutions to solve it and to make an effective decision in choosing the best solution to solve the problem</li> </ul>
	Group work aimed at developing budgeting skills	<ul style="list-style-type: none"> <li>Budgeting as a key area in relapse prevention</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>An activity to develop budgetary skills through a fake budget</li> </ul>
	Group work aimed at developing effective time-management skills	<ul style="list-style-type: none"> <li>Focus areas in time-management following treatment</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>A mini-lecture on focus areas in time-management and an exercise to plan and implement a weekly time-management planner</li> </ul>
	Group work aimed at developing skills to deal with cravings and temptations	<ul style="list-style-type: none"> <li>The impact of temptations (triggers) of cravings for chemical substances</li> </ul>	<u>Functional aid: exercise to assist with:</u> <ul style="list-style-type: none"> <li>An exercise to identify triggers that lead to cravings, an exercise for reflecting on previous responses to a trigger and planning alternatives, and a mini-lecture on techniques to control cravings</li> </ul>

## **Interventions addressing the interpersonal needs of chemically addicted adolescents in aftercare**



Interventions addressing interpersonal needs are aimed at learning interpersonal skills to develop and strengthen relationships. Group work, as a primary method of Social Work intervention, may be used to assist clients in this regard (Toseland & Rivas, 2005:294). Focusing on the utilisation of group work with adolescents specifically, the group activities which form part and parcel of the group work programme should lead to self-discovery; a sense of competence; and the experiences of being liked, of being accepted, and of belonging (Malekoff, 2004:21, 167). An additional advantage of the group work method is that the social worker assists group members to become comfortable with certain life skills such as assertiveness, problems-solving and conflict-management (Allen-Meares & Garvin, 2000:275; Gazda, Ginter & Horne, 2001:291; Perkinson, 2008:236). Therefore, based on the research findings, in addition to presenting functional aids and strategies on how to address interpersonal needs related to 1) the adolescents' need for assistance and skills regarding how to deal with peers and 2) the need for assistance to help rebuild their relationships with their parents and families, this section also provides some functional aids and strategies to be implemented in an interpersonal context and directed at the development of the following skills: communication-, assertiveness-, conflict-, anger- and stress-management skills; problem-solving and decision-making skills; life skills such as budgeting and time-management; and skills to deal with cravings and temptations.

## **Mobilising the family to become supportive of the adolescent in aftercare**



While poor family management, a lack of positive parenting and dysfunctional care-giving have been strongly related to substance abuse among adolescents, family support has been identified as a strong protective factor (Thompson, Pomeroy and Gober, in Hilarsky, 2005:208). The CAA's

ability to become independent and well-adjusted following treatment is determined and influenced by: parental happiness; the parents' ability to make decisions; parental communication skills and fairness; boundaries within the family; and care and emotional support (Meyer, in Wait et al., 2005:170). Mobilising and including the family in aftercare services therefore aims to assist the family to become aware of, and to change, dysfunctional patterns (such as communication that does not lead to trust and a feeling of acceptance and belonging) and to provide the adolescent with a home environment in which he/she receives support and guidance that will enable him/her to adapt to the recovery lifestyle. A healthy communication style within the family furthermore can ensure a supportive family environment. The aftercare worker therefore assists the family to develop communication skills that lead to the ability to communicate honestly, increase trust, give clear and direct messages, and disagree and negotiate in a healthy manner (Barker, 2007:119-123). Additionally, Fuller (2007:112) advises that families should include the following activities in their lifestyles to ensure family cohesion and support: eating together; playing games; exercising together; looking after a pet together; camping; collecting things; and sharing household chores.

The functional aids and strategies below may be used to improve family relationships by: 1) providing them with information; 2) addressing dysfunctional family patterns, and 3) and mobilising them to become involved in the recovery process by means of a family plan that will provide the CAA with a supportive family environment.



**Functional aid: Mobilising the family to become supportive of the adolescent in recovery, through knowledge about the addiction and recovery processes**

The ***aim of this functional aid*** is to mobilise the family to get involved in the adolescent's aftercare treatment programme and to support him/her through obtaining knowledge about the addiction and recovery processes, as well as to understand the craving responses and withdrawal symptoms that may still

be present following treatment, in order to become able to assist the adolescent to deal with these responses and symptoms.



### **Strategy on how to implement the knowledge base and functional aid**

The social worker, CAA and family members engage in group sessions where information is shared regarding the following:

- The **addiction process and the associated craving responses**: For this purpose, the social worker uses the information provided under the heading “phases in the addiction process and the associated craving responses” (see pp. 282-287, Figures 2-9) and presents it to the adolescent and his/her family members as a brief mini-lecture. The family members are then requested to identify the phase of addiction in which the adolescent functioned before entering treatment, based on their identification of the craving responses that typified his/her behaviour. Then the adolescent is encouraged to explain to his/her family the associated craving responses inherent in his/her current phase. This discussion is followed by a time for asking questions and answering them through group discussions. The social worker points out to the family members that these craving responses continue to threaten the recovery, and that the adolescent needs support in this regard. The session is concluded after the adolescent and the family members have compiled a list of the adolescent’s needs for assistance, with clear specifications of how the assistance will be provided.
  
- **Withdrawal symptoms**: In the next session, the social worker provides information related to the **recovery process** (discussed under the heading “the stages of recovery following addiction” on pp. 289-292) with specific emphasis on the withdrawal symptoms of each phase, to further assist the family to develop an understanding of the adolescent’s recovery needs. The adolescent is encouraged to explain to his/her family the withdrawal symptoms associated with the stage of recovery his/she is currently in. By using the information provided by the social worker and the adolescent, the family is then requested to make a list of withdrawal symptoms they



identify as typical of the adolescent's current behaviour. The social worker again explains that these behaviours continue to threaten the recovery, and that the adolescent needs support in this regard. The session is concluded after the family, in conjunction with the adolescent, has compiled a list of those aspects the adolescent needs assistance with, and how this assistance will be provided.

Apart from the knowledge and insight obtained during these previous family discussions, it is suggested that attention be given to previous and current family dynamics which hamper/hampered the adolescent's recovery potential. The following functional aid is suggested to assist with this.



**Functional aid: A focused discussion on identifying dysfunctional family dynamics; their impact on the recovery of the adolescent; and interventions to address dynamics that harm the recovery process**

The ***aim of this functional aid is to*** assist the family of the adolescent with the identification of previous and current family dynamics and their impact on the recovery of the adolescent, and to plan interventions to limit family dynamics that impact negatively on the adolescent's recovery potential.



**Strategy on how to implement the functional aid**

In order to realise this aim, the family members are seen as a group<sup>19</sup>. In facilitating this focused discussion, the social worker introduces (with the permission of the adolescent) those family dynamics that were previously identified by the adolescent (during the assessment of his/her aftercare needs focusing on the family of origin/association) as problematic in his/her family context. Furthermore, the adolescent is requested to identify those family dynamics that he/she currently experiences to be a challenge and that impacts on his/her journey towards developing a sober lifestyle.

Where, for one or other reason, earlier assessments did not focus on family dynamics and their impact on the adolescent in terms of developing and

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<sup>19</sup> **Note:** The adolescent and/or his/her addiction are not the focus of these session/sessions.

maintaining a sober lifestyle, the social worker can pose the following questions to the adolescent and the family members present in the session:

- What happenings within the family before the adolescent's addiction could have contributed to his/her decision to use drugs? Why? How?
- What happenings within the family during the adolescent's addiction could have contributed to his/her inability to recover from the addiction? Why? How?
- What current happenings within the family may impact on the adolescent's efforts to build a recovery lifestyle? Why? How?

As this may be a sensitive and painful experience for both the adolescent and the family members individually, the social worker informs them that the reason for this discussion is not to place blame, but rather to initiate a help-seeking venture to affect change where previous and current family dynamics hampered the adolescent's recovery potential and/or helped in developing and maintaining the addiction. The social worker needs to bring it to the attention of the family that as they become aware of the need for change, and subsequently reach out for help and support, the adolescent is being supported and sustained on the road to recovery and towards a sober lifestyle as a result. Once the adolescent and the family members have been granted an opportunity to identify the previous and current family dynamics and their impact on the recovery of the adolescent, the focus of the discussion shifts towards 1) what help is needed to affect the identified changes that need to be made; 2) where help can be obtained, and 3) the levels of commitment to embrace help and bring about change of the family as a whole and the individual members. If and where intervention is needed, the social worker, with the consent of all parties concerned, continues to make referrals to appropriate service providers. In instances where the social worker rendering aftercare services to the adolescent also acts as the person rendering family care services, separate sessions are advised to deal with the different family-related dynamics impacting on the adolescent's recovery potential.

Should parental/sibling addiction to chemical substances be identified as a problem related to the family dynamics impacting on the adolescent's

recovery potential, it is suggested that the social worker, in separate sessions with this parent and/or siblings, uses the motivational interviewing technique as described earlier (pp. 294-301), to motivate and prepare these people go for treatment.

Once the social worker is satisfied that the family members know enough about the addiction process and withdrawal symptoms, and the family dynamics that impact on the recovery of the CAA have been addressed, the focus shifts to motivating the family to become involved in the recovery process to support the adolescent's efforts to develop a sober lifestyle. A functional aid that can be used for this purpose is presented next.



**Functional aid: A focused discussion for motivating the family to become part of the adolescent's recovery process and to develop a family activity plan to assist the adolescent with his/her reintegration into the family during aftercare**

The *aim of this functional aid* is to motivate the family members to participate in the recovery process of the adolescent, in order to provide him/her with the needed support to maintain changes made during treatment and aftercare. Additionally, the adolescent and his/her family are assisted to draw up a manageable family activity plan that can assist the adolescent with his/her reintegration into the family fold.

**Table 21:** Activities to be attended to in view of assisting the chemically addicted adolescent with integration back into the family (adopted and adapted from Allen-Meares & Garvin, 2000:309; Lessa & Scanlon, 2006:193; Arterburn & Burns, 2007:117; Matrix Institute on Addiction, 2008a:27-30)

In order to assist the CAA with his/her integration back into the family fold, the following tasks/activities must be attended to ...	Tasks and activities (How) and executed by whom
The manner (ways) and frequency of family communication needs to be adjusted. More communication needs to take place	For example: <ul style="list-style-type: none"> <li>We need to set time aside each day to communicate with each other, for example we will eat together as a family</li> </ul>

The way in which family members show respect to one another must be clearly spelled out	For example: ➤ I would like the members of my family to respect me, by not calling me names that remind me of my previous addiction.
The ways in which family members will show that they trust the CAA and he/she shows that he/she trusts the family must be spelled out	For example: ➤ As his/her mother I will show that I trust him/her by not going through his/her personal belongings looking for drugs
A plan for shared leisure time, play and having fun as a family must be drawn up	For example: ➤ Every Sunday afternoon we will go and have a picnic at the river
Rules regarding household tasks and curfew times must be spelled out	For example: • The adolescent must make his/her bed every morning
Ways to deal with problems must be spelled out	For example: • When a family member experiences a problem, he/she will share this with the rest of the family, followed by a discussion on how this problem can be solved
Ways to make decisions in the family must be spelled out	For example: • .... (the father/mother, etc.) will present the situation that needs a decision to all the family members and ask how each member would like the situation to be addressed. He/she will then make a decision based on everyone's input and explain why he/she made this specific choice
A plan to engage in practising shared religious activities must be drawn up	For example: • We will try to do bible study before dinner on Saturday evenings
Conditions for when to ask for help	For example: • We will make a list of situations where help from outside the family will be requested, as well as from whom the help will be asked
Rules relating to the availability and use of chemical substances in the household must be drawn up	For example: • We will not have any alcohol or drugs in our house
Ways in which family members should express emotions and feelings appropriately must be spelled out and indications provided on how the expressed feelings/emotions will be dealt with	For example: • We will express our emotions in such a way that we do not harm fellow family members  • I will request my family to provide me with some space to deal with emotions
Ways for self-monitoring of the adolescent for lapses (reverting to behaviour related to the addiction) must be spelled out	For example: • We will make a list of things we used to do to deal with the adolescent's addiction which did not work previously. This list will be placed where every member can see it regularly as a reminder
Ways in which the family could monitor the adolescent for lapses must be spelled out	For example: • We will make a list of things the adolescent used to do while using drugs. This list will be placed where every member can see it regularly as a reminder



### **Strategy on how to implement the knowledge base and functional aid**

The social worker introduces the focused discussion by posing the following question to the adolescent's family members present in the family group discussion: "*What kind of support do you think do adolescents need from their families during aftercare to be enabled to move towards developing and maintaining a sober lifestyle?*" The family members are requested to elaborate on the answers they provide. Next, the family members are requested to take a moment and to think of: 1) the reason why he/she wants to support the adolescent, and 2) ways in which he/she is prepared to assist and support the adolescent. They are then requested to share this information in the group while the social worker compiles a list of who will provide what kind of support to the adolescent in aftercare.

In assisting the family to involve themselves in supporting the adolescent during aftercare, the social worker should have a list of resources available on support groups for family members of addicts (e.g. NARANON, the family support group of Narcotics Anonymous), and should encourage them to join these support groups for information and support for themselves while supporting the adolescent.

Next, the adolescent and his/her family are assisted with drawing up a family activity plan which will enable the adolescent during aftercare with his reintegration into the family system. The social worker places Table 21 above on a flipchart. She/he then shares this information about possible tasks/activities to assist with the adolescent's reintegration into the family following treatment with the family as a group. Each member is then asked to indicate which of the aforementioned tasks/activities he/she thinks should be included in a task/activity plan to assist the adolescent to come back into the family fold. They are also invited to add other tasks/activities they think are appropriate and omit the ones that seem to be inappropriate and not applicable.

Upon completion of this discussion, the social worker shifts the focus of the discussion to “how” each of plans/activities indicated in column 1 of the table should be operationalised. Each person is asked for input on how to execute these tasks/activities. Next the focus of discussion moves to the column indicating “who must do what and when” in order to execute the plans/activities. The family must then be given an opportunity to choose activities and tasks that they feel comfortable with, and encouraged to implement this between sessions. Once they have succeeded in these activities and tasks, they are encouraged to choose other activities and tasks to add to the list. In order to sustain change, activities and tasks that were completed successfully remains on the list. The social worker, adolescent and family discuss the implementation of the list on a weekly/bi-weekly basis to encourage continued efforts in this regard, and to deal with obstacles experienced.

**Developing the ability to make new friends as a means to disengage from substance-using peers who endanger the recovery process**

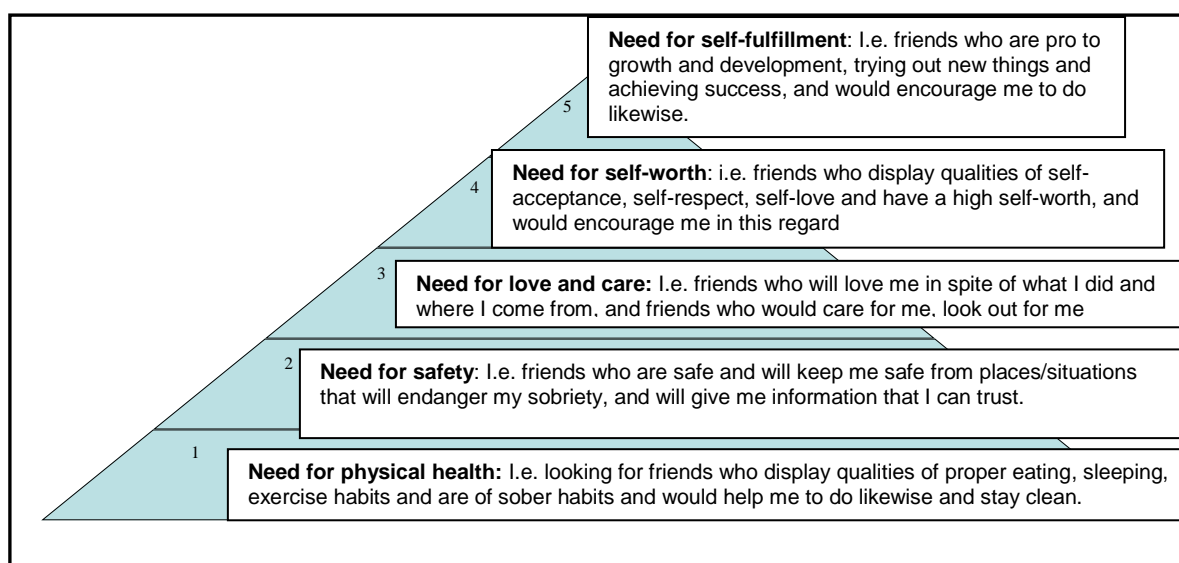


A way to stay clean in recovery is to end relationships and connections with substance-using friends, and to acquire knowledge and skills on how to establish a new circle of friends who are sober. The group work method can assist adolescents in aftercare in this regard. Group members can experience acceptance, which is viewed as an important motivational factor that can influence the choices made following treatment (Louw & Louw, 2007:281). A lack of friends and meaningful relationships, or rejection by peers, negatively impacts on self-confidence, leading to harmful choices, as the adolescent will conform to the values and norms of the group that accepts him/her (Louw & Louw, 2007:282).

The functional aid and strategy below are aimed at assisting the adolescents in the context of social group work to find out how to look for qualities in friends who will assist them in meeting their needs in recovery. McTavish (2004:103) refers to a hierarchy of needs (based on Maslow’s exposition) - i.e. a need for physical health, a need for safety, a need for love and care, a need

for enhancing self-worth, and a need for self-fulfilment. Figure 18 below explains these needs. This author notes that these needs can only be fully realised in the context of an interpersonal connectedness and relationships with friends who can contribute towards helping the individual meet these needs.

**Figure 18:** Needs of the chemically addicted adolescent in recovery and the qualities they need to look for in friends when establishing a new circle of friends to help them address these needs (as adopted and adapted from McTavish, 2004:103)



Through this interpersonal intervention, the adolescent in aftercare will not only be furnished with knowledge and skills on how to befriend individuals who display qualities that will help with need-fulfilment, but will also gain insight on how to be a good friend to others. In addition, a platform is provided to practise skills to act in a “relationship-friendly” manner.

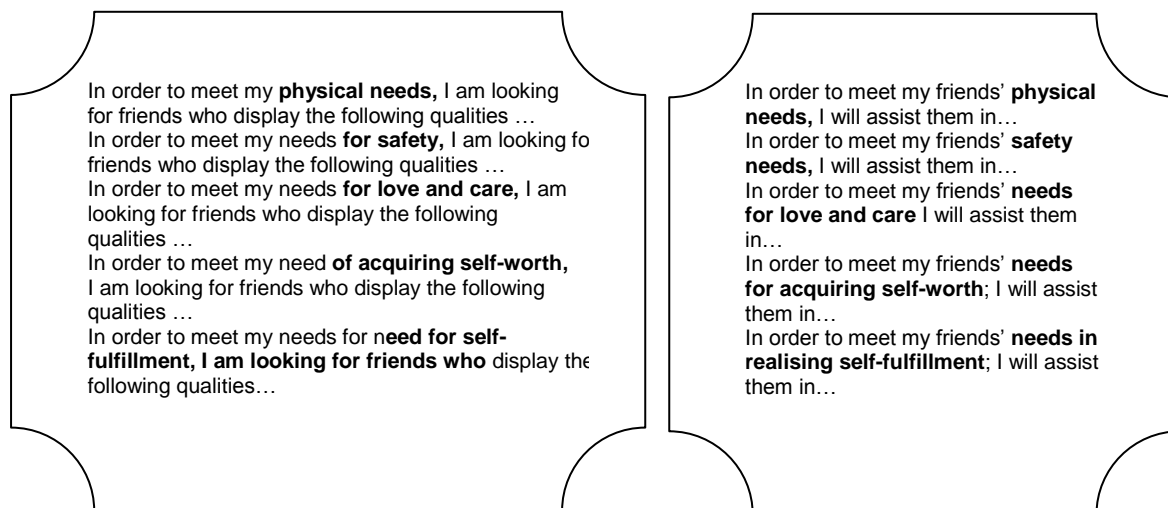


**Functional aid: An exercise to assist adolescents in identifying qualities to look for in friends to help them fulfil their recovery needs, as well as to develop skills to act in a “relationship-friendly” manner**

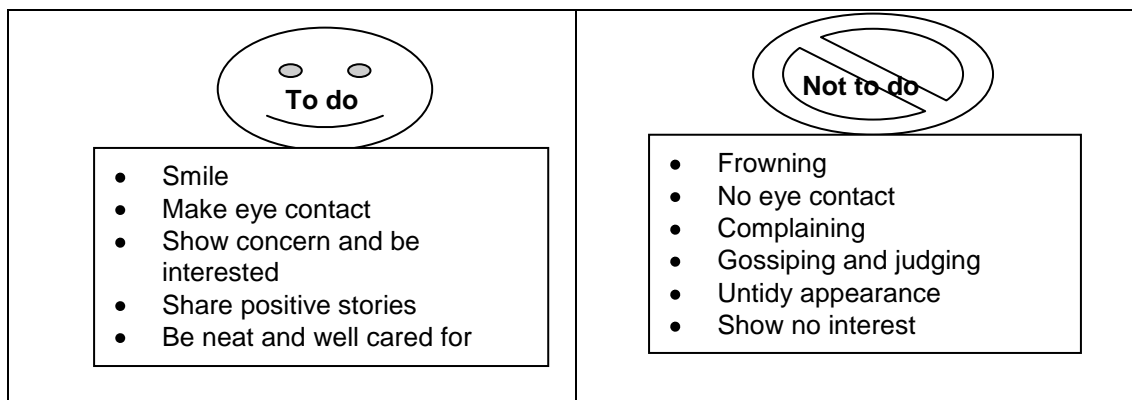
The **aim of this functional aid** is to assist adolescents to identify qualities they need to look for in friends to help them fulfil their recovery needs in order to develop and maintain a sober lifestyle through a group work exercise. In order to engage in new healthy friendships, a further aim is therefore to

develop skills to act in such a manner that the group members become able to engage in a “relationship-friendly” manner to prospective friends.

**Figure 19:** Choosing friends and being a friend (adopted and adapted from Perkinson, 2008:313)



**Figure 6.20:** What to do, or not to do, to attract people (Perkinson, 2008:429)



### Strategy on how to implement the knowledge base and functional aid

The social worker places an enlarged version of Figure 18 on a flipchart and in a mini-lecture to follow she/he explains the hierarchy of needs the adolescent experiences in recovery. Emphasis is placed on the fact that meaningful relationships are needed to address such needs. Upon completing this mini-lecture, the social worker allows time for questions and generates answers to these questions through a group discussion.



Based on the information obtained, the social worker then hands out a worksheet depicted in Figure 19 above, and requests the group members to complete the worksheet by indicating what qualities they are looking for in friends, to help them to address the various needs depicted in the figure. Furthermore, they also need to indicate what they can offer in return to friends, helping them in addressing the various needs they experience. Upon completion of the worksheets the group members (one at a time) share their responses with the group. The social worker continues to facilitate a group discussion through the following questions to the group, while brainstorming some answers:

- Do you have friends who display the qualities you are looking for to assist you in meeting the various needs you are experiencing now in recovery?
- If you have such friends, how do you/are you planning to make your needs known to them?

The social worker can make use of role-plays where a group member who expressed a particular need engages in a role-play with a fellow group member to practise his/her skills on how to express his/her needs and how he/she would like the friend to assist him/her in addressing this need.

In cases where group members cannot identify friends who can assist them in addressing their needs, a brainstorm session can be conducted on how and where new friends can be found, and how friendships with them can be established. Once again role-plays can be used to practise skills on how to approach another person with a view to establishing a friendship with him/her. The social worker should also have a resource list of support groups (i.e. contact persons) available in the adolescents' communities which they can access with a view to finding new friends and support systems.

This activity is concluded with an explanation that, in order to engage in new healthy friendships, the adolescents will need skills to act in a "relationship-friendly" manner. A worksheet with Figure 20 above (but not with the examples provided in the figure) is placed on the floor in the middle of the

group. The social worker provides one example of a personal attribute that will attract people, as well as one that will have the opposite effect. Following on to this, the social worker instructs the group members to complete the rest of the worksheet through a group discussion, by identifying more personal attributes that will attract people or push people away. The social worker then deepens the focus of the discussion by asking the group members to complete the following open-ended sentences in writing, and once all of them have completed the exercise, to share their answers in a roundabout manner in the group:

- Qualities/attributes I have that attract people to me are ...
- Qualities/attributes I have that push people away from me are ...

On completion of the previous exercise, the social worker encourages the group members to, in an advisory capacity, provide each other with tips and advice on how to nurture the attributes they possess that make them “relationship-friendly” and to manage those causing them to be labelled as “relationship-unfriendly”.

Adolescents in aftercare can also benefit from learning constructive communication skills and how to act assertively in an interpersonal context. A prerequisite knowledge base, functional aids and strategies to use in this regard will be presented in the next sub-section.

### **Acquiring constructive communication skills and skills to act assertively in interpersonal contexts**

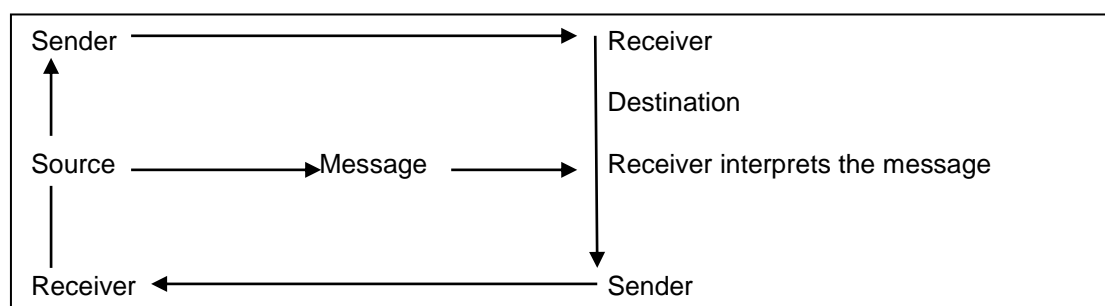


Constructive communication skills can arm adolescents in recovery with tools to assist them in building healthy and sober friendships, making new friends, and enabling them to act assertively when tempted by triggers (i.e. people and situations) in recovery (Teesson, Degenhardt & Hall, 2002:87-89). Through social group work, information, exercises and role-plays can be used to provide group members with constructive communication skills on: 1) how to communicate their thoughts, ideas, intentions and feelings; 2) how to make and maintain eye contact; 3) how to express appreciation and respect;

4) how to use “I”-messages; 5) how to seek a compromise; and 5) how to listen and attempt to understand the other person’s point of view (Page & Page, 2003: 69-76). Building-blocks of constructive communication (as adopted and adapted from Alpaslan, 1997:176-183) will briefly be discussed below.

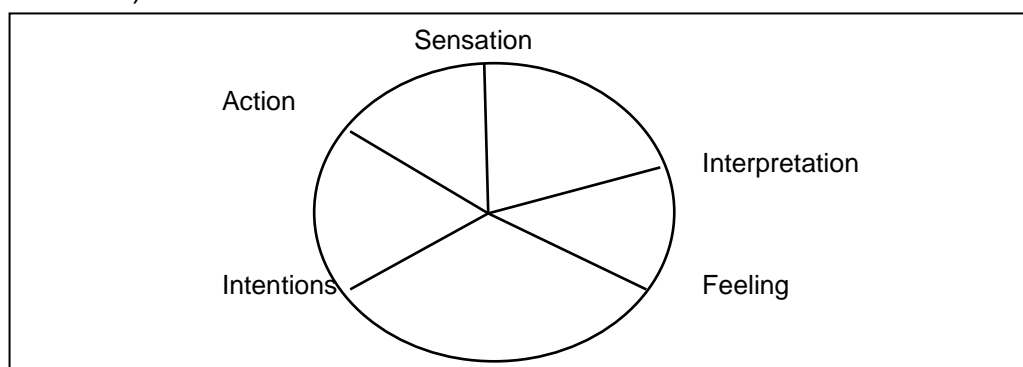
**1) The communication process** includes the following three elements: 1) a source (communicator), 2) a message (facts, feelings and behaviour), and 3) a destination (listener/receiver). A diagram of the process is provided in Figure 21 below.

**Figure 21:** The communication process (from Alpaslan, 1997:176-183)



**2) The awareness wheel** (Alpaslan, 1997:73-74) may be used to create awareness of own and others’ experiences.

**Figure 22:** The awareness wheel in constructive communication (Alpaslan, 1997:73-74)



➤ *Sensations*: All outside information comes to us through our senses, i.e. seeing, hearing, smelling, tasting and touching.

- *Interpretations*: The message that is received through the awareness of senses is interpreted through impressions such as beliefs, conclusions, assumptions, ideas, opinions, expectations and evaluations. *For example*: I see (sensation) Sonya is laughing. She may be laughing because she has heard a good joke (interpretation).
- *Feelings*: Feelings arise from the message which came through senses and which was followed by an interpretation. *For example*: Sonya's laughter (sensation) because of a good joke (interpretation) makes me feel happy/jealous, etc.
- *Intentions*: This is how the person wants to react to the message. *For example*: I want to find out what Sonya is laughing about.
- *Actions*: Intentions are expressed through actions. *For example*: Asking Sonya what she is laughing about.

Constructive and complete communication requires that one uses more than one "spoke of the awareness wheel" in conversations.

**3) Levels and styles of communication** as described in Alpaslan (1997:74-76):

- *Cliché conversation*: This communication style is friendly, conventional and pleasant and is intended to keep the conversation going. This includes general small talk. *For example*: "How are you?" "What are you doing?"
- *Reporting facts*: On this level facts are communicated, but without any (or with little) commentary. *For example*: The mother may ask: "Where are you going?" The child replies: "Out!"
- *The control style*: This style is used to put the person in charge of the communication situation/the relationship. The focus is especially on the other person. The style is direct, persuasive, authoritarian and instructive. *For example*: "You must pick up your clothes."
- *Sharing/requesting ideas and opinions*: Intimate communication begins when the person risks disclosing own thoughts, ideas and opinions. *For example*: "I agree using drugs can cause one's death."
- *Sharing feelings*: At this level the person is prepared to share innermost thoughts and emotions. *For example*: "I feel sad when.... happens."

Some people use more than one level and style of communication in conversations.

**4) Rules to keep in mind for constructive communication** (Alpaslan, 1997:73-74):

- When you want to have another person's undivided attention to discuss something of importance, choose the right time to talk to him/her.
- Use a pleasant tone of voice – it is not only what you say, but also how you say it.
- Be clear and specific. *For example:* "I would like you to help me to get a weekend-job."
- Use "I-messages" when communicating thoughts, feelings and intentions.
- Be positive. Avoid fault-finding, blaming, condemning and giving someone a piece of your mind (see the communication stumbling-blocks below).
- Be sensitive to the needs and feelings of the other person.

**5) Communication stumbling-blocks** (McTavish, 2004:118): The following are considered to be stumbling-blocks in the way of constructive communication:

- Ordering: "Hang up your clothes."
- Warning and threatening: "If you dare to do it again, I'll ..."
- Moralising: "Don't you know this is wrong/sinful?"
- Evaluating, blaming and criticising: "It's your fault."
- Ridiculing, name-calling, using put-downs: "You're a druggie!"
- Interpreting, diagnosing and psycho-analysing: "You're crazy."
- Preaching, correcting: "Don't leave the dirty glasses on the table."

**6) Tips for active listening:** In order to become a good listener, the following tips for effective listening must be kept in mind (Perkinson, 2008:429):

- Keep good eye-contact.
- Give the person talking your undivided attention.
- Show an interest in what you hear (i.e. nodding, smiling etc.)

- Verbalise agreement, interest and understanding.
- Ask well-worded questions for the sake of clarity.

The functional aids and strategies below may be used to assist the adolescent group members in this regard.



**Functional aid: A mini-lecture on the building-blocks of constructive communication and exercises to develop skills in this regard**

The ***aim of this functional aid*** is to give the adolescent group members information about the building blocks of constructive communication through a mini-lecture. The information is complemented by exercises to develop the skill of constructive communication.



**Strategy on how to implement the knowledge base and functional aid**

The session starts with a mini-lecture on constructive communication. The social worker puts the information provided above on a flipchart for members to review when doing the following exercises. He/she then gives each group member an empty sheet of paper, and asks the members to work alone and to think of something that happened over the past week. They are then asked to write down the answers to the following questions:

- What did I sense – see, smell, taste, hear, touch?
- What did I think – how did I interpret the situation?
- What did I feel – what was my emotional reaction?
- What were my intentions – what did I want to do/how did I want to react?
- How did I react – verbally and non-verbally?

The group members are requested to share their answers, in a roundabout manner, with the rest of the group. The social worker can also divide the group into dyads and let them share their responses with each other. Next,

the social worker reads the following statements (one at the time) to the group, and lets them decide which “spoke of the awareness wheel” best illustrates each statement.

- I feel angry and frustrated when you call me a “druggie”.
- I don’t think she likes me.
- I smell nice food.
- I see you aren’t smiling ... you must be angry.
- I am jealous of my sober friends.

Before ending the session, the social worker divides the group members into pairs of two and lets each dyad choose a topic which they would like to discuss. Give each member of the dyad 3 minutes to be a communicator and 3 minutes as a listener. In other words, one will communicate about the topic for 3 minutes while the other listens, then they will change roles and continue with the conversation for another 3 minutes. Afterwards the social worker asks the following questions:

- As the communicator, what was easy/difficult for you?
- What communication style did you mostly use?
- How was it for you as listener to listen to the person communicating? What did you like/not like about his/her style of communication?
- For you as communicator, how was it for you to talk to the listener? What did you like/not like about his/her style of listening?

The following functional aid and strategy can be used to furnish CAAs in aftercare with skills to communicate assertively in response to triggers (i.e. people and situations) that endanger the development and maintenance of a sober lifestyle.



### **Functional aid: Developing the skill to assertively say “No” to triggers that endanger the development and maintenance of a sober lifestyle**

The *aim of this activity* is to introduce the skill to assertively say “No” to triggers making use of pointers provided by Jarvis, Tebutt and Mattick (2005:104) in order to enhance the development and maintenance of a sober lifestyle.



### **Strategy on how to implement functional aid**

The social worker explains that the activities that follow will provide group members with alternative ways to deal with temptations and triggers. He/she introduces the activities one at a time and allows time for practice and discussion before he/she proceeds to a following activity. More than one session may be used.

- **Learning the ability to say “No”:** Group members identify situations (i.e. people and places) where they need to say “No” in order not to jeopardise their recovery from addiction (e.g. substance-using friends who invite the adolescent to spend time with them). Through the use of rounds, each member gets an opportunity to name something which requires a “No”. The other members then shout “No” each time a member makes reference to such a trigger.
- **Considering alternative actions when tempted by triggers:** In a round-about fashion, group members are requested to identify situations where they are/might be tempted to subject to triggers. These triggers are noted on a flipchart. This is followed up by the social worker asking each of the group members to respond to the following questions:
  - In the past how have you dealt with these triggers?
  - How did this way of dealing with the trigger help/hinder you?



- If these triggers tempt you now, how will you deal with them/or how will you deal with them differently than before?

After this the social worker shifts the focus to the group as a whole and lets them brainstorm some alternatives that they can use in dealing with triggers that might tempt them on their recovery journey. Each group member is then requested to write down those alternatives that he/she will be able to use in the future.

The following sub-section relates to knowledge prerequisite and functional aids and strategies to assist the adolescents with conflict management, constructive conflict resolution and anger-management.

### **Identifying the adolescent's conflict-management styles, guidelines for constructive conflict-management and alternative anger-management styles**



Conflict in interpersonal relationships appears when people have different motives, intentions and opinions, and are unable to find “common ground” between these differences. For the CAA, conflict results in a high-risk situation which can lead to a relapse (Malhotra, Basu & Gupta, 2007:8). Constructive conflict-management skills enable the adolescent in recovery to become able to communicate constructively in a conflict situation (Johnson, 2006:254), thereby addressing the potential high-risk situation to prevent a relapse.

Conflict often results in anger. The ability to manage anger should therefore be included when adolescent group members are being equipped to deal with conflict. In order to develop anger-management skills in a group, social workers assist group members to distinguish between direct and indirect anger-management styles (Johnson, 2006:312). In the *direct anger-management* style, the source of the anger is addressed directly. The angry person confronts the person/situation that caused the anger, in order to solve the situation. An alternative style is *indirect anger-management*, where the angry person does not confront the person/situation that caused the anger. Anger is dealt with in an indirect way, e.g. writing a letter. The adolescent

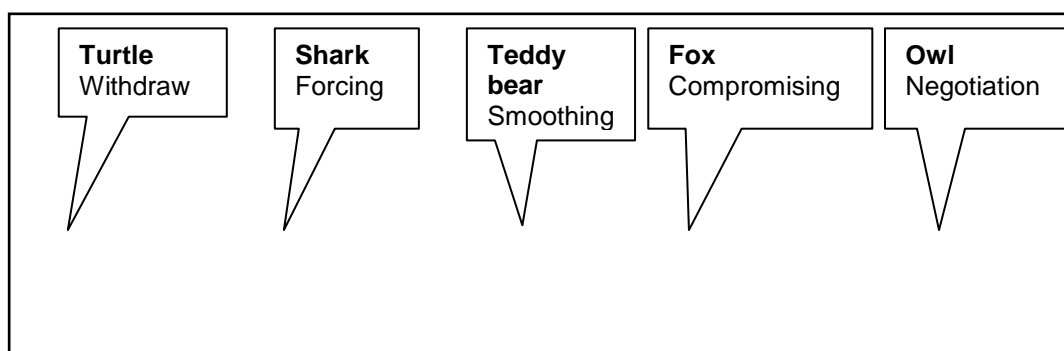
needs to distinguish between the two styles, and learn to choose an appropriate style when dealing with a specific situation. The value of this choice is that the adolescent is provided with alternatives to ensure that he/she deals with anger in such a way that he/she, as well as the other person, is not harmed when reacting to anger.



**Functional aid: An activity to identify the conflict-management style used by the adolescent and to provide guidelines for constructive conflict-management**

The **aim of this functional aid** is to assist the group members to identify the conflict-management style they normally use to resolve interpersonal conflicts, and to provide guidelines for constructive conflict resolution.

**Figure 23:** Developing a conflict-management style (adopted and adapted from Johnson, 2006:254)



**Strategy on how to implement the knowledge base and functional aid**

The social worker puts a poster version of Figure 23 on the wall, and explains to the group that the way in which they manage interpersonal conflicts reminds one of a specific behaviour or characteristic ascribed to a particular animal, for example:

- A turtle pulls his head into the shell when conflict occurs.

- The shark attacks (i.e. forces his/her opinion on other during conflict)
- The teddy bear is cuddly and friendly and attempts to smooth the conflict situation by pleasing everyone.
- The fox is sly and will make a compromise in order to settle the matter (conflict), but normally only to his/her advantage
- The owl is wise and negotiates to settle the matter (conflict) to everyone's advantage. This is viewed as the constructive way in which to solve interpersonal conflicts.

The group members are then requested to identify what animal(s) they tend to be, based on their style of conflict resolution. They are then requested to think about a scenario where they have acted as a turtle/a shark/a teddy bear/a fox/an owl, and describe how they felt afterwards about themselves and the situation, for using this particular conflict management style. Then they are encouraged to share their thoughts and perceptions on how the other person felt about the style(s) used. The social worker creates insight by stating that the conflict management style depicted by the owl can be viewed as the "constructive conflict-management style." He/she then proceeds to give each member a page with the following guidelines for constructive conflict-management (adopted and adapted from Alpaslan, 1997:185).

**Guidelines to follow in constructive conflict resolution:**

The following guidelines depict the owl's character and are suggested for constructive conflict resolution:

- ✓ *Choose the right time and place:* Deal with conflict as soon as possible, but when feelings run high, allow the dust to settle first.
- ✓ *Speak frankly:* Be specific, use "I"-messages. Support your feelings with facts, for example: "Every time you tell me I am lazy and don't clean my room properly, I feel hurt."
- ✓ *Do not change the subject:* Deal with the issue under discussion. Don't refer to issues of the past.
- ✓ *Show respect:* Do not reproach, offend, blame and criticise. Respect the other person's right and privilege to have his/her own viewpoint, even if you disagree.
- ✓ *Reach mutual solutions:* After both parties have expressed facts and feelings in a constructive way, compile a list of possible solutions to resolve the conflict.
- ✓ *Evaluate the solutions:* Consider the pros and cons of every solution. Choose the solution that will provide an opportunity where both parties can win.

Based on the guidelines provided, the social worker encourages the group members to engage in role-plays by acting out the conflict scenarios currently and constantly causing interpersonal conflict. Upon completion, group

members are engaged in a discussion reflecting on what they have learnt from this, as well as how they will react differently when a similar conflict scenario presents itself in reality in the future.



### **Functional aid: A focused discussion on alternative anger-management styles**

The ***aim of this functional aid*** is to provide the group members with knowledge about alternative styles to use when managing anger, to ensure that the reaction to anger is dealt with in such a way that neither the angry person nor the person who caused the anger is harmed.



### **Strategy on how to implement functional aid**

Each group member is requested to list at least two situations that made him/her angry over the past week. In a roundabout fashion, these situations are shared with the group while the social worker records what is shared on a flipchart. The social worker then asks the group members to share how they reacted when they were angry. These answers are recorded on a separate flipchart. The social worker chooses one of these reactions, and encourages group members to voluntarily respond to the following questions, while recording the answers on the flipchart.

- How does this reaction help to address the situation that caused the anger?
- How does this reaction hamper the solution to the situation that caused the anger?
- How does one feel when reacting like this?
- How does this reaction make the other person feel?

The social worker summarises what was written on the blackboard, and creates insight by explaining that when an anger-management style damages how one feels about oneself, or one's relationship with others, it must be viewed as a "destructive anger-management style."

The group members are then given a scenario where each of them is angered by being falsely accused of breaking a window. They are then encouraged to identify and share alternatives to deal with this anger, without harming themselves or others (e.g. exercise, doing relaxation exercises, focus on something else). As a homework assignment, the group members are encouraged to use these alternatives when confronted with anger. In follow-up group sessions, the social worker asks what caused group members to become angry in the past week and how they reacted. The reactions are noted. The group members are invited to vote for the most constructive way or skill used for managing anger. The winner receives the rotating “Award for constructive anger-management” for that particular week (cf. Plummer, 2008:180). This award could be a coffee mug, a framed certificate, etc.

Knowledge prerequisite, a functional aid and a strategy to assist with developing functional stress-management skills will be provided next.

### Developing constructive stress-management skills



Stress is experienced in all spheres of life. A positive outcome of stress is that it motivates the individual to address certain situations (e.g. to study hard to pass a Grade 12). However, stress can lead to feelings of hopelessness and physical discomfort. The latter often leads addicts to find comfort in chemical substances. In order to deal with stress and prevent relapses, the CAA group members must learn how to limit stressful situations and to deal with stressful situations that cannot be avoided (Gouws, Kruger & Burger, 2000:148).

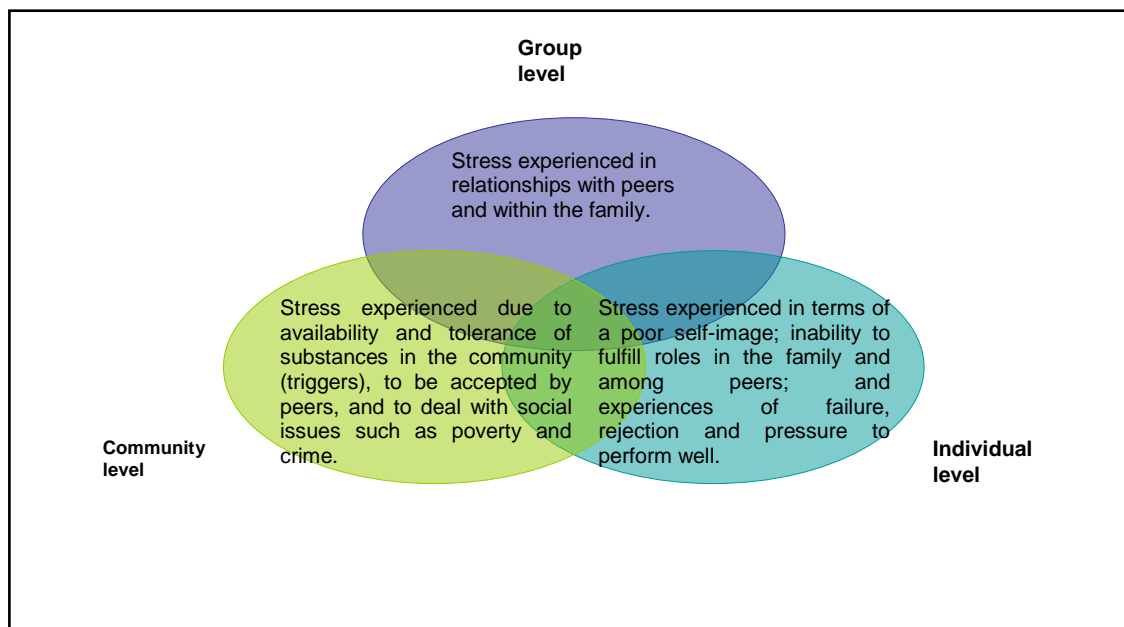


**Functional aid: A focused discussion and an exercise to identify the sources of stress that the adolescent experiences in recovery and ways to deal with this stress constructively**

This **functional aid aims** to assist group members to become aware of the sources of stress that they are experiencing while journeying on the recovery

road and to furnish them with pointers on how to deal constructively with the stress.

**Figure 24:** Sources of stress (adapted and adopted from Gouws et al., 2000:148)



### Strategy on how to implement the knowledge base and functional aid

The social worker sticks a poster version of Figure 24 on the wall. She/he explains to the group that stress can be caused by factors on individual, group, and community levels, as indicated in the figure. Making use of rounds, each member is requested to name one thing that causes him/her stress on an individual level, while writing all the responses down on a clear example of the figure. The next two rounds are used to identify causes of stress group members experience in relation to being part of groups and their respective communities. The identification of causes of stress is then related to the subsection below regarding problem-solving and decision-making.

The social worker shifts the focus of the discussion to enquire about how the group members manage the stress they experience on an individual, group, and community level. Their responses are recorded. They are then asked to

evaluate the effectiveness of the stress-management skills they are currently using. In the mini-lecture to follow, the social worker provides the following information and handout on ways to manage stress effectively.

**Ways to effectively manage stress**

The following are some ways for effective stress management (Page & Page, 2003:101-112; McTavish, 2004:150):

- ✓ Exercise by means of participation in sport (i.e. go for a walk, run, ride a bike, swim, join a gym, join a hiking group)
- ✓ Relaxation through listening to music, dancing and/or singing, start a hobby or leisure activity
- ✓ Learning the skill of meditation and find a quiet place for meditation
- ✓ Join a support group
- ✓ By using humour, e.g. recalling something funny to think about when stress occurs

Following the mini-lecture, the social worker allows time for questions and discussion of the questions. Subsequently, each group member is provided with a piece of paper and crayons. They are requested to write down at the top of the page, the most stressful situation that they are currently facing, followed by the way they will normally go about addressing this stressful situation. By using the information received during the mini-lecture, they are encouraged to choose an alternative way for dealing with the stressful situation, and depict their choice with a drawing on the left on the page.

Next, the group members are introduced to the idea of compiling a “stress-management resource list”. The social worker provides each of them with an index card and instructs them to identify people whom they can call when they struggle to manage their stress effectively. Each person should have the names and contact details of such people at hand, and the group members are also encouraged to avail themselves as sources of support for each other. Members are encouraged to utilise these resources when the need arises.

The following sub-section will focus on knowledge prerequisite, a functional aid and a strategy to assist the adolescent in aftercare with developing functional problem-solving and decision-making skills.

## Developing constructive problem-solving and decision-making skills



Constructive problem-solving includes the ability to make decisions about how to deal with problems (Gouws et al., 2000:124-127). Page and Page (2003:80-82) advise that the following process should be followed when addressing problems, and deciding on how to deal with them: 1) identify the problem; 2) identify resources needed to address the problem, and ways to use them; 3) identify consequences of the problem; 4) identify possible solutions, and possible results of each solution; 5) choose a solution; and 6) implement the chosen solution and develop ways to measure progress and to maintain change. Constructive problem-solving skills can assist the adolescent to become assertive and resilient, and therefore able to deal with challenges and stress in the recovery process.



**Functional aid: An activity to assist adolescents to identify a problem, explore different solutions to solve it and to make an effective decision in choosing the best solution to solve the problem**

The *aim of this functional aid* is to equip the adolescent group members with skills on how to identify a problem, generating possible solutions to solve the problem and then taking a decision on how to effectively solve the problem in an effort to deal with stress, and to manage high-risk situations that may lead to a relapse.

**Table 22:** Exploring the problem and alternative solutions and coming to a decision (adopted and adapted from Barber, 2002:136-137; Page & Page, 2003:80-82; Lessa & Scanlon, 2006:288)

<p>Step 1: Identify your problem by answering the following questions:</p>	
<ul style="list-style-type: none"> <li>➤ What is it that you currently experience as a problem?</li> <li>➤ Where does the problem come from and when did it start becoming a problem for you?</li> <li>➤ What are the reasons for it being a problem?</li> </ul>	



Step 2: (1) Previous attempts to solve this problem:  (2) Reasons why the previous attempts to solve the problem were unsuccessful  (3) Other possible solutions to solve the problem	
Step 3: Deciding on a solution to solve the problem	
Tasks, activities and resources to execute the solution:	



### Strategy on how to implement the knowledge base and functional aid

The social worker, in a mini-lecture, provides the following information about steps one needs to take to solve a problem (Barber, 2002:136-137; Page & Page, 2003:80-82; Lessa & Scanlon, 2006:288).

- Step 1: Identify the problem. Describe the problem experienced in terms of what the problem is, where it originates from, and what the reasons are for it to be viewed as a problem.
- Step 2: Once the problem has been identified and clearly described, questions that need to be answered are: *How did I try to solve the problem before? Was this effort successful, and if not, why not? What else can I do to solve the problem? Who can help me with the problem?*
- Step 3: Based on the list of alternative solutions for solving the problem, a decision must be taken about which solution will be employed to solve the problem and how it will be done.

The group members are then given a worksheet as depicted in Table 22 above, and requested to complete it in view of a problem they are currently experiencing. Once they have completed the exercise, they share the information (one at a time) with the group. The social worker enlists the help of the group to brainstorm and select tasks, activities and resources to execute the solution decided upon. In a follow-up group session, the social worker allocates some time and requests feedback from the group members about the implementation of the solutions decided upon in the previous session and their success in solving the problem. Where the decisions

decided upon seemed unsuccessful, the social worker once again involves the group to assist a member to decide on another alternative and to plan tasks, activities and resources in relation to this alternative.

Another functional aid that can be used in future group sessions to aid with deciding on how to solve problems is the following: Group members are invited (between sessions) to write letters describing the problems they are experiencing and need assistance with. These letters are placed in an envelope and posted in a post-box provided for this purpose. At the end of each session, two of these letters are read aloud to the group and members engage in a brainstorm to decide on a way to address the problems experienced.

In the previous sub-sections the focus was on providing adolescents in aftercare with interpersonal skills (i.e. constructive communication, conflict resolutions, alternatives for anger-management, problem-solving and decision-making skills). **In the next sub-sections the focus moves to developing life skills by focusing on budgeting skills, time-management skills and skills for dealing with cravings and temptations.**

### Developing budgeting skills



Fisher and Harrison (2005:162) identify budgeting/financial planning as a key area to be addressed in relapse prevention, as the inability to deal with money often acts as a trigger for relapses. The development of this skill should also assist the adolescent to address the financial losses that occurred during his/her addiction (Fisher & Harrison, 2005:162). In addition, social workers involved in aftercare groups should be sensitive to the cultural and socio-economic differences among group members, as some members might come from backgrounds where financial stress (poverty) is experienced (Jacobs, Masson & Harvill, 2002:184; Lessa & Scanlon, 2006:62). The following activity could be considered to ensure sensitivity towards the different circumstances of the members, as personal detail is not shared among the group members.



### **Functional aid: An activity to develop budgetary skills through a fake budget**

This **functional aid aims** to assist the group members to become skilled in the art of budgeting by means of a fake budget, where the income is balanced with expenditures.

**Table 23:** An example of a budget

Budget for Susan for the month of May			
Sources of Income		Expenses	
Pocket money per month	200,00	Toiletries	100,00
		Buy clothes	200,00
Earnings from a part-time (weekend) job	800,00	Movies	100,00
		Eating out with friends	150,00
		Hiring of videos or DVDs	100,00
		Buying magazines	100,00
		Cell phone air-time	150,00
Total income:	1000,00	Total expenses:	900,00
Surplus (Saving)	100,00		



### **Strategy on how to implement the knowledge base and functional aid**

The social worker explains that a budget is not primarily a plan to save money; it is a plan to distribute the income so that the person may have what is considered to be most essential. Learning the art of drawing up a budget does not only encourage one to live within one's means, but helps with monthly financial management and future financial planning (Alpaslan, 1997:118). Following this introduction, the social worker places a poster version of the example of a budget depicted in Table 23 on the wall, and explains that it is an example of a budget for a particular month.

The group members are then encouraged to discuss the contents of this budget; and to brainstorm ways to obtain extra money through part-time jobs, what they need to spend their money on, how they can save money (i.e. not spending money on unnecessary items), and how to ensure that money in their hands would not lead to temptations to buy chemical substances.

Subsequently, each of the group members is provided with a budget template and instructed to do a budget indicating their sources of income and expenditure. In order to be sensitive, this is a homework exercise and not shared with the rest of the group.

### Developing effective time-management skills



Boredom has been identified as a trigger for relapses (Matrix Institute on Addiction, 2008c:3). Acquiring proper time-management skills following formal treatment is therefore needed to address boredom, and to provide the adolescent with a plan for day-to-day living that will be conducive to the recovery from chemical addiction (Page & Page, 2003:206). Time-management entails the development of a daily plan to enhance a balanced lifestyle, and should include time for relaxation; socialisation; and work/school. It aims to “unlearn” the substance-related lifestyle, and to replace it with a recovery lifestyle (Velasquez, Maurer, Crouch & DiClemente, 2001:181; Fisher & Harrison, 2005:167). Table 24 provides a list of functional and meaningful activities to be included in time-management to ensure that the adolescent is able to find joy in the new recovery lifestyle.

**Table 24:** A list of functional and meaningful activities to fill time in recovery after treatment for chemical addiction (adopted and adapted from Page & Page, 2003:206-208; Fuller, 2007:154-155; Perkinson, 2008:427-428)

Quick and easy activities	Outdoor activities	Voluntary work	Go a little crazy
<ul style="list-style-type: none"> <li>• Create a TV series</li> <li>• Play board games/cards/build puzzles</li> <li>• Engage in acting, singing, arts and crafts</li> <li>• Become a pen pal and write letters to pen pals</li> <li>• Read newspapers, magazines, novels</li> <li>• Go to the movies, church, cultural and socials gatherings, support groups with friends who are of sober habits.</li> </ul>	<ul style="list-style-type: none"> <li>• Join a sport club</li> <li>• Engage in outdoor activities</li> <li>• Play soccer, rugby, or cricket</li> <li>• Join a cycling, hiking club</li> </ul>	<ul style="list-style-type: none"> <li>• Render services to the aged by visiting the sick and the elderly, assist them with shopping</li> <li>• Join the SPCA and care for pets</li> <li>• Help to clean up the environment</li> </ul>	<ul style="list-style-type: none"> <li>• Christmas in June</li> <li>• Award ceremony</li> <li>• Pretend to be a tourist</li> <li>• Hide and seek</li> <li>• Dress up</li> <li>• Write a song</li> <li>• Make a TV series</li> </ul>

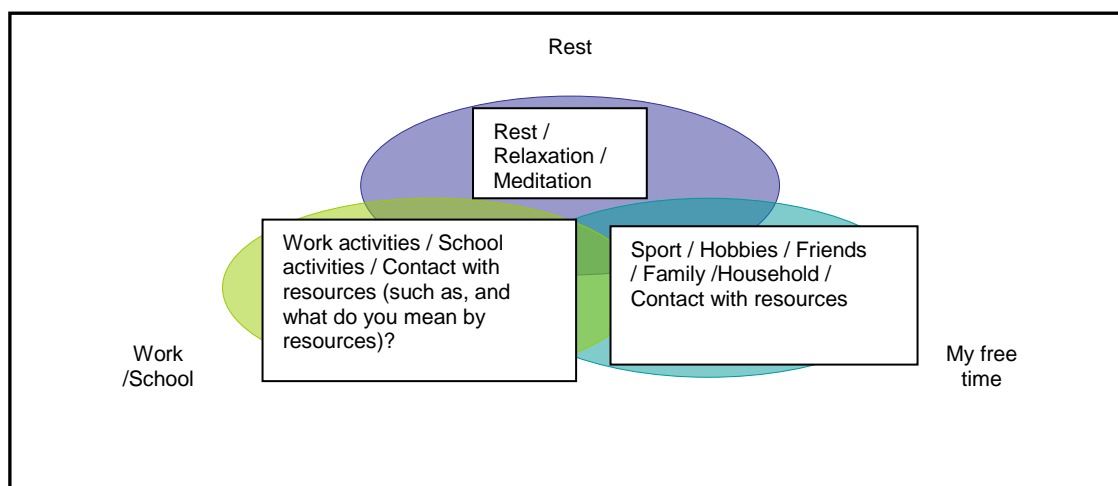
The following functional aid and strategy is aimed at providing information about how to divide time according to focus areas, and how to use a weekly time-management planner to gain insight in how time is managed on a day-to-day basis, and become skilled in planning functional and meaningful activities to fill time.



**Functional aid: A mini-lecture on focus areas in time-management and an exercise to plan and implement a weekly time-management planner**

The **aim of this functional aid** is to assist the group members to manage their time productively and to find meaning in day-to-day activities to sustain their recovery after treatment. For this purpose, the group is utilised as a vehicle for providing the adolescents in aftercare with information on how time available should be divided into certain focus areas, to introduce an exercise to create awareness and insight on how they fill their time, and based on this to make adjustments and plan to fill time with functional and meaningful activities.

**Figure 25:** Focus areas amongst which available time should be divided



**Table 25:** A day-to-day-time management planner for a week

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
0h00							
8h00							
12h00							
14h00							
17h00							
20h00							
22h00							
24h00							



### **Strategy on how to implement the knowledge base and functional aid**

The social worker introduces the topic of time-management by means of a poster version of Figure 25 on the wall, and begins the mini-lecture with the fact that there are 24 hours in a day. Dividing it into three, one has three sections consisting of eight hours each. The sections consist of eight hours to rest, eight hours to work or to go to school and do homework, and eight hours to relax and plan “free-time” activities.

Each group member is provided with a day-to-day time-management planner for a week (as depicted in Table 25 above), and instructed to complete it in terms of how they are currently filling their time over one week. Once they have completed this exercise, each of the group members is granted an opportunity to present their time-management planner to the group. The social worker continues by asking each of the group members to identify times when they feel bored and have time to kill. They are asked to identify activities they feel do not add value to the different spheres of their lives, or fulfil a specific function.

Based on the information provided, the social worker divides the group into pairs, and provides each member with a clean template of the time-management planner. He/she then places on the wall a poster version of Table 24 above, depicting a list of functional and meaningful activities to fill time in recovery. The group members are requested to assist one another in their respective pairs to fill the blank spaces on the time-management planner. The pairs join the large group and mention what functional and

meaningful activities they plan to incorporate in their day-to-day planner for the week. The social worker enquires about possible obstacles that might occur during an attempt to implement the planners. The group is encouraged to brainstorm solutions to possible obstacles. At the beginning of each group session to follow, members provide feedback on progress made with the implementation of their timesheets.

This section is concluded with knowledge prerequisite, a functional aid and a strategy to assist the adolescents in aftercare with developing skills to deal effectively with cravings and temptations.

### Developing skills to deal with cravings and temptations



Cravings for chemical substances are intense and often long-lasting. Encounters with temptations (hereafter referred to as “triggers” – people/places/events associated with substance use) lead to these cravings (Matrix Institute on Addiction, 2008c:32). Focusing on how to deal with cravings in the context of group work, adolescents in recovery are assisted to identify triggers, as well as ways to deal with the triggers in order to become able to deal with cravings. Triggers that lead to cravings include: use of other chemical substances; association with friends who use chemical substances; access to money and a lack of financial planning skills; roads/streets/neighbourhoods associated with the chemical substance use; boredom and a lack of time-management; substance-related music; insomnia; anxiety; and substance-related paraphernalia (Matrix Institute on Addiction, 2008c:3, 7). Thoughts about triggers lead to feelings, which in return determine reactions or behaviours (Perkinson, 2008:93). These triggers and craving for chemical substances threaten the ongoing recovery of adolescents following treatment, and must be addressed during aftercare. The functional aid and strategy below address the identification of triggers, evaluation of old responses to triggers and developing new responses to triggers, as well as the development of techniques to deal with craving responses.



**Functional aid:** An exercise to identify triggers that lead to cravings, an exercise for reflecting on previous responses to a trigger and planning alternatives, and a mini-lecture on techniques to control cravings

The *functional aid being presented below aims* to 1) create an awareness of and insight into the triggers that can lead to a craving for chemical substances; 2) provide the adolescents in recovery with an opportunity to revisit previous responses to a regular occurring trigger and to consider alternative responses in relation to this trigger; and 3) provide the adolescents with information about techniques to control their cravings for chemical substances following formal treatment.

**Table 26:** Identifying triggers that may lead to cravings (as adopted and adapted from Teesson et al., 2002:87-89)

We view the following people as triggers	We view the following places as triggers	We view the following things as triggers	We view the following events as triggers

**Table 27:** Identifying previous and alternative responses to a regularly occurring trigger (adopted and adapted from Perkinson, 2008:93)

The trigger (person, place, thing, event) that occurs regularly and results in a craving			
	Previous responses to a regular trigger		Alternative responses to the trigger
What were your thoughts previously about the trigger?		In view of the fact that your thoughts lead to feelings and behaviour (reactions), what can you think and do to respond differently to the trigger?	
What feelings did you harbour about the trigger?			
How did you previously react on the trigger?			
What was the result of your reaction?			



**Figure 26:** Reminder cards (adopted and adapted from Van Wormer & Davis, 2003:202)

<p><b>A reminder card of what to do when cravings occur:</b></p> <p>I need to STOP IN MY TRACKS</p> <p>I need to STAY CALM</p> <p>I need to THINK OF WHAT I THOUGHT OF AND WHAT I PREVIOUSLY DID TO DIVERT MY ATTENTION FROM THE CRAVING</p> <p>THINK THOSE THOUGHTS ...</p> <p>DO THOSE THINGS...</p> <p>THINK of WHAT I CAN DO DIFFERENTLY to divert my thoughts from the craving and take immediate action</p>
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### **Strategy on how to implement the knowledge base and functional aid**

The session is introduced with a poster version of Table 26 above on the wall. Group members are then requested to identify people, places, things and events that acted as triggers in the past and that currently might trigger them to develop a craving for chemical substances. These responses are written down on the poster.

Following this discussion, the social worker provides the group members with an example of a worksheet (Table 27 above). He/she instructs them to think of a trigger that occurs regularly, and to write it in the space provided in the first row, second column on the table. The focus of the exercise then shifts to the questions in the first column under the heading “previous responses to a regular trigger”. The group members are asked to write down their answers next to the questions in the space provided in the second column. Following this, they are encouraged to share their answers in a roundabout fashion. The social worker then instructs them to answer the question provided in column three and to write down their answers in column four on the worksheet. On completion of this task, they share their answers in the group. They are then encouraged to utilise the alternative responses as a guide when confronted

with the trigger between sessions, and to report on its outcome of at the next sessions.

Before the social worker dismisses the group work session, or at the next session, he/she gives a mini-lecture on techniques that the adolescent group members can use to assist them to deal with cravings for chemical substances in recovery. The information can be given as a handout to the group members (see the example below).

**A handout on techniques to assist adolescents on how to deal with the craving for chemical substances in recovery**

The following are low-cost and user-friendly techniques (as provided by Westermeyer, 2007:1-4) that could assist you to react preventatively to a craving for drugs during recovery:

- Visualisation: Close your eyes and think about what you have been through as a result of your addiction and your successes since you have left treatment
- Snapping: Put a rubber band around your arm and every time the craving for the drug arises pull and release the rubber band on your arm as an attempt to divert the attention away from the craving
- Engage in prayer and personal devotions
- Engage in physical activities
- Call someone (making use of NA sponsors and other community resources)
- Employ the “Robot Technique”: This technique is also known as “thought stopping” (De Klerk & Le Roux, 2003:62). The “red light” represents thoughts that lead to cravings, the “orange light” represents actions to be taken to divert thoughts, “green light represents” the preferable outcomes. Every time your mind starts to drift towards a craving, or you are confronted with a trigger, think “STOP

This topic is concluded by creating reminder cards. Each group member is provided with an empty template of the reminder card (Figure 26). The reminder cards can be made as part of an art activity. Members receive magazines, paint/crayons, scissors and pens to create an individual reminder card. They are then encouraged to carry the reminder card on them, in an effort to prevent relapses through craving control techniques.

In addition to the above discussion, the following section provides guidelines (as illustrated in the table below) for social workers to address environmental challenges and needs, as identified during the assessment.

**Table 28:** The goals and objectives for interventions addressing the environmental needs and challenges of chemically addicted adolescents in aftercare, and the knowledge and strategies required by social workers to realise the goals and objectives

Goals	Objectives	Knowledge base prerequisite	Functional aid and strategy to realize the goals and objectives
Interventions addressing the environmental needs and challenges of chemically addicted adolescents in aftercare	Community work aimed at developing and mobilising networks with relevant resources	<ul style="list-style-type: none"> <li>The role of churches, schools, self-help/support groups, as well as the treatment centres the adolescents attended in ensuring that the addicted adolescents' aftercare needs are met</li> </ul>	<p><u>Functional aid: exercise to assist with:</u></p> <ul style="list-style-type: none"> <li>1) identifying role-players rendering aftercare services to adolescents, 2) establishing an action committee investigating the possibility of networking among resources, 3) establishing a committee assisting unemployed adolescents in recovery with skills to find employment, and 4) establishing self-help or support groups in the community to support the adolescent in aftercare</li> </ul>
	Community work aimed at involvement of community leaders and institutions to address the availability and tolerance displayed toward chemical substances in communities	<ul style="list-style-type: none"> <li>The impact of the availability and tolerance of chemical substances in the community on the recovery potential of addicted adolescents</li> </ul>	<p><u>Functional aid: exercise to assist with:</u></p> <ul style="list-style-type: none"> <li>Identifying and mobilising community leaders and institutions to address the availability of and tolerance towards chemical substances in the community</li> </ul>
	Community work aimed at joining a community action group in an effort to assist the adolescents to reintegrate into the community following treatment	<ul style="list-style-type: none"> <li>The value of social involvement</li> </ul>	<p><u>Functional aid: exercise to assist with:</u></p> <ul style="list-style-type: none"> <li>Becoming contributing members of their communities in aftercare</li> </ul>

## Interventions addressing the environmental needs and challenges of chemically addicted adolescents in aftercare



Interventions directed at addressing the aftercare needs and challenges of CAAs in relation to their environments (communities in which they function) revolve mainly around 1) connecting them with concrete resources, 2) expanding their social networks, and 3) developing physical environments that will facilitate the achievement of recovery goals (Toseland & Rivas, 2005:302). In order to address the abovementioned focus areas, community work (as a primary method of Social Work) is specifically focused on the empowerment of the community into which the CAA needs to be reintegrated; to meet his/her environmental needs (Hepworth et al., 2006:182). In community work, the social worker acts as a facilitator, creating a supportive environment 1) through which a community is enabled to make relevant and adequate decisions and changes for the good of all its members, and 2) in which individuals and groups make positive contributions to the community (Swanepoel & de Beer, 2000:33).

The following focus areas in community work relate to aftercare services to addicted adolescents: finding employment/continuing with education following treatment; making contact with support/self-help groups; becoming involved in spiritual activity; developing networks with law-enforcement agencies, addressing the availability of chemical substances and recognition of the social problem; mobilising networks (resources and service organisations); social marketing to assist in changing the community's perception of CAAs to promote social integration and a sense of belonging in community; and community education to address the acceptability and tolerance of chemical substances (Brandt & Delpont, 2005:173; Zhang, Gerstein & Friedman, 2008:288-400; Perkinson, 2008:126). Community work aims to address the adolescent's aftercare needs as assessed when identifying environmental challenges and resources available and needed to support the adolescent in recovery (p. 308). The content of this section provides guidelines related to networks with relevant resources, addressing availability and tolerance of chemical substances in the community, as well as the adolescent's need to reintegrate into the community following treatment.

## Developing and mobilising networks with relevant resources



In an effort to ensure that aftercare services are available and accessible to CAAs in recovery, social workers may implement the social planning model inherent to community work, as described by Weyers (2001:149-150). The aim of the utilisation of this model is to encourage coordination and cooperation between different community organisations and resources in order to meet the aftercare needs of addicted adolescents. The table below provides an overview of the possible role-players that may become involved in rendering aftercare services to adolescents:

**Table 29:** Possible role-players that may become involved in rendering aftercare services to chemically addicted adolescents

Mental Health Practitioners	Physical Health Practitioners	Social institutions	Volunteers
<ul style="list-style-type: none"> <li>• Mental Health Organisations</li> <li>• Psychiatrists and psychiatric nurses employed at clinics of the Department of Health</li> </ul>	<ul style="list-style-type: none"> <li>• Doctors and nurses employed at clinics of the Department of Health and private clinics</li> </ul>	<ul style="list-style-type: none"> <li>• Schools</li> <li>• Churches</li> <li>• Police</li> <li>• NICRO</li> <li>• Sport clubs</li> <li>• Treatment centres</li> <li>• Department of Social Development</li> <li>• NGOs</li> </ul>	<ul style="list-style-type: none"> <li>• Persons interested in involvement of services to CAAs</li> <li>• Community leaders</li> </ul>

In the literature consulted, references were found on how churches, schools, self-help/support groups, as well as the treatment centres the adolescents attended, can become involved in ensuring that the addicted adolescents' aftercare needs are met. The discussion below provides a theoretical framework related to the role of these resources in aftercare.

The role of **churches** in aftercare to addicted adolescents is to provide assistance that will lead to their spiritual well-being. Spiritual well-being is an important component of relapse prevention, as it assists the adolescents to change and sustain beliefs, care for others, and deal with negative and painful thoughts and emotions (Sussman & Ames,

2001:119). Spiritual connections (with other fellow believers) can also lead to hope, support and encouragement; and provide guidance on their recovery journeys (Van Wormer & Davis, 2003:17). Hope derived from spiritual well-being increases the belief that they “can do it”, referring to remaining sober (Van Niekerk & Prins, 2001:73).

Adolescents are normally part of the **school** community, which therefore is a valuable resource to involve in providing aftercare services to adolescents. Addressing aftercare needs in the school environment addresses the concern regarding the high drop-out rate from aftercare services as the school can provide social workers access to these adolescents (Barrett & Ollendick, 2004:337). The desired role of the school is that schools will provide a platform to educate the adolescents regarding the impact and dangers of substances, assist them to develop the ability to distinguish between pleasant and unpleasant consequences of substance use, assist in developing friendships outside the substance-use culture, assist in dealing with problems, and to develop healthy leisure-time habits to combat boredom. The school can also ensure that it presents and facilitates youth activities to encourage the development of healthy lifestyles and to increase among learners the sense of belonging (Pretorius & Le Roux, 2005:274; 278; 298). Regarding employment needs, addicted adolescents must be assisted (through local schools) to make career choices based on realistic perceptions of their abilities, interests and ideals, and the requirements of the options they consider (Meyer, in Wait et al., 2005:176).

**Self-help/support groups** can also be viewed as an important source of support to adolescents during the recovery and aftercare following treatment. Self-help groups have the advantage that a professional person’s involvement is not needed, and can thereby “transcend the budgetary limitation of health and welfare agencies”, they lead to interaction with others “who know what it feels like”, and provide CAAs with sponsors to support them to implement the NA 12-Steps Programme (McLeod, 2003:449).

**Treatment centres** which provide in- and out-patient treatment can also be utilised for rendering aftercare service to ensure that changes made during formal treatment are maintained and internalised during aftercare (Sussman & Ames, 2001:110).

The functional aid and strategy below may be used as a guide for identifying resources in the community to support the adolescent in recovery, and establish networks between these resources.



**Functional aid: Guidelines for 1) identifying role-players rendering aftercare services to adolescents, 2) establishing an action committee investigating the possibility of networking among resources, 3) establishing a committee assisting unemployed adolescents in recovery with skills to find employment, and 4) establishing self-help or support groups in the community to support the adolescent in aftercare**

The **aim of this functional aid** is to assist social workers to 1) identify role-players rendering aftercare services to adolescents, 2) establish an action committee investigating the possibility of networking among resources, 3) establish a committee assisting unemployed adolescents in recovery with skills to find employment, and 4) establish self-help/support groups in the community to support adolescents in aftercare through the utilisation of the community work method of intervention. A further aim is to provide CAAs with multiple resources to utilise following treatment.

**Table 30:** An example of the information to be contained in a resource list of resources rendering aftercare services to chemically addicted adolescents

A description of the resource in terms of name, contact person and contact details	Services provided by the specific resource	Referral procedures



**Strategy on how to implement the functional aid**

**Guidelines for identifying a resource list of role-players** rendering aftercare services to addicted adolescents will be presented first:

- The social worker's first task is to identify within his/her community individuals, organisations and institutions that provide any kind of formal treatment to adolescents suffering from a chemical addiction. A good starting point for this will be to use the local telephone directory and look for the telephone numbers of the Departments of Health, Social Development, Education and the various social service organisations/offices, schools and churches in the community, to find out who renders treatment services to these adolescents. During the contact-making with these resources, the social worker could ask them who else renders this kind of service. Based on the information provided, these organisations can be contacted and in so doing a resource list with all the local resources related to rendering services to CAAs, and their contact details, can be drawn up. This list can then be made available to all individuals, institutions and organisations rendering aftercare services to adolescents. In Table 30 above, an example is provided of what should be included in such a resource list.
- In view of establishing a network among the identified resources, the social worker can arrange a meeting with role-players and/or their representatives. At this meeting the social worker provides each of the role players/representatives present an opportunity to describe his/her organisation/institution's scope of service to addicted adolescents. The social worker subsequently investigates the possibility of compiling a resource list of service providers (i.e. individuals, organisations, and institutions) who are rendering aftercare services to addicted adolescents and those who would like to become involved in this area of service. Deducting from the interest, the social worker proceeds with the election of an action committee that can assist with compiling such a resource list and distributing it as widely as possible. The action committee is also tasked with the responsibility to update the resource list at regular intervals, and to distribute the latter to the relevant role-players.

**Guidelines for establishing networks among the role-players** rendering aftercare services to addicted adolescents:

- If the assignment of identifying role-players and compiling a resource list of individuals, organisations and institutions rendering aftercare services to addicted



adolescents be a success, the social worker (who initiated this action) or the elected action committee, can investigate the possibility of networking among role-players to prevent duplication of services. The aim of such a network is to enable the different role-players to share resources. To realise this suggestion, is to conduct meeting where every role-player articulates his/her field of focus and expertise and indicates his/her commitment to become part of a network rendering aftercare services to addicted adolescents.

**Guidelines for establishing a committee to assist unemployed adolescents** who have finished their secondary schooling, or who dropped out of school in aftercare, with finding employment:

From the resource network, the social worker can ask for volunteers, and establish an action committee to assist with the following:

- **Realistic identification of employment opportunities:** The action committee is tasked with the responsibility to contact businesses and to enquire if they would be willing to employ adolescents who have finished school and/or dropped out of school and who are in recovery from chemical addiction. If they express willingness, the action committee needs to find out what job opportunities are available and what competencies and skills are required by applicants who want to apply for the positions available.
- **Recruitment of volunteers to avail themselves for training of CAAs in preparing them for job opportunities in the job-market:** The action committee is encouraged to identify and contact possible volunteers who will be able to give their time, skills and expertise in providing training to CAAs to get skilled to become employable in the job-market. The committee is also tasked with finding community resources that will sponsor/fund adolescents to finish their schooling or provide them the opportunity for further education and training. In addition, the committee needs to enlist the help of volunteers to assist the adolescents with compiling curriculum vitas, how to apply for a vacancy, and preparing them for job interviews.

### **Guidelines for establishing self-help/support groups for adolescents in aftercare:**

- When the social worker comes to the conclusion that there are no self-help/support groups available to provide support to the adolescents during aftercare, she/he contacts such groups in other areas to obtain information on existing groups and some practical advice on how to start such groups in a specific community. The social worker consults her/his own caseload or that of other colleagues inside and outside her/his service organisation to identify adolescents who will benefit from such a group, and to identify individuals who are active in recovery (“sober addicts”) and can become the leader of such a self-help/support group. The individuals who are displaying leadership qualities are then trained by either the social worker or by the facilitators of existing groups in basic group work skills and in how to run a self-help/support group. Once the training is completed the self-help/support group is advertised and the newly established self-help/support group is then included in the resource network.

#### **Involvement of community leaders and institutions to address the availability and tolerance displayed toward chemical substances in communities**



The availability of chemical substances in the community, as well as the tolerance displayed towards substance use in the community, leads to the presence of triggers that lead to cravings and relapses. “Triggers” in this context refer to the presence of substances and substance-using peers at specific places and events in the community into which the adolescent has to reintegrate, following treatment (Matrix Institute on Addiction, 2008c:7). This aspect should be addressed through the involvement and mobilisation of community leaders, as discussed below (Treatment for Alcohol and Other Drug Abuse, 2007).



**Functional aid: An exercise for identifying and mobilising community leaders and institutions to address the availability of and tolerance towards chemical substances in the community**

The **aim of this functional aid** is to mobilise the action committee (referred to in the previous sub-section) to identify community leaders and institutions that are related to, or have the power to address, the problem of availability of and tolerance towards chemical substances in the specific community into which the adolescent has to reintegrate following treatment, in order to prevent triggered relapses.

**Table 31:** Action plan for community leaders and institutions to address the problem of availability and tolerance of chemical substances

<b>Objective:</b> To organise an initiative to address the problem of availability of and tolerance towards chemical substances in the community of.....	<b>Activity:</b> In order to realise this objective the following tasks/activities must be executed:	<b>Role-players:</b> The following role-players need to be contacted and their involvement in this initiative be pointed out and obtained:	<b>Resources:</b> The following resources will be needed to execute this initiative:	<b>Time-frame:</b> The timeframe in which the activities need to be completed:



### **Strategy on how to implement the functional aid**

At an action committee meeting conducted for the purpose of identifying community leaders and institutions that are related to, or have the power to address, the problem of availability of and tolerance towards chemical substances in the specific community, the social worker requests the members to engage in a brainstorm activity to identify such community leaders and institutions. The members of the action committee are then requested to contact the community leaders and the institutions, and ask them if they would be able to get involved in a campaign to arrest the problem of availability of and tolerance towards chemical substances in their specific community. If they indicate their interest, the action committee members convene a meeting with their respective contacts to decide on a plan of action in this regard. At this meeting Table 31 above

can be presented in a poster format to structure the plan of action to address the issue at hand.

- The nature of the initiatives to address this problem can be as follows:
  - A campaign to collect information on drug providers in the community, and sharing the information with the South African Police
  - Community education campaigns to 1) sensitise the community about the value of aftercare and support to adolescents following treatment, 2) change perceptions that addicted adolescents will not recover from their addiction, 3) raise awareness about the existence of specific services related to providing aftercare to adolescents and their families, and 4) recruit and train volunteers to act as “guardians”/”buddies” to the adolescents and provide them with support in recovery.

Once the action plan is drawn up, the social worker suggests regular meetings to plan and execute the action decided upon, and to monitor and evaluate the progress as well as evaluating its effect, efficiency and impact.

The following sub-section shifts the focus from the involvement of community members/institutions/organisations to the involvement of the CAAs in community affairs.

**Joining a community action group in an effort to assist the adolescents to reintegrate into the community following treatment**



In order to ensure that the adolescents are accepted by the community, and thereby successfully reintegrate following treatment, the social worker should assist the adolescents, through a community work effort, to become contributing members of their community. The involvement and contribution of CAAs in community affairs following treatment can lead to a sense of worthiness, purpose and belonging, as well as to acceptance by the community members (Saleeby, 2006:202). Furthermore, the development of a concern regarding social issues, and commenting about and raising questions about social issues, is seen as an essential component of cognitive development during adolescence, and contributes to the development of an ability to

become a worthy member of society. However, this concern must be integrated into the lifestyle of recovery, ensuring that the adolescents are involved in social activities and concerns that they deem important (Gouws et al., 2000:39). The purpose of becoming involved in community affairs is that it promotes the following characteristics that are conducive to reintegration and purposeful living: kindness; unselfishness; patience; tolerance; forgiveness; and justice, as well as working towards a common goal (Van Niekerk & Prins, 2001:80).

In order to assist an adolescent to reintegrate into his/her community following treatment, it is advised that the social worker should encourage him/her to join a community action group. Although group work is used as a platform to raise awareness, and to prepare adolescents to become involved in community affairs, the outcome of this activity is in line with the focus of community work, i.e. mobilising individuals and groups to become contributing members of their communities (Van Niekerk & Prins, 2001:80; Saleeby, 2006:202).



### **Functional aid: Encouragement of chemically addicted adolescents to become contributing members of their communities in aftercare**

The ***aim of this functional aid*** is to encourage adolescents in aftercare to become involved in community affairs by joining an action group in order to enhance reintegration into their communities, and through such an experience to develop a sense of social responsibility and a social consciousness.



### **Strategy on how to implement the functional aid**

The social worker uses the aftercare group as a platform to engage members in community activities. She/he introduces the topic of social issues present in a community by asking the group members to respond to the following question: “*What are the social issues and concerns in your community?*” The answers are noted on a flipchart. On completion of this discussion, the group members are provided with

magazines and newspapers, and requested to go through them and to identify social issues in which they would like to become involved. These may be actions to clean the streets, assisting the elderly, assisting with caring for pets at the SPCA, and so on. These issues are then listed on a flipchart and each of the group members is provided with a homework assignment to go and find out in the next week, what community actions are available in his/her community to address these social issues, and the contact person(s) or organisations one should contact to become involved in these community actions and join these action groups. At the next group session, the social worker requests members to provide feedback. He/she also has a telephone at hand, and provides the group members in a roundabout fashion access to phone the contact person responsible for this community action, and inform them that they would like to become involved in the community action. The individual members are then provided with practical assistance and support to become involved with the social issue of their choice.

## THE EVALUATION AND TERMINATION OF AFTERCARE SERVICES



The last goal of aftercare is the evaluation and termination of the aftercare intervention. The two objectives are therefore 1) monitoring and evaluation of aftercare services, and 2) the termination of formal aftercare. The intervention process is monitored throughout the implementation of the intervention plan. Re-planning takes place when the social worker identifies that a specific area should be included and/or when different methods, aids and/or techniques are needed to attain the aftercare goals. Once the social worker detects that goals have been attained, the intervention process is evaluated and the client is prepared for termination (Sheafor & Horejsi, 2006:474).

## Monitoring and evaluation of aftercare services



Monitoring should be a continuous activity, and every evaluation effort must focus on the client's growth and experiences, the intervention techniques and approach, the social worker's input and roles, and the desired outcome (Sheafor and Horejsi, 2006:474-478). Regarding monitoring of aftercare services, the Western Cape Department of Social Development (2008:10) proposes the following focus areas to be included: 1) Efficiency of the service and the service provider: Verifying the input with the outcome of the aftercare services; 2) Effectiveness of the aftercare plan: The extent to which the aftercare service achieves the specific goals and objectives of the aftercare plan; and 3) Impact of the changes made through aftercare: Determining whether or not which aftercare services made a difference to the situation of the CAA and his/her family.



### Functional aid: Implementing monitoring and evaluation tools

The **aim of this functional aid** is to provide social workers with ideas on how to monitor progress during aftercare intervention, and to evaluate the outcome of services.



### Strategy on how to implement the knowledge base

The functional aids pertaining to the first two stages of the intervention process (i.e. assessment and development of aftercare goals, objectives and plans) can be used as monitoring and evaluation tools. It is recommended that the following functional aids as provided earlier in this manual be used:

- Dealing with the pros and cons of chemical addiction
- My resource list
- Eco-diagram to identify individual needs

- An exercise to depict the adolescent's relationships with the respective members of his/her family
- Contributing factors in relapses among CAAs
- Worksheet for identifying risk factors that could endanger the adolescent's recovery process and the maintenance of a sober lifestyle, and a plan for preventing these risk factors
- A sample of a working agreement between CAAs and their parents

The social worker makes use of these monitoring tools at specific intervals that are determined by both the social worker and the adolescent. The differences in the results are noted, acting as a monitoring tool, as well as a tool to motivate the adolescent.

## Termination of aftercare services



The focus of termination of the case and group work methods of intervention should be on 1) dealing with feelings relating to the termination and 2) the development of an ongoing plan of action to ensure sustainable change and ongoing growth. It is advisable that the frequency of contacts be decreased to ensure that the client is slowly introduced to the termination of the intervention process. In addition, the adolescents and their parents are encouraged to remain involved as role-players in ongoing community work projects and programmes, as well as to continue to participate in support/self-help groups (Sheafor & Horejsi, 2006:498-500).



### **Functional aid: Planning for maintenance of change following the termination of formal aftercare services**

The ***aim of this functional aid*** is to provide the adolescent with a plan to ensure that the changes that occurred during formal treatment and aftercare are maintained, in order to prevent relapses, and to ensure ongoing growth.



**Table 32:** A framework for ongoing efforts to maintain changes made during treatment and aftercare

Activities related to a recovery lifestyle to be continued with	Frequency: How often and when will these activities be implemented	Resources required to implement these activities



### **Strategy on how to implement the knowledge base and functional aid**

The CAA is provided with a template of the worksheet depicted in Table 32 above and guided to complete it by requesting to:

- List the things he/she wants to continue doing once formal services are terminated.
- He/she then determines how often the identified activities would be implemented.
- The adolescent is encouraged to identify resources he/she would contact should further assistance be needed, and to list them in the last column.

### **Conclusion of the manual for aftercare services to chemically addicted adolescents from a social work perspective**

The guidelines were formulated in terms of the following characteristics of practice guidelines as described in the literature (Howard & Jenson, 1999:360; Brause, 2000:131; Proctor & Staudt, 2003:230; Proctor, 2004:228-231; Hofstee, 2006:159; Sheafor & Horejsi, 2006:82-86): The manual is based on an empirical foundation; it is based on existing theory, including different models, perspectives and approaches; it is clear and understandable; it is based on specific goals and objectives; it is aimed at a specific target audience; it is motivational in nature, thereby addressing possible resistance; it provides guidance and direction regarding the how, where and why of the steps undertaken during the various phases of the change process; it ensures feasibility; it focuses on the person as well as his/her environment; and it should lead to affordable and accessible services.

The reference list below is recommended for further reading.

### **6.3 Conclusion**

The background and rationale of this study; together with the research problem, research questions and research goals were presented in Chapter 1 of this document. In Chapter 2, the reader was provided with an outlay of the research methodology implemented in this study.

This chapter was informed by Chapters 3 and 4 (the empirical findings of this study) and Chapter 5 (the description of existing technology relating to aftercare services). In order to address the needs of both the CAAs and the social workers who participated in this research regarding aftercare services, the guidelines presented in this chapter focused on 1) the assessment of the CAA following treatment; 2) the development of aftercare goals and an aftercare plan; 3) goal attainment through intervention directed at intrapersonal, interpersonal, and environmental needs; 4) monitoring and evaluation of progress; and 5) termination of services. This has resulted in a manual with practical guidelines for aftercare services to CAAs by social workers.

Chapter 7 will conclude this study and focus on the summary, conclusions and recommendations following from the completion of this research endeavour.

## CHAPTER 7

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 7.1 Introduction

The focus of this study was on the lack of aftercare service delivery to chemically addicted adolescents (CAAs) as experienced in Social Work practice, and on how to present such service. In response to this, the development of aftercare practice guidelines from a Social Work perspective became the central goal of this study. Chapters 1-5 of this report focused on the following: Chapter 1 introduced the research problem, research questions, the goal and task objectives that guided the research process and research methodology. A description of how the chosen research methodology was implemented was given in Chapter 2. In Chapters 3 and 4 the research findings based on the sample groups' contributions, complemented by a literature control, were provided. Chapter 5 focused on existing technology found and referred to in literature relating and alluding to aftercare. The information from these chapters (in particular Chapters 3-5) informed, assisted and guided the researcher in the development of a manual with practice guidelines from a Social Work perspective, comprising a series of functional aids and strategies for their implementation.

In this final chapter, a summary of the previous chapters, the conclusions drawn from this study and the recommendations will be presented.

#### 7.2 Summary: The research problem, research question, goals and objectives of this study

The **research problem** that informed this study was: Feedback from practitioners involved in the field of treatment of CAAs in the Western Cape indicated a lack of aftercare services available to them following in- or out-patient treatment, which had a

negative impact on the relapse potential of these adolescents. In line with this feedback, the initial literature studied placed emphasis on the fact that aftercare forms an integral part of the treatment process (cf. Sussman & Ames, 2001:103; Meyer, 2005:292-293; Simpson, 2005:5; Department of Social Development Western Cape, 2008:1; Matrix Institute on Addiction, 2008b). It was therefore concluded that Social Work services to CAAs should include a specific aftercare service, to offer them ongoing and adequate support in their efforts to maintain sobriety, and to prevent relapse. This conclusion resulted in the following **research questions**:

- What are the specific aftercare needs of CAAs following treatment?
- What are the perceptions and experiences of social workers involved in services to CAAs regarding aftercare services?
- Based on the perspectives of the CAAs and the social workers, what are the key elements that should be included in practice guidelines for aftercare services to CAAs?
- Based on the perspectives of the CAAs and the social workers, how should aftercare practice guidelines for services to these adolescents be implemented?

The **goal** of this study, directed at addressing the research problem and answering the above questions, was to develop practice guidelines from a Social Work perspective relating to the provision of aftercare services to CAAs.

To actualise the goal, the following **objectives** (research and task-related) were formulated:

- To explore and describe the specific aftercare needs of relapsed CAAs following treatment relating to services by social workers;
- To explore and describe the perceptions and experiences of social workers regarding aftercare services to CAAs;
- To review literature that relates to aftercare services to CAAs;
- Based on the above findings, to develop practice guidelines from a Social Work perspective relating to the rendering of aftercare services by social workers to CAAs following treatment.

Following the above, the remainder of Chapter 1 was devoted to introducing the research methodology proposed for this research project. Chapter 2, as summarised in the following sub-section, was dedicated to a description of how the research methodology proposed in Chapter 1 was implemented.

- **Conclusions: The research problem, research question, goals and objectives of this study**

On completion of the study, the researcher arrived at the following conclusions pertaining to the research problem, questions, and goal and task objectives:

- The research problem articulated by representatives from practice who did not form part of the study's sample (and whose comments were included in Chapter 1 under the heading "Theoretical background and rationale" (p. 9) were confirmed by both participant groups. The participating CAAs reported a lack of availability of aftercare workers, while the social workers referred to a lack of aftercare services to CAAs.
- The research questions formulated at the outset of the study were indeed answered through the task objectives. In Chapter 3 of this report, a description of the aftercare needs of CAAs following treatment was provided. In Chapter 4, and the perceptions and experiences of social workers providing aftercare services to CAAs, together with suggestions in respect of guidelines for aftercare service delivery were captured. Chapter 5 of this report bore testimony to the knowledge and technologies in literature, focusing specifically on aftercare to chemically addicted client-systems. Chapter 6 was proof of the fact that the last task objective stated in respect of this study had been realised, as it contained guidelines for aftercare services to CAAs from a Social Work\_perspective, packaged as a manual comprising functional aids and strategies in view of the implementation thereof.

### **7.3 Summary: The research methodology implemented in this study**

The **qualitative research approach** was chosen based on the task objectives of this research, which pointed towards the exploration and subsequent description of

aftercare needs of CAAs, as well as the perceptions and experiences of social workers relating to aftercare services in this field, and suggestions regarding such guidelines. In addition, this research endeavour fell in the ambit of **applied research**, as it aimed to bring about change in a troublesome situation (i.e. the lack of tailored aftercare services to CAAs in practice, impacting negatively on relapse prevention after treatment). The researcher implemented the **intervention research design**, employing the Intervention Design and Development (IDD) Model of Rothman and Thomas (1994:3-51), and in particular Phases 1 and 2, Step 2 of Phase 3 and Step 1 of Phase 4 of the IDD-model (*as summarised below*) for the development of practice guidelines focusing on aftercare services to CAAs from a Social Work perspective.

**Phase 1** of the IDD-model of Rothman and Thomas (1994) concerns itself with **problem analysis and project planning** and is divided into the following five steps:

### **Step 1: Identifying and involving clients**

The identification and involvement of clients refers to the population of the study, which was defined as follows for the purpose of this study: 1) all chemically addicted adolescents in the Western Cape who had relapsed after in-patient treatment, and 2) all Social Work service providers dealing with adolescent chemical addiction in the Western Cape. To choose a sample that was information-rich and could provide insight into the particular field of interest, the **purposive sampling technique** was used. The criteria for inclusion for the CAA interest group were: all chemically addicted adolescents who had previously undergone in-patient treatment and had had contact with social workers, relapsed thereafter, and were back in in-patient treatment programmes in the Western Cape. The criteria for inclusion of the Social Work interest group were: registered social workers employed by the Department of Social Development and Non-Governmental Social Work Organisations (NGOs) providing aftercare services to CAAs in the Western Cape. The **sample size** for this study was determined by data saturation, which was detected after 31 narratives (obtained from CAAs) and seven focus groups (with a total of 29 social workers involved in providing aftercare Social Work services to CAAs).

### **Step 2: Gaining entry and cooperation from settings**

Access to the sample selected from the population of chemically addicted **adolescents** was obtained through contact with in-patient treatment centres in the Western Cape catering for CAAs. The researcher requested them to participate in the study and to identify possible participants. Upon identification of possible participants by the centre representatives, an introduction interview with these adolescents and their parents/guardians followed, which provided them with information pertaining to the purpose and the process of the study. The ethical aspects relating to the research, namely: the participants' rights to withdraw at any time from the study, the confidential treatment of information and identities of participants, as well as the intention to do no harm, were discussed in detail. Willing and interested participants were then presented with signed consent forms. In order to gain access to the sample selected from the population of **social workers** rendering services to CAAs, the researcher negotiated entrée to the participants by means of an introduction letter to Social Work service providers working with this group. Interviews with willing participants were arranged, during which time the purpose of the study and the research process were given to them. Those who agreed to participate were given consent forms, which were explained to them, and which they were requested to sign.

### **Step 3: Identifying the concerns of the populations**

The researcher used the exploratory, descriptive and contextual **research designs** as a qualitative strategy of enquiry with both the adolescents and Social Work\_interest groups. In order to explore and describe the needs of chemically addicted **adolescents** following treatment, they were asked to write **narratives** based on the following theme: "The things social workers can help me with to maintain my sobriety after treatment".

**Focus groups** as a method of **qualitative interviewing** aimed to promote understanding from the **social workers'** point of view. Complementary to this method, participant observation as another qualitative method of data collection was employed. The following questions were asked of the participants, to explore the nature of current Social Work\_aftercare services to CAAs:

- What are your views in general regarding aftercare services to CAAs?
- Tell me about the services you employ to address aftercare to CAAs.
- What resources are available to you to support your work?
- What restrictions do you experience?
- If you were to compile practice guidelines for social workers in view of rendering aftercare services to CAAs, what would you include?

The **method of data recording** for the data obtained from the adolescents was their written narratives. Data obtained from the social workers was recorded by means of tape-recordings and field notes, which were transcribed later.

#### **Step 4: Analysing the identified concerns**

Tesch's (in Creswell, 2009:186) eight steps for qualitative **data analysis** were implemented by both the researcher and an independent coder, to ensure a systematic and comprehensive manner of data analysis, once data became repetitive and data saturation was reached. **Data verification** ensured that the findings of the research accurately represented what was happening in the situation being studied (Welman et al., 2005:142). The trustworthiness of the qualitative data obtained through this study was based on Guba's model (as cited in Krefting, 1991:214-222), addressing the truth value, applicability, consistency and neutrality of this research study.

#### **Step 5: Setting the goals and objectives**

The final step in the first phase of the IDD-model focused on the identification of goals and task objectives of the study, as provided in sub-section 7.2. Based on the empirical findings, the initial goal (to develop practice guidelines from a Social Work perspective relating to the provision of aftercare services to chemically addicted adolescents) became more specific at this stage of the research process. The goal was therefore broadened to: To develop aftercare practice guidelines for chemically addicted adolescents following treatment and to disseminate the research findings and the developed aftercare practice guidelines (in the format of a manual comprising functional



aids and strategies for the implementation thereof) to social workers and organisations involved in service delivery to chemically addicted adolescents.

**Phase 2** of the IDD-model of Rothman and Thomas (1994) focuses on **information gathering and synthesis** and comprises three steps:

### **Step 1: Using existing information sources**

This step relates to accessing and utilising existing information sources to become knowledgeable about the state of the art (i.e. knowledge and technologies available on the topic). The implementation of this step assisted the researcher to obtain a knowledge base regarding the existing literature and technology related to the focus of this study, including: addictive chemical substances; adolescence; aftercare and reintegration; chemical addiction; intervention research; practice guidelines; recovery; relapse and relapse prevention; Social Work intervention; and treatment programmes.

### **Step 2: Studying natural examples**

Studying natural examples refers to looking at how the people experiencing a troublesome situation are directly affected by it. In Chapter 1, service providers who did not form part of the sample shared their views, and Chapters 3 and 4 bear testimony of how CAAs and social workers rendering aftercare services view the aspects of aftercare, aftercare services, the needs of adolescents in aftercare and the social workers' perceptions and experiences in relation to rendering aftercare services. After implementation of the IDD-model, the researcher came to the conclusion that this step (i.e. studying natural examples) linked and overlapped with the activities as described in Step 3: Identifying the concerns of the population in Phase 1.

### **Step 3: Identifying the functional elements of successful models**

This step entailed the exploration of different aftercare models, practice guidelines and suggestions, and evaluation of their effectiveness in addressing the research problem (Rothman & Thomas, 1994:33). The features, advantages and limitations of the identified models, practice guidelines and suggestions were evaluated in terms of their

suitability and possible usability in view of adopting and/or adapting them for inclusion in the manual of guidelines for aftercare services to CAAs. The outcome of this step is documented in Chapter 5 of this report.

**Phase 3** of the IDD-model focused on the **design of human technology**. In this phase, the researcher used **Step two**, namely **specifying the procedural elements of the intervention** (i.e. how the aftercare guidelines packaged in a manual format comprising functional aids and strategies can be implemented and put into practice) **concurrently with Step 1 of Phase 4 (early development)**, namely developing a prototype intervention (i.e. the manual with guidelines for aftercare services to CAAs from a Social Work perspective).

- **Conclusions relating to the research methodology**

- The researcher came to the conclusion that the IDD-model as developed by Rothman and Thomas (1994), and specifically the phases and steps utilised in this research project, was an appropriate strategy to follow in view of operationalising the goal of this research study. The utilised Phases and chosen Steps (inherent to each phase) served the researcher well in that they provided her with a road map and framework on how to progress from an articulated research problem to the development of a social technology that can be implemented in practice to address the problem. These characteristics of the present study also confirm that applied research was implemented, as this research endeavour made use of, among others, a descriptive research design to find a solution for the problem of adolescent chemical addiction (cf. Bless et al., 2006:44). On reflection upon the IDD-model and the Phases and Steps utilised, the researcher concluded that Phases 3 and 4 of the model is not as clearly and instructively described as the preceding Phases and Steps, and this challenged her to become creative and add her own interpretations.
- The researcher also concluded that the chosen research methods that were used for operationalising Step 3: Phase 1 (Identifying the concerns of the population) and Step 2: Phase 2 (Studying natural elements) were appropriate and well-suited. The

purposive sampling technique was appropriate to procure participants who could be viewed as “experts” when exploring and describing aftercare needs (relapsed CAAs) and perceptions and experiences of current aftercare services and service delivery to CAAs (social workers). The researcher, however, experienced some difficulty in obtaining adolescent participants who met the criteria for inclusion. A comment from a practitioner in this field gave a possible explanation for this obstacle: “*A contributing factor could be the fact that treatment demands for chemically addicted adolescents are increasing. When admission is considered for addicts applying to enter treatment centres, persons who have not previously had access to treatment are admitted first*” (Du Toit, 2008). Despite this obstacle, the researcher was able to collect data from the adolescent interest group until data saturation was observed, and is this criterion still viewed as appropriate.

- It was concluded that the exploratory, descriptive and contextual research designs within the qualitative research paradigm enabled the researcher to obtain a “thick” description of the data. In addition, the chosen methods of data collection (narrative writing, the focus group interviews and the participant observation) proved to be appropriate in the context of this study. Both interest groups were able to voice their perceptions and experiences in such a way that the research questions were answered adequately. Tesch’s steps (in Creswell, 2009:186) for how to analyse the qualitative generated data were viewed as clear, practical and user-friendly, and assisted the researcher in tackling the daunting task of dissecting the masses of information into smaller pieces and organising them in such a way that the emergence of a larger, consolidated word picture as depicted in Chapters 3 and 4 of this report, became possible.

#### **7.4 Summary of the empirical findings**

The empirical findings will be summarised by focusing firstly on the **research findings related to the aftercare needs of chemically addicted adolescents** presented in Chapter 3. Hereafter the conclusion arrived at will be presented. Secondly, the **social workers’ perceptions and experiences of aftercare services to chemically**

**addicted adolescents** as depicted in Chapter 4 will be summarised and complemented by conclusions.

#### **7.4.1 Research findings: The aftercare needs of chemically addicted adolescents**

- **Demographic data of the chemically addicted adolescents who participated in this study**

A visual presentation of the demographic data of the participating adolescents was provided in Table 3.1 (see p. 105). All the participants in this study were male. Most of the participants were 17 years old. The 19-year-old age group was represented the least in this study. The youngest age group was 14 years of age. Most of the participants came from the Coloured community, followed by the African community, the Asian community, and then the White community. The majority of participants were Afrikaans-speaking, followed by English, IsiXhosa and Se-Sotho. Most of the participants who reported substance use among their parents wrote that their parents were using alcohol, while the minority reported parental use of marijuana, mandrax and methamphetamine. The majority of the participants had completed Grades 8 to 10, while only one participant had completed Grade 12. Methamphetamine was the substance of choice among the majority of the participants, followed by marijuana, alcohol, heroin and cocaine. Regarding treatment opportunity, the majority of the participants were in the treatment centres for the second time.

#### **Themes and sub-themes emanating from the data analysis process related to the aftercare needs of chemically dependent aftercare needs**

Data analysis resulted in a “unique” theme and two themes. These themes, together with sub-themes and a category that emerged from the data, were as follows:

**Unique theme**: Chemically addicted adolescents’ previous experiences with social workers

**Sub-theme 1**: Chemically addicted adolescents reported negative previous experiences with social workers

**Sub-theme 2:** Chemically addicted adolescents reported positive previous experiences with social workers

**Theme 1:** Chemically addicted adolescents have specific expectations of social workers rendering aftercare services

**Sub-theme 1.1:** Chemically addicted adolescents expressed the need and have the expectation for a personal relationship with social workers who render aftercare services to them

**Category 1:** Chemically addicted adolescents' expectations about the relationship qualities to be demonstrated by social workers rendering aftercare services to this client-system

**Sub-theme 1.2:** Chemically addicted adolescents expect social workers to be knowledgeable about addiction and recovery from addiction

**Sub-theme 1.3:** Chemically addicted adolescents requested regular contact with, and availability of, social workers during aftercare

**Theme 2:** Aspects chemically addicted adolescents would like to be assisted with during aftercare

**Sub-theme 2.1:** Participants' need for assistance and skills regarding how to change the old habits relating to their addiction

**Sub-theme 2.2:** Participants need assistance and skills regarding how to break down defence mechanisms

**Sub-theme 2.3:** Participants' need for assistance and skills regarding how to deal with old friends and make new ones

**Sub-theme 2.4:** Participants' need for assistance and skills regarding how to act assertively in an interpersonal context, and how to manage anger and stress

**Sub-theme 2.5:** Participants' need for assistance and skills regarding how to solve problems and make decisions

**Sub-theme 2.6:** Participants' need for assistance and skills regarding how to deal with emotions

**Sub-theme 2.7:** Participants' need for assistance and skills with budgeting

**Sub-theme 2.8:** Participants' need for assistance with regard to planning an after-treatment recovery plan that will prevent relapses, maintain sobriety, and teach how to manage their time

**Sub-theme 2.9:** Participants' need for assistance and skills regarding how to deal with cravings and temptations

**Sub-theme 2.10:** Participants' need for assistance and skills regarding how to develop a realistic self-image

**Sub-theme 2.11:** Participants' need for assistance in relation to their spirituality

**Sub-theme 2.12:** Participants' need for assistance regarding implementation of the NA's 12-Steps Programme

**Sub-theme 2.13:** Participants' need for assistance with finding employment and/or returning to school

**Sub-theme 2.14:** Participants' need for assistance to help rebuild their relationships with their parents and to be reintegrated with their families

**Sub-theme 2.15:** Participants' need for assistance in becoming integrated into their communities

- **Conclusions from the research findings related to the aftercare needs of chemically addicted adolescents**

From the themes, sub-themes, categories, supportive storylines provided in terms of the former, and literature control, the researcher arrived at the following conclusions:

- CAAs' previous experiences of social workers can be categorised as "negative" or "positive". A disregard for and lack of assessment of their personal needs on the side of the social worker; a judgemental attitude of the social worker, and a perceived lack of passion for their work, all contributed to the negative attitudes of some of the participants towards the social workers. Social workers who continued to motivate CAAs to re-enter treatment following a relapse were perceived in a positive light.
- CAAs have a need for a relationship with the social worker rendering aftercare services, and such a relationship should be characterised by trust, a belief that they

can confide in the social worker, openness, genuine interest and a concern for the adolescent, the social worker acting as a role model, objectivity and a non-judgemental attitude (cf. Hepworth et al., 2006:34-42).

- The unavailability and inaccessibility of Social Work aftercare services to CAAs is concerning, and this impacted negatively on the development of a personal, trusting relationship with aftercare workers (cf. Moos & Moos, 2004:89; Arterburn & Burns, 2007:157).
- CAAs have the need and expectation that social workers who render aftercare services should be knowledgeable about addiction and recovery; they must be informed about the content of the treatment programmes which CAAs attend, and be able to assist them to continue with the growth achieved during treatment (cf. Juhnke & Hagedorn, 2006:61).
- CAAs' aftercare needs in terms of the psychosocial functioning are diverse and multi-levelled. On an *intrapersonal* level, they need assistance with dealing with defence mechanisms, changing substance-related behaviour, making lifestyle changes in order to develop a recovery plan that will prevent relapses, addressing feelings that impact on their recovery and developing a realistic self-image (cf. Toseland & Rivas, 2005:286-294). In terms of their *interpersonal* functioning following treatment, assistance from social workers rendering aftercare services is needed to repair CAAs' relationship with families, and to address parental use of chemical substances. In addition, support from aftercare workers is needed regarding developing new friendships with sober peers, and to learn how to deal with substance-using peers who could tempt CAAs following treatment. Another aftercare need is to acquire: effective communication; assertiveness; conflict-management; anger-management; stress-management; and problem-solving and decision-making skills. In addition, there is a need for a focus of aftercare services on life skills with specific reference to budgeting- and time-management skills, as well as skills to deal with cravings and triggers (temptations). These skills are aimed at building resilience to deal with challenges in recovery on an interpersonal level (cf. Toseland & Rivas, 2005: 294-302). CAAs also need assistance in terms of their functioning in relation

to their *environments*. Aftercare should aim to assist CAAs to be reintegrated into and accepted by their communities, and to utilise support groups in the community. Aftercare services also need to address the availability of chemical substances and the chemical substance sub-culture in communities. Finally, as part of the need to be reintegrated into communities, assistance is needed to link with community resources to find work and/or return to school; and to become accepted and part of spiritual activities/accepted back into the church communities (cf. Department of Social Development Western Cape, 2008:1-3).

- Aftercare services to CAAs must be pitched at their level of comprehension and in a language that will be clear and understandable to them.

#### **7.4.2 Empirical findings: Social workers' perceptions and experiences of aftercare services to chemically addicted adolescents**

The empirical findings relating to the perceptions and experiences of social workers regarding aftercare to CAAs, together with a literature control, were provided in Chapter 4. The demographic data relating to this participant group and the themes and sub-themes resulting from the analysis of the data are summarised below.

- **Demographic data of social workers participating in this study**

A visual presentation of the demographic data of the participating social workers was provided in Table 4.1 (see p. 168). Twenty-six of the 29 Social Work participants were female. The majority of the social workers were in the younger age category. Eleven social workers were between 21 and 28 years of age, while seven social workers were between 29 and 35 years, eight social workers were between 36 and 49 years of age, and three were older than 50 years. The language distribution of the Social Work participants was: 19 spoke Afrikaans, seven spoke English, two spoke IsiXhosa, and one spoke Se-Sotho. The cultural distribution of the Social Work participants was: 16 social workers were from the Coloured community, eight were from the White



community and five were from the African community. None of the social workers were from the Asian community. Two social workers had completed their master's degrees in Social Work, while the basic Social Work qualification was the highest educational qualification among the remainder of the sample group. Eleven social workers had one to five years' experience as social workers, six had six to ten years' experience, eight had 11 to 19 years' experience, and four had more than 20 years' experience.

- **Themes and sub-themes emanating from the data analysis process**

Six themes (with accompanying sub-themes) emerged from the analysis of the focus group discussion transcriptions, and are presented below in summary form:

**Theme 1:** Social workers perceive aftercare to chemically addicted adolescents as essential for life-long recovery

**Theme 2:** Social workers' perceptions and experiences of current aftercare services delivered to chemically addicted adolescents

**Sub-theme 2.1:** Although social workers saw aftercare as a "specialised field" of service delivery it was currently not the case in practice

**Sub-theme 2.2:** Social workers' comments on the format and content of aftercare services in practice currently rendered to chemically addicted adolescents

**Theme 3:** Social workers expressed a need for further knowledge relating to aftercare services to chemically addicted adolescents

**Theme 4:** Obstacles experienced by social workers in the rendering of aftercare services to chemically addicted adolescents

**Sub-theme 4.1:** A skills deficiency owing to a lack of training/uncertainty about the nature of training to equip community resources to render effective aftercare service

**Sub-theme 4.2:** The lack of contact and alignment of programmes offered at treatment centres with aftercare service initiatives

**Sub-theme 4.3:** Lack of transport, inaccessibility, lack of knowledge about aftercare services and employment-related challenges

**Sub-theme 4.4:** A high drop-out rate amongst chemically addicted adolescents and lack of commitment to aftercare services

**Sub-theme 4.5:** Difficulties experienced by chemically addicted adolescents in internalising new behaviour

**Sub-theme 4.6:** The lack of time to render aftercare services due to a lack of manpower and funds

**Sub-theme 4.7:** Social workers expressed frustration when there is a lack of resources

**Theme 5:** Social workers' views of the role of the family in aftercare to chemically addicted adolescents

**Sub-theme 5.1:** Families lack insight into the recovery process

**Sub-theme 5.2:** The reintegration of the chemically addicted adolescent into the family

**Sub-theme 5.3:** Families need training and support to be able to support chemically addicted adolescents

**Sub-theme 5.4:** Family members must be supported to address their own problems that impact on recovery potential of chemically addicted adolescents

**Theme 6:** Social workers' suggestions with reference to the development of practice guidelines for rendering aftercare services to chemically addicted adolescents

**Sub-theme 6.1:** Practice guidelines for rendering aftercare services to chemically addicted adolescents should be standardised, and structured in a step-by-step format

**Sub-theme 6.2:** Practice guidelines relating to aftercare services to chemically addicted adolescents should be visual, written in easy language, and should include practical and fun activities

**Sub-theme 6.3:** Guidelines relating to the management, linking and networking of resources

**Sub-theme 6.4:** Aftercare services should be provided through case work, group work and community work as primary methods of Social Work service delivery

**Sub-theme 6.5:** Suggestions relating to the content to be included in guidelines for aftercare services to chemically addicted adolescents

- **Conclusions from the research findings relating to social workers' perceptions and experiences of aftercare services to chemically addicted adolescents**

From the themes, sub-themes, categories and the supportive storylines provided in terms of the former, the researcher arrived at the following conclusions:

- The recovery from chemical addiction is a life-long process (cf. Gorski as cited in Fisher & Harrison, 2005:158). The provision of aftercare services to CAAs is therefore essential; it should form part of the treatment regime, and should not be viewed as an optional service following treatment.
- There seems to be a lack of information amongst social workers about the “what” and the “know-how” relating to the aftercare component of the treatment of CAAs.
- Aftercare services to CAAs are perceived to be a “specialised field” of service delivery (cf. Fisher & Harrison, 2005:155), but in practice this is not currently the case.
- Current service delivery to CAAs is mainly conducted through the case and group work methods of Social Work, and the services planned and rendered focus mainly on assisting the adolescent in acquiring life skills (cf. Marlatt & Gordon, 1985:46; Dodgen & Shea, 2000:119); development of insight into the consequences of the addiction (cf. Falkowski, 2003:65); dealing with the various damages owing to the chemical addiction (cf. Fisher & Harrison, 2005:162-169); reparation of relationships (cf. McTavish, 2004:103); and family therapy (cf. Matrix Institute on Addiction, 2008a:27-30).
- Various obstacles hamper the delivering of current aftercare services to CAAs. These obstacles are situated within the social worker’s own knowledge and skill components (cf. Taleff, 2006:2), the working conditions and work-related realities confronted by social workers (cf. Chilwane, 2009:1) and the disposition of the CAA and his/her family network (cf. Falkowski, 2003:46).
- There is a reported need for guidelines to assist social workers in practice to provide aftercare services to CAAs. Such guidelines should be standardised and structured in a step-by-step format, be visual and in easy language, and include practical and fun activities.
- Treatment and aftercare services to CAA should be coordinated and well managed, and linking and networking between resources should take place.

## **7.5 Summary: Models, guidelines and suggestions from literature relating to aftercare services**

This research endeavour was based on the theoretical framework of the Disease Model of Addiction. Within this framework, services to chemically addicted client-systems are based on the acknowledgement of the progressive nature of chemical addiction, the loss of control over the intake of the substance, and withdrawal when the use of substances is terminated or interrupted (McLellan et al., 2000:689). According to this model, the focus of in- and out-patient services, as well as aftercare, should include the physical, cognitive, emotional, social and spiritual functioning (related to the impact of chemical substances) of the client (Clark, 2009:1). Focusing on aftercare services specifically, areas relating to the recovery process developed and described by Jellinek, (1960:13) provide guidance as to what areas in the client's functioning should receive attention in order to prevent relapses and to assist in the development and restoration of his/her lifestyle.

The researcher focused specifically on literature relating to aftercare and relapse prevention models that referred to the Disease Model of Addiction and were consistent with its characteristics, as this model was widely referred to the literature (cf. White, 2000, Falkowski, 2003; Fisher & Harrison, 2005; Clark, 2009:1). The models that were viewed as relevant were subsequently discussed (see Chapter 5). These models included the Draft Systems Model for Prevention and Aftercare, developed by the Department of Social Development (2008); Relapse Prevention Therapy Model (RPT) of Marlatt and Gordon (1985); Cenaps Model for Relapse Prevention of Gorski (1988); Matrix Model for Recovery and Relapse Prevention of the Matrix Institute on Addiction (2008b); the Treatment Process Model as described by Sussman and Ames (2001); and the Texas Christian University (TCU) Treatment System as described by Simpson (2005). Each of these models was introduced in terms of its characteristics, limitations and applicability for inclusion in the aftercare guidelines developed in this study in Chapter 5. In addition to the literature search for models for aftercare, the researcher extended the search to information, suggestions and guidelines (related to the empirical

findings of this study as well as to the Disease Model of Addiction) focusing on the recovery process of chemical addiction. Resulting from this exercise, the researcher found the following information applicable for inclusion in this study, especially in view of the adoption, adaptation and assimilation thereof in the development of practice guidelines for aftercare services to CAAs: 1) Task-orientated activities to increase resilience (cf. NIDA, 2008:8-9), 2) The recovery process of chemical addiction (cf. Matrix Institute on Addiction, 2008b:2-31), 3) Life skills associated with a recovery lifestyle (cf. Durant & Thakker, 2003:41; Fisher & Harrison, 2005:166-169), 4) including families in aftercare services (cf. Matrix Institute on Addiction, 2008a:27-30), 5) motivational interviewing as a technique in aftercare service delivery (cf. Powis, in Becker, 2005:172-173), and 6) The 12-Steps programme of Narcotics Anonymous (NA) (cf. Fisher & Harrison, 2005:175).

- **Conclusions: Models, guidelines and suggestions from literature consulted relating to aftercare services**

The researcher arrived at the following conclusions based on the models, guidelines and suggestions from literature consulted relating to aftercare services:

- None of the models in the literature consulted were specifically developed for aftercare service delivery to the chemically addicted *adolescent*, underscoring the need for the development of practice guidelines for aftercare service delivery to CAAs.
- There seems to be lack of models indigenous to Social Work focusing on aftercare services to chemically addicted client-systems in general, and CAAs specifically.
- Literature that focused on social service delivery referred to services addressing intrapersonal, intrapersonal and environmental needs of chemically addicted client-systems.
- The literature described services to chemically addicted client-systems aimed at relapse prevention primarily in terms of the development of life skills, as well as the development of a healthy lifestyle to aid in building resilience.

- The models consulted seem to overlap in terms of the focus areas to be addressed in aftercare service delivery and interventions.
- The models consulted are proponents of different approaches (i.e. the systems, cognitive-behavioural, task-centred, and solution-focused approaches) and some overlap in approaches was observed.
- The conclusion was reached that no one approach was better than another, and that all of them had functional elements, that were adopted, adapted and assimilated into the developed practice aftercare guidelines for rendering aftercare services to CAAs from a Social Work perspective.

## **7.6 Summary: Guidelines for aftercare to chemically addicted adolescents from a Social Work perspective**

The empirical findings and a literature study (as summarised and concluded above) culminated in guidelines for aftercare to CAAs from a Social Work perspective. It was presented in the form of a manual which consisted of functional aids and strategies on how to implement the former. In addition, the researcher included information from literature to provide social workers with prerequisite knowledge for rendering aftercare services to CAAs.

The practice guidelines consisted of seven goals: 1) Assessment of the chemically addicted adolescent's functioning and recovery needs following treatment; 2) formulation of aftercare goals and developing an aftercare plan; 3) Attaining the goal of the aftercare plan; 4) interventions addressing the intrapersonal needs of chemically addicted adolescents in aftercare; 5) interventions addressing the interpersonal needs of chemically addicted adolescents in aftercare; 6) interventions addressing the environmental needs and challenges of chemically addicted adolescents in aftercare; and 7) the evaluation and termination of intervention.

- **Conclusions: Guidelines for aftercare to chemically addicted adolescents from a Social Work perspective**

Considering the findings of the empirical component of this research endeavour, as well as existing models, guidelines and suggestions from literature consulted relating to aftercare services, the guidelines resulting from this study aimed to:

- Address intrapersonal, interpersonal and environmental needs of CAAs;
- Provide social workers with prerequisite knowledge, functional aids and strategies on how to implement the former in terms of the Social Work intervention process (i.e. assessment and planning, intervention and monitoring, as well as evaluation and termination of aftercare services to CAAs);
- The goals reflected the requests and suggestions from the participants, as well as pointers from practice. Each goal was described in terms of objectives, together with prerequisite knowledge, functional aids and strategies to implement the former. It is therefore concluded that the goal of this research study was attained, and that the guidelines serve as an indicator thereof.

The conclusions above must, however, also be viewed in terms of the limitations of the study, as described in Chapter 2 (see p. 98). The summaries and conclusions above, together with the consideration of the limitations of this study, were utilised to formulate recommendations, which will be presented in the next section of the chapter.

## **7.7 Recommendations**

The recommendations presented below are structured around the following:

- Recommendations relating to the research methodology employed.
- Recommendations relating to practice, policy and training and education
- Recommendations relating to further and future research.

### 7.7.1 Recommendations related to the research methodology employed

It is recommended that:

- Articles be published by researchers who have employed the IDD-model of Rothman and Thomas (1994) in professional Social Work journals focusing specifically on how they have applied this model in their respective research endeavours.
- Articles be published by researchers and specialists in the field of IDD and development research and the creators of the IDD-model (i.e. Rothman and Thomas themselves) in professional Social Work journals, providing a more detailed, step-by-step guideline or format on the design phase of the model, as it was stated earlier on that the researcher found this step in the model to be non-specific in comparison with the previous phases of the model.
- Researchers be encouraged to utilise the IDD-model of Rothman and Thomas (1994) when encountering social problems requiring intervention through the development of social (human) technologies to address these problems. The value of this continued effort would be that intervention in addressing these social problems would be informed and founded on a research-based knowledge base. (I.e. The phases and steps inherent to the IDD-model ensure that models/programmes/practices/guidelines designed are tailor-made to address the social problems or issues at hand, and are informed by both empirical findings and existing technologies.) The IDD-model is therefore a helpful tool for practice research. Comer et al. (2004:250) confirm this viewpoint when mentioning that this model is “flexible, capitalises on small samples and diverse populations, and explicitly values practitioners’ insights”.
- Researchers must look at the purpose of the research and nature of information or evidence required when setting out on a specific research journey. Where the purpose is to 1) explore and describe an experience, a context, or a process; 2) discover or learn more about a phenomenon; 3) develop an understanding of an



experience or context, and 4) report on an experience, context or process, a qualitative approach is recommended (cf. Ritchie and Lewis, 2005:32).

### **7.7.2 Recommendations related to practice, policy, training and education**

In relation to practice, policy, training and education, the following recommendations are made:

- That the research findings be disseminated in publications in professional journals and be brought to the attention of social workers and other health professionals through talks at meetings, workshops, seminars and symposiums.
- That the research findings be brought to the attention of the general public through talks and presentations at schools, churches, community meetings and talks on the radio, as well as in feature articles in the printed media. The focus should be to highlight the needs of CAAs in aftercare following treatment, as well as their need for support and how support structures in the adolescent's family network and community can be mobilised to assist them during aftercare on their journey to developing a recovery life-style.
- That, in view of the fact that social workers in practice lack knowledge and skills relating to the provision of aftercare services to CAAs, training and education opportunities are recommended in the form of continuous professional development workshops to train social workers and other health professionals in the "how" and "what" of aftercare service delivery to CAAs.
- That, in view of the reported need for knowledge and skills relating to aftercare services to CAAs, the research findings and practice guidelines be provided to tertiary education institutions to be included, where relevant, in curriculums.
- That, in view of the fact that aftercare services to CAAs are perceived as a "specialised field" of Social Work service, but in practice not regarded as such, it is recommended that education and training courses be developed by training

institutions and organisations/individuals specialising in chemical addiction, to train social workers to become specialists in this field.

- That treatment centres adjust and expand their policies on service rendering to incorporate aftercare services to CAAs as part of their menu of services.
- That medical aids be provided with information pertaining to the essential role of aftercare in the treatment of chemical addiction, in order to encourage the adjustments of current policies in this regard so as to cover the costs for aftercare services.
- That treatment centres/organisations/individuals specialising in the field of the treatment and aftercare of chemical addiction be encouraged to write up their models and practices used in interventions with chemically addicted client-systems.

### **7.7.3 Recommendations related to further research**

It is recommended that the researcher, as part of post-doctoral studies, undertake a research project to evaluate the usability of the developed guidelines in practice. In view of this, the following is proposed:

- That desired outcomes should be conceptualised and indicators should be identified in order to monitor the impact of the content of the aftercare manual.
- That the implementation of the guidelines (packaged in manual-format and as functional aid), as well as the outcomes thereof be monitored.
- That the guidelines be refined based on the results of the monitoring process described above.
- That the refined product be disseminated to all the relevant role-players in the field of adolescent chemical addiction (i.e. social workers, social service delivery organisations and treatment centres).

**Research into the following focus areas related to this topic under investigation for future research is recommended:**

- The specific aftercare needs of female chemically addicted adolescents
- The challenges and coping resources of the parents whose children are addicted to chemical substances
- The needs for aftercare services, as identified by the parents of CAAs
- Social workers' perspectives on the usability of the practice guidelines for aftercare to CAA from a Social Work perspective (as developed as an outcome of this study)

## **7.8 Conclusion**

This last chapter of the present research document has provided the reader with a summary and conclusion of 1) the background rational and research problem of this research endeavour, and the research questions, research goal and task objectives; 2) the research methodology implemented in this study; 3) the empirical findings of the study; 4) models, guidelines and suggestions from literature related to the research topic; and 5) the guidelines for aftercare to CAAs from a Social Work perspective. The chapter was concluded with recommendations related to the research methodology employed, practice, policy, training and education, and further research.

The findings of this research study provided insight regarding chemically addicted adolescents' specific aftercare needs following treatment. It is concluded that by addressing these needs in Social Work aftercare service delivery, the relapse potential among these young people could be reduced, and that their ability to reintegrate into their families and communities could be improved. The findings relating to the perceptions and experiences of social workers regarding aftercare services to this client-system has highlighted the need for further training and guidance in this regard. The existing models for aftercare and relapse prevention studied by the researcher did not focus on adolescents specifically. The developed guidelines for aftercare to

chemically addicted adolescents from a Social Work perspective therefore addressed the needs identified through the empirical, as well as the literature study.

The researcher hopes that, through the implementation of the developed guidelines, chemically addicted adolescents will be supported to find meaning in their lives, in order to become valuable members of society following treatment. A quote from the Recovery Devotional Bible (in Becker, 1993:1297) concludes this study:

*“In recovery, we learn what our particular handicaps are. We work on becoming as functional as possible. We use the tools we need (books, counselling, and support groups) to keep up with the stresses of life. We allow ourselves time and space to work out our recovery – and we understand that God allows us the same.”*

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## Annexure A: Letter of invitation to adolescent treatment centres

**For attention:** \_\_\_\_\_

I, Marichen van der Westhuizen, the undersigned, am a lecturer in Social Work in service of the Huguenot Collect in Wellington, and also a part-time doctorate student in the Department of Social Work at the University of South Africa. In fulfilment of requirements for the doctoral degree, I have to undertake a research project and have consequently decided to focus on the following research topic: **Aftercare to chemically addicted adolescents: practice guidelines from a social work perspective.**

In view of the fact that **your patients are best informed** to speak authoritatively about the topic, I hereby approach you with the request to participate as a “gatekeeper”, allowing me access to your patients, in the study. For you to decide whether or not to participate in this research project, I will provide you with information regarding the need for the study, the goal of the study, what your patients will be requested to do during the study, the risks and benefits involved by participating in this research project, and their rights as participants in this study.

This research project originated as a result of a **need** for practice guidelines relating to aftercare services to chemically addicted adolescents following treatment, as identified by role-players in the field of services to chemically addicted adolescents. It is also based on the specific needs of chemically addicted adolescents, as identified through a previous research study among relapsed chemically addicted adolescents. The **aim** is to develop practice guidelines for social work aftercare services to chemically addicted adolescents. The information gathered from this study **contributes** towards the planning and execution of aftercare services to chemically addicted adolescents.

Should you agree to participate, your patients would be requested to participate in **writing one essay** on the following topic: **The things social workers can help me with to maintain my sobriety after treatment.** It is estimated that the exercise will last approximately 60 minutes.

The essays will be kept strictly **confidential**. The patient's name will not appear on the essay to protect his/her identity. The essays will be stored in a safe place and only I will have access to them. The essays will be made available to my research promoters, a translator (if needed), and an independent coder with the sole purpose of assisting and guiding me with this research undertaking. They will each sign an undertaking to treat the information shared by the patient in a confidential manner. The narratives will be destroyed upon the completion of the study. Please note that participation in the research is completely voluntary. Your patients are not obliged to take part in the research.

The patients that I would like to include as part of this research project should comply with the following **criteria for inclusion**: 1) Chemically addicted adolescents 2) who previously underwent in-patient treatment 3) relapsed thereafter, 4) currently back in treatment in-patient programmes 5) in the Western Cape. The sample will include Afrikaans-, English- and Xhosa-speaking adolescents between the ages of 11 and 21 years, from both genders.

If you have any questions/concerns about the study, contact me at the following number: 021-8731181. Please note that this study has been approved by the Research and Ethics Committee of the Department of Social Work at Unisa. Should you have any questions/queries not sufficiently addressed by me, you are more than welcome to contact the Chairperson of the Research and Ethics Committee of the Department of Social Work at Unisa. His contact details are as follows: Dr AH (Nicky) Alpaslan, telephone number: 012 429 6739, or email [alpasah@unisa.ac.za](mailto:alpasah@unisa.ac.za), or the Chairperson, Human Ethics Committee, College of Human Science, PO Box 392, Unisa, 0003.

Based upon all the information provided to you above, I would like to ask for your assistance to introduce me to patients who comply with the criteria for inclusion stated above in view of participation in this study.

Kind regards: Marichen van der Westhuizen \_\_\_\_\_

## **Annexure B: Letter of invitation to adolescent participants**

**For attention:** \_\_\_\_\_

I, Marichen van der Westhuizen, the undersigned, am a lecturer in Social Work at the Huguenot College in Wellington, and also a part-time doctorate student in the Department of Social Work at the University of South Africa. For the doctoral degree, I have to undertake a research project and have consequently decided to focus on the following research topic: **Aftercare to chemically addicted adolescents: guidelines for social workers.**

In view of the fact that **you have the necessary knowledge and experience** to speak about the topic, I hereby request you to take part in the study. For you to decide whether or not to take part in this research project, I will provide you with information regarding the need for the study, the goal of the study, what you will be asked to do during the study, the risks and benefits when taking part in this research project, and your rights as participants in this study

This research project is based on a **need** for aftercare guidelines to help social workers to assist teenagers following treatment, as identified by both social workers and teenagers who have relapsed following treatment. The **aim** is therefore to develop such practice guidelines.

Should you agree to take part, you would be asked to **write one essay** on the following topic: **The things social workers can help me with to maintain my sobriety after treatment.** It is estimated that the exercise will last approximately 60 minutes.

Your essay will be kept strictly **confidential**. Your name will not appear on the essay to protect your identity. It will be stored in a locked place and only I will have access to them. The essay will be made available to my research promoters, a translator (if needed), and an independent coder with the sole purpose of assisting and guiding me



with this research project. They will each sign an undertaking to treat the information shared by you in a confidential manner. Your essay will be destroyed upon the completion of the study. Please note that your participation is completely voluntary. Your decision to participate, or not to participate, will not affect you in any way now or in the future. Should you agree to take part and sign the information and informed consent document herewith, as proof of your willingness to participate, please note that you are not signing your rights away. If you agree to take part, you have the right to change your mind at any time during the study. As the researcher, I also have the right to dismiss you from the study if you fail to follow the instructions or if the information you have to share upsets you. Should I conclude that the information you have shared left you feeling upset, I am obliged to refer you to a counsellor for debriefing or counselling (should you agree).

If you have any questions/concerns about the study, contact me at the following number: 021-8731181. Please note that this study has been approved by the Research and Ethics Committee of the Department of Social Work at Unisa. Should you have any questions/queries not sufficiently addressed by me, you are more than welcome to contact the Chairperson of the Research and Ethics Committee of the Department of Social Work at Unisa. His contact details are as follows: Dr AH (Nicky) Alpaslan, telephone number: 012 429 6739, or email [alpasah@unisa.ac.za](mailto:alpasah@unisa.ac.za), or the Chairperson, Human Ethics Committee, College of Human Science, PO Box 392, Unisa, 0003.

Based upon all the information provided to you above, you are asked to give your written consent should you want to take part in this research by signing and dating the information and consent form provided herewith and initialling each section to indicate that you understand and agree to the conditions.

Thank you for your participation

Marichen van der Westhuizen \_\_\_\_\_

## **Annexure C: Letter of invitation to parent/parents/guardians of adolescent participants**

**For attention:** \_\_\_\_\_

I, Marichen van der Westhuizen, the undersigned, am a lecturer in Social Work in service of the Huguenot Collect in Wellington, and also a part-time doctorate student in the Department of Social Work at the University of South Africa. In fulfilment of requirements for the doctoral degree, I have to undertake a research project and have consequently decided to focus on the following research topic: **Aftercare to chemically addicted adolescents: practice guidelines from a social work perspective.**

In view of the fact that **your child is best informed about the topic**, I hereby approach you with the request to allow him/her to participate in the study. For you to decide whether or not to allow him/her to participate in this research project, I will provide you with information regarding the need for the study, the goal of the study, what he/she will be requested to do during the study, the risks and benefits involved by participating in this research project, and their rights as participants in this study.

This research project is based on a **need** for aftercare guidelines to help social workers to assist teenagers following treatment, as identified by both social workers and teenagers who have relapsed following treatment. The **aim** is therefore to develop such practice guidelines.

If you agree to your child's participation, he/she would be requested to participate in **writing one essay** on the following topic: **The things social workers can help me with to maintain my sobriety after treatment.** It is estimated that the exercise will last approximately 60 minutes.

Your child's essay will be kept strictly **confidential**. His/her name will not appear on the essay to protect his/her identity. The essay will be stored in safe place and only I will

have access to them. The essays will be made available to my research promoters, a translator (if needed), and an independent coder with the sole purpose of assisting and guiding me with this research undertaking. They will each sign an undertaking to treat the information shared by him/her in a confidential manner. Please note that participation in the research is completely voluntary. You are not obliged to allow your child to take part in the research. His/her decision to participate [based on your allowance thereof], or not to participate, will not affect him/her in any way. If you agree to allow your child to participate and sign the information and informed consent document herewith, as proof of your willingness to participate, please note that you are not signing your rights away. Your child is free to withdraw from the research without any loss of benefits. As the researcher, I also have the right to dismiss your child from the study if he/she fails to follow the instructions or if the information he/she has to divulge is emotionally sensitive. Should I conclude that the information he/she have shared left him/her feeling emotionally upset, I am obliged to refer him/her to a counsellor for debriefing or counselling (should he/she agrees).

If you have any questions/concerns about the study, contact me at the following number: 021-8731181. Please note that this study has been approved by the Research and Ethics Committee of the Department of Social Work at Unisa. Should you have any questions/queries not sufficiently addressed by me, you are more than welcome to contact the Chairperson of the Research and Ethics Committee of the Department of Social Work at Unisa. His contact details are as follows: Dr AH (Nicky) Alpaslan, telephone number: 012 429 6739, or email [alpasah@unisa.ac.za](mailto:alpasah@unisa.ac.za), or the Chairperson, Human Ethics Committee, College of Human Science, PO Box 392, Unisa, 0003.

Based upon all the information provided to you above, and being aware of your rights, you are asked to give your written consent should you want to allow your child to participate in this research study by signing and dating the information and consent form provided herewith and initialling each section to indicate that you understand and agree to the conditions.

Thank you for your participation, Marichen van der Westhuizen \_\_\_\_\_

## Annexure D: Informed Consent Form

### Chemically addicted adolescents and their parents/guardians

TITLE OF RESEARCH PROJECT: Aftercare to chemically addicted adolescents:  
practice guidelines from a social work perspective

REFERENCE NUMBER OF PARTICIPANT: \_\_\_\_\_

**PRINCIPAL RESEARCHER:** **Marichen Ann van der Westhuizen**

Address: PO Box 16

Wellington

7654

Contact number: 021-8731181

<p><b>DECLARATION BY OR ON BEHALF OF THE PARTICIPANT:</b></p> <p>I, THE UNDERSIGNED, _____ (name), [ID No: _____] the participant or in my capacity as _____ of the participant [ID No _____] of _____ (address)</p> <p><b>A. HEREBY CONFIRM AS FOLLOWS:</b></p> <p>1. I/the participant was invited to participate in the above research project which is being undertaken by Marichen van der Westhuizen under the guidance of the Department of Social Work in the School of Social Science and Humanities at the University of South Africa, Pretoria, South Africa.</p>	<p><u>Initial</u></p>
<p>2. The following aspects have been explained to me/the participant: Aim: The researcher is undertaking a research project with the aim of developing practice guidelines that will assist social workers in rendering aftercare services to chemically addicted adolescents.</p>	<p><u>Initial</u></p>
<p>2.1 I understand that</p> <ul style="list-style-type: none"> <li>• I will have access to the results of this project.</li> <li>• My/the participant's anonymity is ensured and that I/he/she will enter this project on a voluntary basis.</li> <li>• I/myself, on behalf of the participant, can withdraw from the project at any time.</li> <li>• Only the researcher, translator (if needed), editor, independent coder and the researcher's promoters will have access to data.</li> </ul>	<p><u>Initial</u></p>
<p>2.2 I identify the following concerns and possible risks in this study: The information that I share might unsettle me emotionally. Should that in any</p>	<p><u>Initial</u></p>

<p>way happen, I may voluntarily withdraw from the study without penalty. Should the researcher come to the conclusion that this exercise is harming me in any way, she might exercise the right to withdraw me from the study and/or refer me to counselling services which I have the right to decide whether or not to use.</p>	
<p>Possible benefits: As a result of my participation in this study I understand that it could lead to practice guidelines that can assist social workers to support me with my efforts to remain sober.</p>	<u>Initial</u>
<p>3. The information above was explained to me by _____ in Afrikaans/English/Sotho/Xhosa/Zulu/other _____ and I am in command of this language/it was translated to me satisfactorily by _____. I was given the opportunity to ask questions and all these questions were answered satisfactorily.</p>	<u>Initial</u>
<p>4. No pressure was exerted on me to consent to participate and I understand that I may withdraw at any stage from the study without any penalty.</p>	<u>Initial</u>
<p>5. Participation in this study will not result in any additional cost to me.</p>	<u>Initial</u>
<p><b>B. I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE PROJECT.</b></p> <p>Signed/confirmed at _____ on _____ 20__</p> <p>_____ Signature or right thumbprint of participant</p> <p>_____ Signature of witness</p>	

## Social workers

TITLE OF RESEARCH PROJECT: Aftercare to chemically addicted adolescents:  
practice guidelines from a social work perspective

REFERENCE NUMBER OF PARTICIPANT: \_\_\_\_\_

**PRINCIPAL RESEARCHER:** Marichen Ann van der Westhuizen

Address: PO Box 16

Wellington

7654

Contact number: 021-8731181

<p>DECLARATION BY THE PARTICIPANT:</p> <p>I, THE UNDERSIGNED, _____ (name), [ID No: _____] the participant of _____ _____ _____(address)</p> <p><b>A. HEREBY CONFIRM AS FOLLOWS:</b></p> <p>1. I was invited to participate in the above research project which is being undertaken by Marichen van der Westhuizen under the guidance of the Department of Social Work in the School of Social Science and Humanities at the University of South Africa, Pretoria, South Africa.</p>	<p><u>Initial</u></p>
<p>2. The following aspects have been explained to me/the participant: Aim: The researcher is undertaking a research project with the aim of developing practice guidelines that will assist social workers in rendering aftercare services to chemically addicted adolescents.</p>	<p><u>Initial</u></p>
<p>3. I understand that</p> <ul style="list-style-type: none"> <li>• I will have access to the results of this project.</li> <li>• My anonymity is ensured and that I will enter this project on a voluntary basis.</li> <li>• I can withdraw from the project at any time.</li> <li>• Only the researcher, translator (if needed), editor, independent coder and the researcher's promoters will have access to data.</li> </ul>	<p><u>Initial</u></p>
<p>4. I identify the following concerns and possible risks in this study: The information that I share might unsettle me emotionally. Should that in any way happen, I may voluntarily withdraw from the study without penalty. Should the researcher come to the conclusion that this exercise is harming me in any way, she might exercise the right to withdraw me from the study and/or refer me to counselling services which I have the right to decide whether or not to use.</p>	<p><u>Initial</u></p>
<p>5. Possible benefits: As a result of my participation in this study I understand that it could lead to practice guidelines that can assist social</p>	<p><u>Initial</u></p>

workers to support chemically addicted adolescents with their efforts to remain sober.	
6. The information above was explained to me by _____ in Afrikaans/English/Sotho/Xhosa/Zulu/other _____ and I am in command of this language/it was translated to me satisfactorily by _____. I was given the opportunity to ask questions and all these questions were answered satisfactorily.	<u>Initial</u>
7. No pressure was exerted on me to consent to participate and I understand that I may withdraw at any stage from the study without any penalty.	<u>Initial</u>
8. Participation in this study will not result in any additional cost to me.	<u>Initial</u>
<p><b>B. I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE PROJECT.</b></p> <p>Signed/confirmed at _____ on _____ 20__</p> <p>_____ Signature of participant</p> <p>_____ Signature of witness</p>	

## Annexure E: Letter of invitation to social workers

**For attention:** \_\_\_\_\_

I, Marichen van der Westhuizen, the undersigned, am a lecturer in Social Work in service of the Huguenot Collect in Wellington, and also a part-time doctorate student in the Department of Social Work at the University of South Africa. In fulfilment of requirements for the doctoral degree, I have to undertake a research project and have consequently decided to focus on the following research topic: **Aftercare to chemically addicted adolescents: practice guidelines from a social work perspective.**

In view of the fact that **you are well-informed about the topic**, I hereby approach you with the request to participate in the study. The purpose of this research is not to evaluate your services, but only to develop an understanding. For you to decide whether or not to participate in this research project, I will provide you with information regarding the need for the study, the goal of the study, what you will be requested to do during the study, the risks and benefits involved by participating in this research project, and your rights as a participant in this study.

This research project originated as a result of a **need** for practice guidelines relating to aftercare services to chemically addicted adolescents following treatment, as identified by role players in the field of services to chemically addicted adolescents. It is also based on the specific needs of chemically addicted adolescents, as identified through a previous research study among relapsed chemically addicted adolescents. The **aim** is to develop practice guidelines for social work aftercare services to chemically addicted adolescents. The information gathered from this study **contributes** towards the planning and execution of aftercare services to chemically addicted adolescents.

Should you agree to participate, you would be requested to participate in one focus group. It is estimated that the interview will last approximately 60 minutes. During the interview the following questions will be directed to you:

- What are your views in general regarding aftercare services?



- Tell me about the services you employ to address aftercare to chemically addicted adolescents.
- What resources are available to you to support your work?
- What restrictions do you experience?
- If you have to compile practice guidelines for social workers in view of rendering after care services to chemically addicted adolescents, what would you include?

With your permission, the interview will be audio taped. The recorded interviews will be transcribed word-for-word. Your responses to the interview (both the taped and transcribed versions) will be kept strictly confidential. The audiotape will be coded to disguise any identifying information. The tapes will be stored in a safe place and only I will have access to them. The transcripts (without any identifying information) will be made available to my research promoters, a translator (if needed), and an independent coder with the sole purpose of assisting and guiding me with this research undertaking. They will each sign an undertaking to treat the information shared by you in a confidential manner. The audiotapes and the transcripts of the interviews will be destroyed upon the completion of the study. Please note that participation in the research is completely voluntary. Your decision to participate, or not to participate, will not affect you in any way. Should you agree to participate and sign the information and informed consent document herewith, as proof of your willingness to participate, please note that you are not signing your rights away. If you agree to take part, you have the right to change your mind at any time during the study. However, if you do withdraw from the study, you would be requested to grant me an opportunity to engage in informal discussion with you so that the research partnership that was established can be terminated in an orderly manner. As the researcher, I also have the right to dismiss you from the study if you fail to follow the instructions or if the information you have to divulge is emotionally sensitive and upset you to such an extent that it hinders you from functioning physically and emotionally in a proper manner. Should I conclude that the information you have shared left you feeling emotionally upset, or perturbed, I am obliged to refer you to a counsellor for debriefing or counselling (should you agree).

You will be included in this research if you comply with the following **criteria for inclusion**: 1) Registered social workers, 2) employed by the Department of Social Development and NGO's in the Western Cape 3) rendering services to chemically addicted adolescents. The sample will include Afrikaans and English speaking participants.

If you have any questions/concerns about the study, contact me at the following number: 021-8731181. Please note that this study has been approved by the Research and Ethics Committee of the Department of Social Work at Unisa. Should you have any questions/queries not sufficiently addressed by me, you are more than welcome to contact the Chairperson of the Research and Ethics Committee of the Department of Social Work at Unisa. His contact details are as follows: Dr AH (Nicky) Alpaslan, telephone number: 012 429 6739, or email [alpasah@unisa.ac.za](mailto:alpasah@unisa.ac.za), or the Chairperson, Human Ethics Committee, College of Human Science, PO Box 392, Unisa, 0003.

Based upon all the information provided to you above, and being aware of your rights, you are asked to give your written consent should you want to participate in this research study by signing and dating the information and consent form provided herewith and initialling each section to indicate that you understand and agree to the conditions.

Thank you for your participation.

Marichen van der Westhuizen

## Annexure F: Statement by the researcher, translator, promoter and independent coder

<p><b>DECLARATION BY RESEARCHER</b></p> <p>I, _____, declare that</p> <ul style="list-style-type: none"> <li>• I have explained the information given in this document to _____ and/or his/her representative _____;</li> <li>• he/she was encouraged and given ample time to ask me any questions;</li> <li>• this conversation was conducted in Afrikaans/English/Sotho/Xhosa/Zulu/other _____ and this conversation was translated into _____ by _____.</li> </ul> <p>Signed at _____ on _____ 20____ (place) (date)</p> <p>_____ Signature of investigator/representative</p> <p>_____ Signature of witness</p>	
<p><b>DECLARATION BY TRANSLATOR</b></p> <p>I, _____, confirm that I</p> <ul style="list-style-type: none"> <li>• translated the content of this document from English into _____ to the participant/participant's representative;</li> <li>• explained the content of this document to the participant/participant's representative;</li> <li>• also translated the questions posed by _____, as well as the answers given by the investigator/representative, and</li> <li>• conveyed a factually correct version of what was related to me.</li> </ul> <p>Signed at _____ on _____ 20____ (place) (date)</p> <p>_____ Signature of translator</p> <p>_____ Signature of witness</p>	
<p><b>DECLARATION BY PROMOTER</b></p> <p>I, _____, confirm that I</p>	



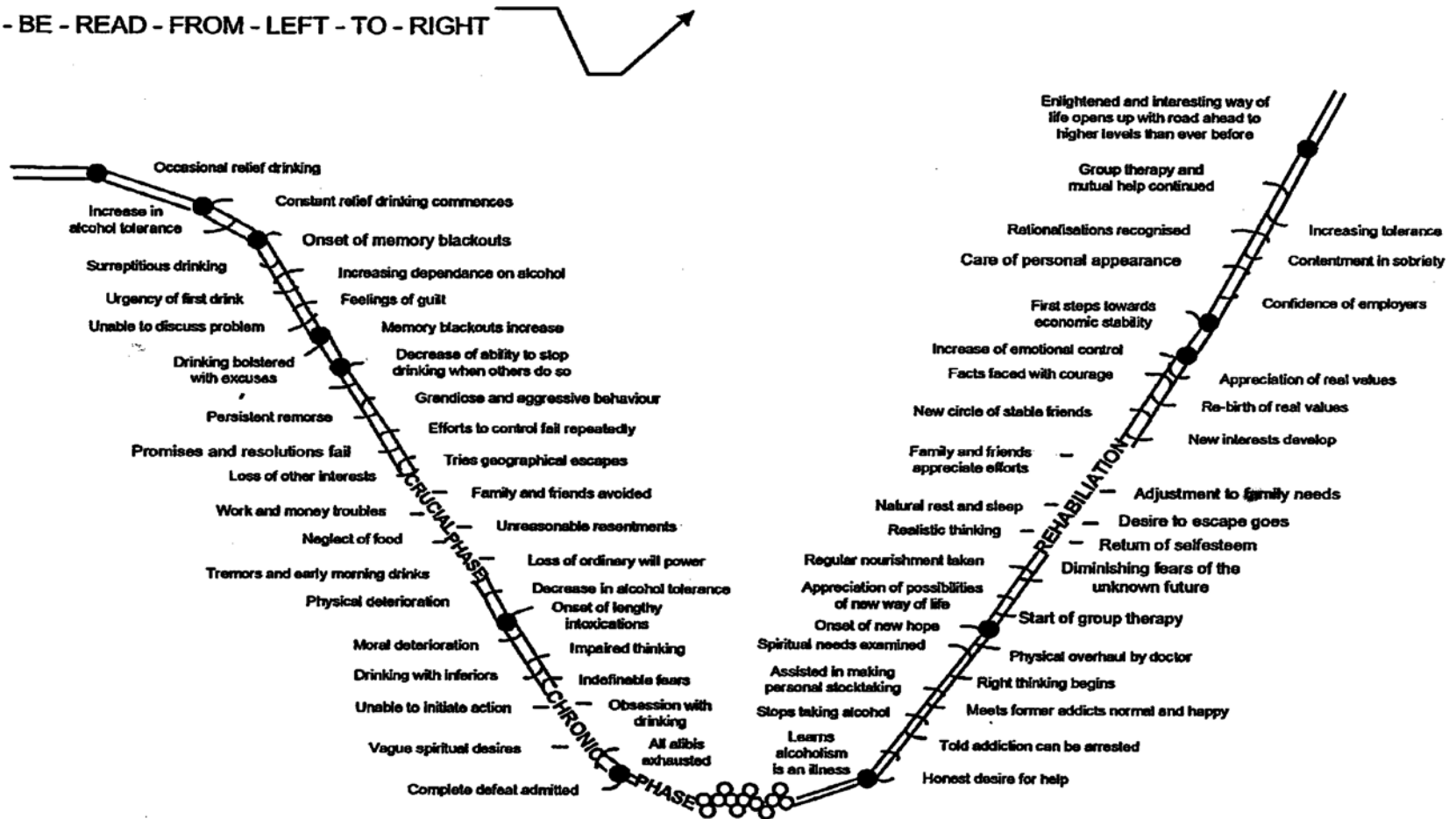
## **Annexure G: Guidelines for the writing of narratives**

When writing the essays on *the things social workers can help me with to maintain my sobriety after treatment* it is important that you give me your own ideas and stories. You should not be influenced by your fellow patients when writing your story. Therefore you will be requested to write the essays in the following manner:

- You will be seated on your own
- You will not be allowed to talk to the fellow patients during this time
- Should you have any concerns or requests during that time, you are requested to call the researcher
- Should you feel tired or in need of a break, you will be escorted by the social worker when leaving the room

Annexure H: Jellinek curve

TO - BE - READ - FROM - LEFT - TO - RIGHT



Obsessive drinking continues in vicious circles

The Jellinek Chart of Alcohol Addiction and Recovery