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PREVENTING RELAPSES AMONGST CHEMICALLY ADDICTED ADOLESCENTS: EXPLORING THE STATE OF CURRENT SERVICES

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INTRODUCTION

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, 2006:13). A report from the South African Community Epidemiology Network on Drug Abuse (2007:3) highlights that, of the 2 798 persons who received in-patient treatment in the Western Cape, 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 itself, and also after-care services to ensure that the addicted adolescent develops skills to maintain sobriety (Meyer, 2005:292-293). The objectives of the new Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, highlight the point that chemically addicted persons should have access to professional after-care 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 after-care services, indicating the lack of focus on after-care as part of treatment. This concern was confirmed by findings that resulted from previous research regarding relapse experiences of chemically addicted adolescents (Van der Westhuizen & De Jager, 2009:76).

Theoretical background and rationale

Treatment of adolescent chemical addiction is a worldwide challenge. Mood-altering substances are more likely to be used by younger people, thereby putting them at risk of HIV infection and AIDS, crime, violence and accidents (Falkowski, 2003:8). A National Institute on Drug Abuse (2006) survey in America reported an increase in adolescent chemical addiction. It was reported that adolescent chemical addiction is related to a multitude of problems for the public health system, government and American families (Caroufek, 2007:4; McWhirter *et al.*, 2004:117). On the local level, chemical addiction among South African adolescents is becoming increasingly prevalent. In Gauteng a survey among adolescents has shown that 26.1% of Grades 8-11 learners engaged in binge drinking (Department of Health/Medical Research, 2003:102-103). Chemical substances are also readily available to South African adolescents (Dimoff, 2007:2). 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).

In the Western Cape, where this study was conducted, adolescents' methamphetamine addiction in particular has taken Cape Town by storm. A remarkable increase in patients giving methamphetamine as their primary chemical substance of choice has been noted (Caelers, 2005:1; Plüddeman *et al.*, 2007:12). A higher proportion of substance-related injuries have also

been reported in the Cape Town Metropole than in other sites in South Africa (Matzoupolos, 2005:6). Chemical substance-related crimes in the Western Cape increased from 19 940 in 2003/2004 to 30 432 in 2004/2005 (Western Cape Department of Social Development, 2007:15).

In order to understand the issue of chemical addiction, it is important to consider its nature, as "multiple patterns of dysfunctional substance use … occur in multiple types of personalities, with multiple combinations of adverse consequences" (Fisher & Harrison, 2005:49). These consequences lead to "clinically significant impairment or distress" in terms of changes in behaviour, mood and thought, and is associated with self-defeating behaviour (Schlebush, 2005:135). On the other hand, adolescence is characterised by a search for independence and experimentation, which puts youngsters at risk of chemical addiction (Youth at the United Nations, 2006). It is estimated that 20% of adolescents who experiment with chemical substances move to addiction (United Nations Office on Drugs and Crime, 2002:22). Adolescents suffering from chemical addiction are a major public health problem. This addiction puts them at risk of 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 (World Health Organisation, 2004:12).

As a result of the increase in adolescent chemical addiction, the demand for treatment of chemically addicted adolescents (hereafter primarily referred to as CAAs[1]) 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. However, Gorski (2001:1) indicates a relapse rate after treatment of 58%. Exploring this high relapse potential, a study by Satre, Mertens, Arean and Weisner (2004:1296) found that young people experience more pressure to use chemical substances and that their relapse potential is therefore higher.

Regarding effective treatment to produce positive change and to reduce relapse potential, an adequate treatment period of between eight and 18 months, and ongoing after-care services are recommended (Gordon, 2003:18). Meyer (2005:292-293) differentiates between three phases in treatment, namely detoxification, treatment programmes and after-care. An after-care period as part of treatment of between 12 and 24 months is advised in order to promote lifetime recovery (Health Resources, 2004). In conclusion, Gorski (2001:4) concurs that ongoing treatment in the form of after-care is vitally important in preventing adolescent relapse. The table below illustrates the key components of relevant after-care models found in the literature.

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[1] Continuous reference to "adolescents who are addicted to chemical substances" and "who had relapsed following treatment" is cumbersome. "Chemically addicted adolescents" has therefore been abbreviated to "CAAs". No labelling, however, is intended.

TABLE 1
KEY COMPONENTS OF AFTER-CARE MODELS

Draft Systems Model for Prevention and After-care (Western Cape Department of Social Development, 2008)	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: ● Coping skills ● Lifestyle change ● Developing a healthy self-image ● Increase intrinsic motivation ● Activities that lead to a sense of achievement ● Linking the client with resources and services in the community ● Encouragement to broaden the support system ● Development of an after-care plan for the client, as well as for the family
Relapse Prevention Therapy (Marlatt & Gordon, 1985)	The aim is to address risk factors and protective factors The cognitive-behavioural approach underscores: ● Addressing unrealistic negative ideas and attitudes ● Adoption of different behaviour by replacing chemical substances with joyful activities Focus areas: ● Motivational enhancement training ● Management of cravings ● Dealing with high-risk situations ● General coping skills ● Management of withdrawal symptoms ● Development of social skills ● Development of life skills ● Dealing with feelings of guilt and failure ● Lifestyle changes ● Assistance with a lapse ● Practical plan to prevent relapse
Cenaps Model for Relapse Prevention (Gorski, 1988)	The following stages of treatment are included in after-care: ● Middle recovery period: development of a balanced living goal ● Late recovery period: personality and behavioural changes ● Maintenance period: continued growth and development Elements associated with the behavioural approach to be included in after-care: ● Rewards for change in behaviour ● Task-orientated activities associated with desired behaviours ● Rehearsal of new behaviours ● Stimulus control ● Control of urges Elements associated with the cognitive approach to be included in after-care: ● Awareness of dysfunctional thoughts/perceptions ● Addresses low self-esteem, unrealistic expectations, irrational fears, depression and lack of assertiveness

	Focus areas of the Cenaps Model: • Recognition of the addiction • Dealing with prolonged withdrawal symptoms • Abstinence from all chemical substances • Acceptance of the addiction and development of non-chemical coping strategies • Recognition and treatment of other problems related to the addiction • Separation from people, places and things that threaten recovery • Development of a social support network • Development of an ongoing recovery plan • Identification and management of emotions and behaviours • Maintaining continued growth and development
Matrix Model for Recovery and Relapse Prevention (Matrix Institute on Addiction, 2008)	Service delivery is based on the cognitive-behavioural approach Characteristic of after-care are: • Lifestyle changes • Relapse prevention education • A non-judgemental approach when relapses occur • Motivational interviewing to deal with relapses and defence mechanisms • Inclusion of families • Implementation of individual and group therapy • Encouragement to use self-help groups • Includes networks with schools and community facilities • Enhancement of motivation for change • Skills in dealings with cravings • Skills to participate in non-chemical substance-using activities • Problem-solving skills • Relationship skills
Treatment Process Model (Sussman & Ames, 2001)	Focus of after-care: • Motivational techniques to continue with after-care • Maintenance of behavioural and cognitive changes Focus of coordination of service delivery: • Content of treatment programme • Behavioural and cognitive changes made in treatment • Identification of any subsequent needs to be addressed in after-care
Texas Christian University (TCU) Treatment System (Simpson, 2005)	Focuses on repeated assessments of: • The client's special needs • Organisational factors to increase effectiveness and adaptability of services Psychosocial intervention based on the cognitive-behavioural approach focuses on: • Alteration of thoughts • Belief systems • Behaviour The organisational structure must be assessed and adjusted according to • The motivation of staff • Availability, mobilisation and utilisation of resources • Organisational climate

The researchers have 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 after-care as the complete treatment package. If after-care is neglected, the addict does not complete the whole treatment process, which will impact negatively on the ability to maintain sobriety.

The situation outlined above is receiving international and national recognition. Both the United Nations' World Programme of Action for Youth and the Western Cape Drug Forum's business plan identified a definite need for social research on the treatment of adolescent substance abuse (Western Cape Drug Forum, 2005:3; Youth at the United Nations, 2006). An initial literature survey of recent studies revealed that there seems to be a lack of knowledge about the nature and challenges of after-care service delivery to CAAs (Bozalek, Henderson, Lambert, Collins & Green, 2007:33; Brandt & Delport, 2005:163-174; Department of Health/Medical Research, 2003:102-103; Noyoo, Patel & Loffell, 2006:97; Van den Berg, 2003:156-196).

This article provides a description of the perceptions and experiences of social workers relating to after-care services to CAAs and is based on the findings of a qualitative research study.[2] The rationale behind the study is that a better understanding of the nature and challenges of social work after-care services to CAAs will assist with the future planning and execution of services.

The ensuing sections of this article will focus on the problem statement, followed by a brief discussion of the research methodology employed and descriptions of the key concepts. The demographic details of the participants in this study will be provided, after which the findings will be discussed and compared with the relevant literature. The article will end with some concluding remarks and recommendations to social workers and organisations involved with service delivery to CAAs.

Problem statement

The objectives of the new Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, highlight the point that CAAs should have access to professional after-care services. However, the Western Cape Drug Forum (2005:3) identified the need for the development of after-care services, indicating the lack of focus on after-care as part of treatment. In the light of this serious matter of a statutory stipulation being disregarded, it is imperative that the issue of after-care services to CAAs in the Western Cape receives attention. The intention of this investigation is to contribute towards improving this situation.

Research methodology

The research question flowing from the research problem, as discussed in the previous section, is: *What are the perceptions and experiences of social workers involved in services to CAAs regarding after-care services*? This section provides a brief description of the research methodology employed to answer the research question.

The goal of this research was to develop an understanding of the perceptions and experiences of social workers relating to after-care services in this field, and to make recommendations to assist social workers and organisations involved with service delivery to CAAs with the future planning and execution of services.

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[2] The article is based on a broader research study conducted for a doctoral degree at the University of South Africa, completed in 2010.

A qualitative research approach was employed. The primary interest was in the meaning that social workers attached to after-care services to CAAs (Babbie & Mouton, 2007:49-54) in order to make recommendations for future planning and execution of services. An exploratory research design was employed as the literature and previous studies do not focus on the nature of, and challenges to, current after-care services to CAAs, thus indicating a need for further elucidation of the topic (Babbie & Mouton, 2007:79). In order to further contribute towards a better objective understanding of the nature of current after-care services, as experienced by social workers involved with services to CAAs (Fox & Bayat, 2007:8), a descriptive research design was employed.

The research question guided the decision on the population for this study (Kumar, 2005:149). The total population for this study was defined as follows: all social work service providers dealing with adolescent chemical addiction in the Western Cape. A sample of the population was selected in order to enhance the validity of the study (Walliman, 2001:232). The criterion for inclusion in the study was: registered social workers employed by the Department of Social Development or non-governmental social work organisations (NGOs), providing after-care services to CAAs in the Western Cape. Alston and Bowles (2003:90) advise that participants in interviews be selected on the basis of relevance to the topic. Purposive sampling was therefore employed to provide the researcher with a sample to access some specialised insights into the phenomena of interest. The sample size for this study was determined by data saturation, i.e. the point at which the information became repetitive (Bless, Higson-Smith & Kagee, 2006:107-108).

The researcher collected the data through seven focus groups with 29 social workers from four different organisations, and data were recorded by means of transcripts of the focus group interviews and field notes. Tesch's framework for data analysis (in Creswell, 2009:186) was employed, while data verification was conducted through Guba's model (in Krefting, 1991:214-222), which included triangulation, peer examination, a dense description of the research methodology, and the use of an independent coder.

A limitation of this study was that only one focus group was conducted with social workers working at the Department of Social Development, thus limiting the input from this group.

Ethical considerations that guided the research were as follows: informed consent was obtained by means of consent forms signed by participants; protection from harm to participants was ensured through safe environments in which the focus groups were conducted; the right to privacy and confidentiality of the data was addressed as participants were not forced to share their experiences and were informed that they could withdraw from the focus groups at any time. Furthermore, participants were informed that only the researcher, editor and independent coder, as well as the researcher's study leaders, would have access to the tape recordings and transcripts.

The following two sections will describe the key concepts of the research, as well as provide the demographic details of the participants to the study, which will form the basis for the discussion of the findings.

Clarification of key concepts

For the purpose of this research, an *adolescent* will be defined as a person between the ages of 11 and 21 years (Louw & Louw, 2007:281-282).

After-care services refers to professional social work services to the CAA in recovery, aiming to assist CAAs with the maintenance of sobriety (Rosenberg, 2008:126).

Chemical addiction implies a condition induced by chemical substances that impairs functioning, and manifests in problems and harmful symptoms (Keegan & Moss, 2008:149).

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).

Relapse prevention is based on the acknowledgement of the addictive cycle, which indicates relapsing after treatment for chemical addiction as common, predictable and preventable (Gordon, 2003:3). This cycle indicates relapsing as a normal part of addiction and recovery, acknowledging that addiction is treatable.

DEMOGRAPHIC DETAILS OF THE PARTICIPANTS TO THE STUDY

TABLE 2
DEMOGRAPHIC DETAILS OF SOCIAL WORKERS WHO PARTICIPATED IN THIS STUDY

Age group			
21-28 years	29-35 years	36-49 years	50 years +
11	7	8	3
Qualifications			
Basic degree in Social Work		Postgraduate degrees in Social Work	
27		2 (Masters)	
Years experience in Social Work			
1-5 years	6-10 years	11-19 years	20 years +
11	6	8	4
Racial group			
African	Coloured	Asian	White
5	16		8
Language			
English	Afrikaans	Xhosa	Sotho
7	19	2	1
Gender			
Male		Female	
3		26	

Research findings
The participants in this study gave detailed descriptions of their perceptions and experiences regarding the nature of, and challenges related to, current after-care services to CAAs. The ensuing section describes their views in terms of: (1) after-care as essential for life-long recovery; (2) the current nature of after-care services; (3) a need for further knowledge; (4) obstacles experienced in rendering after-care services; and (5) the inclusion of families in after-care services.

For the purpose of this article, quotations are presented verbatim. However, comments made in Afrikaans were translated into English.

Theme 1: Aftercare as essential for life-long recovery

The participants viewed after-care as an essential component of services to CAAs, as illustrated by the following statement: *"Like, if we don't help them to remain sober, what's the point in helping them to get sober?"*

They linked this view with the need to achieve life-long recovery from chemical addiction: *"The moment they stop with the maintenance of the recovery, they regress."*

Keegan and Moss (2008:114) concur and note that after-care for CAAs is essential and is viewed as the best predictor of successful recovery. The participants asserted that after-care should not be seen as optional. The following quotation is provided underscores this view: *"The rehabilitation process is not completed without after-care taking place."*

The participants emphasised the important role of after-care when assisting CAAs to develop a new lifestyle following treatment. In confirmation of this, one stated: *"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."*

The goal of after-care is to prevent relapses through the maintenance of cognitive and behavioural changes made in treatment in order to sustain sobriety. The objectives are to prevent relapses by means of installing and utilising coping skills; preventing lapses (i.e. using substances once and then returning to recovery) from escalating into relapses; and maintaining a balanced lifestyle (Alberta Adolescent Recovery Centre, 2007:2; Lessa & Scanlon, 2006:275). Gorski (2001:2) warns that if the impaired development of the CAA is not addressed during and after treatment, the risk of relapsing increases. In further support of this the research points to the fact that after-care 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).

Theme 2: The current nature of after-care services

The data that emerged in relation to Theme 2 being presented in the discussion to follow are divided into two sub-themes.

Sub-theme 2.1: After-care as a "specialised field" of service delivery

The following statement supports the view 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" (Caelers, 2005:1; Plüddeman *et al.*, 2007:12): *"But let us be honest, the tik* [referring to methamphetamine] *problem is a social crisis but is not dealt with as such."*

The participants working at family welfare NGOs reported that they did not focus on addiction and specifically after-care services *per se*, but rendering these services formed part of their caseloads. The following statement confirms this sentiment: *"We focus on family services, and addiction must be addressed if it harms the family."*

On the other hand, the following statements indicate that the participants felt that after-care was being neglected, because it was not viewed as a specialised field and/or focus of attention during service delivery.

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To be honest, it should be a priority but it isn't.

Also, we work with the most desperate people and then the ones who should be contacted for after-care falls behind. 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.

One participant mentioned the fact that the irregularity of presenting after-care services affected the quality of services: *"I have an after-care group, but only once a month. This has a negative impact on continuity."*

The following storyline provide a picture of the perception that an out-patient programme could also be part of an after-care service: *"We also include out-patients in our groups* [i.e. day treatment, where patients remain in the community and participate in day-treatment programmes] *so the after-care and out-patient programmes may overlap."*

Contrary to what is happening in practice as articulated by the participants in the above discussion, Fisher and Harrison (2005:155) agree that "after-care services should be specialised" as they differ from in- and out-patient treatment in that after-care focuses on the maintenance of changes made during treatment. The following statement underscores this view: *"'Bottom-line', our services are limited, and it would just be easier if it is a specialised area. Otherwise it is just never a priority. And everyone should receive standardised training."*

Confirming this need to develop after-care services as a specialised field, a participant reported that the Department of Social Development was attempting to address this issue when she stated: *"There is a shift towards more structured after-care services. The Department appointed an after-care worker who trains volunteers to do after-care."*

The participants also referred to the format and content of current after-care services. These accounts will be presented as the next sub-theme.

Sub-theme 2.2: Format and content of current after-care services to CAAs

The participants stated that current services were offered in the format of case, group and community work and the following comments testify to this:

We mainly work individually, like case work.

I do group work…. Life skills programmes.

We try to make it [referring to after-care 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 organisations have programmes in place, and then we establish networks between these services of different organisations. And we focus on this training, and then 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:

We assess from the beginning to identify new challenges following the treatment.

We have a daily two-hour programme, which includes yoga, exercises, sport and art.

We focus on life skills, such as communication, conflict management, decision-making skills and safe sex.

The focus is on support and a place to talk about problems.

Often we talk about the damage and consequences of their addiction. To make things right.

On how to repair relationships, and how to deal with old friends and temptations.

The literature consulted highlights the following with regards to the content and focus of after-care: 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 (Fisher & Harrison, 2005:162-170).

According to Gruber and Taylor (2006:3), the family should be viewed as an integral part of after-care services, considering that the family is an important potential treatment and recovery resource. In line with this view, the participants also referred to rendering family services as part of their after-care service delivery to CAAs. Two quotations underscore this:

If the family is motivated, we work on issues such as relationships, parenting and trust.

We assist with the adjustment back in the family following treatment.

In the following statements the participants also referred to the way support groups complement their after-care service delivery:

I try to involve NA [Narcotics Anonymous] and CAB [Christelike Afhanklikheidsbond], so then it's a joint effort. They support and I do life skill training.

Support groups, such as AA, NA, Alateen, Tough Love and the AIDS group.

We provide the clients with the information of support groups to use if they want to.

The participants also made reference to the fact that they networked with other welfare organisations in their efforts to provide after-care services and to benefit the CAAs.

You work in a team. If an organisation renders a specific service, such as SANCA (focusing on addiction) then we refer. But we continue with our family services. You work as a team.

Cape Mental Health is great with children who are psychotic. It helps to have ties to assist with withdrawal.

Sometimes we use NICRO and the youth desk of the unemployment office.

The participating social workers expressed a need for further knowledge to assist them with the rendering of after-care services to CAAs, as discussed in the following theme.

Theme 3: A need for further knowledge

Powis (2005:166) and Taleff (2006:2) both assert that many helping professionals often experience working with addicts as frustrating and unrewarding. In the opinion of the latter 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 frustration. The participants specifically requested more information relating to the after-care 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 after-care… Just something on relapse prevention in general."*

The social workers reported that a lack of knowledge impacts negatively on their ability to plan and execute services successfully.

> *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.*

> *You have to start from scratch and you have to figure out what to do as you go along.*

Fisher and Harrison (2005:4) suggest a sound knowledge base regarding after-care and relapse prevention will lead to relevant after-care services. In order to address this lack of knowledge regarding after-care, 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 after-care model. It's mainly theoretical, so it gives us an idea of what the focus should be, but it's not a practical guide.*

In addition to the reported need for further knowledge regarding after-care 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 in the rendering of after-care services
The participating social workers highlighted the following obstacles experienced during after-care service delivery.

Sub-theme 4.1: A skills deficiency among community resources
This obstacle is illustrated in the following quotation: *"It is a problem when our volunteers and people who want to help do not know what to do. They need training."*

Regarding current training opportunities for volunteers, they stated:

> *We try to train two volunteers in 12 districts in the Western Cape. We have a training manual. We train them to run after-care support groups.*

> *Volunteers for CAD are being trained at Toevlug* [an in-patient treatment programme].

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 (Kerwin, Walker-Smith & Kirby, 2006:180; Mangrum & Spence, 2008:156).

Sub-theme 4.2: Lack of alignment between treatment and after-care programmes
After-care was part of the complete treatment package (Meyer, 2005:292-293), as noted by a participant: *"It* [referring to after-care] *should not stand separate from treatment"*. 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 after-care service initiatives as another obstacle in the rendering of after-care services. The following storylines bear testimony to it:

> *We don't really know what the rehabs do. And after-care should actually link with their services.*

> *I don't think new behaviour can be completely internalised at the rehabs. The new behaviour only becomes internalised once they go home.*

I think rehabs tell them about the importance of after-care and support groups, but they still don't realise that it is ongoing and that it is not really an option.

They must be ready for after-care to be open to after-care.

A consequence of this obstacle was identified as being after-care workers who do not have established relationships with the adolescents in treatment. The following statement by a participant refers to this: *"Often our first contact is after they leave the rehabs, because the assessments and intakes are often done by the centres themselves."*

The following remark made by a participant indicates the need and importance of a link between preparation, treatment and after-care: *"If they are well prepared for treatment, they are less afraid and resistance is also less. In the same way, if they are prepared for after-care, they will be more ready to commit to services."*

The participants also noted that the involvement of the family in family conferences at the treatment centres, where the after-care worker is present, could assist in the establishment of a personal relationship between the after-care worker, the adolescent, and the family. The following quotation encapsulates this: *"The family conferences before the child leaves the centre creates an opportunity to prepare the child and the family for after-care. Then you have a starting point once the child is back home, and everyone was present when it was planned."*

In the literature Sussman and Ames (2001:110) emphasise the need for communication and collaboration in view of alignment of the services provided between the treatment centres and after-care service providers. The interaction and cooperation between the sub-systems involved in treatment services, as well as between the systems and field practitioners affected CAAs ability to commit to after-care (Braig, Beutel, Toepler & Peter, 2008:105-108).

Sub-theme 4.3: Challenges for the recipients of after-care services

The lack of transport, as well as the geographical inaccessibility of after-care services limits client-system to utilise the services – *"Transport to support groups can also be a problem. The groups mainly gather at night and it can be dangerous. Especially for the ladies."*

In addition, the inability to attend after-care programmes during day-time because of work obligations and fear of losing their employment were also identified as problems. This was articulated by one participant as follows:

A lot of our clients cannot come for services during the day. Employers think they accommodate them if they agree to once a month, and the children are desperate for the jobs.

A study by Myers, Louw and Fakier (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 after-care services, the fact that after-care services were geographically inaccessible and a lack of awareness about the availability and location of services contributed to the under-utilisation of services.

Sub-theme 4.4: A high drop-out rate amongst CAAs and lack of commitment to after-care services

The participants reported attributed a high drop-out rate from after-care services amongst CAAs to a lack of commitment to after-care services. The following quotation encapsulates this: *"Oh, I struggle with a high drop-out rate. I think they see after-care 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."

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 after-care efforts remind them.*

Malhotra, Basu and Guptra (2007:1) concur that CAAs must learn to value their sobriety and commit themselves to change as the long-term goal of recovery through the development of intrinsic levels of motivation.

Sub-theme 4.5: Difficulties experienced by CAAs in internalising new behaviour

Powis (2005:173-174) postulates that people addicted to chemical substances generally suffer from a fragile sense of self. They use acting-out behaviour to protect themselves. An improved sense of self-worth could therefore contribute to behaviour change.

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 after-care services.

> *The children struggle to internalise the new behaviour.*

> *Following rehab the client must be assisted to learn new behaviour.*

> *New behaviour is not just about replacing old behaviour with new behaviour. The child must practice the new skills until it comes naturally…*

The social workers 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. This was articulated as follows: *"Sometimes it feels like they infect one another. If the majority of the peers are still using the old* [i.e. substance-related behaviour]*, then the minority's impact is just not strong enough."*

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 emphasised. Arterburn and Burns (2007:41) state that acceptance by peers is an important motivational factor in adolescent behaviour. It influences the choices they make and their subsequent behaviour. 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 (Brandt & Delport, 2005:165; Butts & Roman, 2004:195). 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).

Sub-theme 4.6: The lack of time, funds and human resources to render after-care services

The participating social workers referred to a lack of time to deliver proper after-care services, which in turn is the result of a lack of human resources. Comments made in this regard included:

> *We are just busy putting out fires. It feels like we are not doing what we are supposed to be doing* [referring to rendering of after-care services]

> *The lack of manpower* [sic] *and funds causes us to only focus on crisis intervention.*

Rosenberg (2008:27) asserts that the lack of human resources 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. after-care services to continue growth achieved 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.

Sub-theme 4.7: 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. The following statement made reference to this: *"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 participants reported that employers did not always accommodate contact with the adolescents, parents or volunteers, and reported a concern regarding the involvement of schools and churches. The following statements seem to confirm this:

> *We struggle to have access to parents or volunteers during working hours.*

> *I am worried about the churches and schools, because they offer activities that could help the addicts after treatment, but these children are not being accommodated. I think they are not really aiming to help addicts.*

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:

> *We refer people, but often the support groups do not cater for children. And also the transport issue...*

> *It's like they don't understand AA's value, like you will be laughed at if you go there.*

Self-help groups offer the following advantages (Powis, 2005:170): they assist with improved social functioning; they use social support networks to enhance integration into 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. Because it places the emphasis on the fact that the client must accept the disease of addiction, the client could 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 society and therefore concurs that the NA self-help groups and the 12-Steps Programme are available and free of charge, making them accessible.

Theme 5: The inclusion of families in after-care services

The views expressed in this theme correspond with the viewpoints in the literature that after-care should focus on the development of insight into the dysfunctional family communication patterns, rules, roles and boundaries, and that the family should be guided to make the relevant changes to ensure a family environment that is conducive to the recovery of an addicted adolescent (Alberta Adolescent Recovery Centre, 2007:2; Arterburn & Burns, 2007:14-15).

Sub-theme 5.1: Families lack insight into the recovery process

The family's lack of knowledge about recovery from chemical addiction, and the need to make services available to the families of CAAs, can be deduced from the following statement by one of the participating social workers: *"I think the family don't understand that we cannot make people stop, and the addict just isn't ready."*

Gorski (as cited in Fisher & Harrison, 2005:158) identifies the following focus areas that should receive attention when the families are assisted in developing an insight into 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.

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

The following statement by a participant illustrates the need to train and support families to participate in the recovery process:

> *Like if they work according to the Model of Change, and then they will see how their support can help their children.*

The benefits of family involvement in after-care are associated with better treatment compliance and outcomes (Matrix Institute on Addiction, 2008:23). If the family understands the process of recovery, it can contribute accordingly. Family members can support one another; they are able to communicate openly and honestly, and resolve conflict; they are able to change destructive behaviours in the family; family bonds are strengthened; and the CAA is provided with emotional and practical support when dealing with cravings (Keegan & Moss, 2008:111).

However, the participants reported that the families of CAAs often do not realise their significance following treatment. The following statement underscored this:

> *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 after-care.*

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 after-care 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.

The participating social workers acknowledged the value of reintegration into the family as an important after-care need. The following storylines point to this:

> *The children do not know how to adjust back home…*

If they have problems to be accepted back into their home, the temptation becomes big to go back to drug-using friends.

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: 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 their own decisions; developing self-confidence; becoming comfortable with their own values; learning new roles related to independent adulthood; and developing a group identity (Fisher & Harrison, 2005:200). 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 (Gruber & Taylor, 2006:15; United Nations, 2003:4).

The ability to support the CAA to reintegrate into the family following treatment is influenced by the ability of the family members to address their own problems, as discussed next.

Sub-theme 5.4: Support to address parents' own problems impacting on the recovery potential of chemically addicted adolescents

The need to address family members' own problems was identified as follows: *"Often the parents have their own problems that need to be addressed."*

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 after-care becomes apparent. The participants specifically focused on the abuse of chemical substances as an area to address among family members. The following statement made by a participant refers to this: *"I struggle when family members use alcohol and drugs as if it is normal. How must the children recover in such an environment?"*

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 (Saleebey, 2006:204).

Based on the findings described above, the discussion below will focus on concluding remarks and some recommendations relating to the planning and execution of future after-care services to CAAs.

CONCLUDING REMARKS AND RECOMMENDATIONS

This research enabled the researchers to develop a better understanding of the state of current after-care services to CAAs, especially in the Western Cape. The participating social workers viewed after-care to CAAs as a crucial component in the treatment, and asserted that after-care should be acknowledged as a specialised field. They reported that they needed training and guidance regarding addiction and recovery, and specifically regarding after-care and relapse prevention. They noted that current services made use of all three primary methods of intervention (i.e. case, group and community work). The participants furthermore viewed family services as an essential part of after-care. The obstacles that impact negatively on current services were identified as a lack of training and/or uncertainty about the nature of training to equip community resources to render effective after-care service; a lack of contact between and alignment of programmes offered at treatment centres with after-care service

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initiatives; a lack of transport, inaccessibility, lack of knowledge about after-care services and employment-related challenges; a high drop-out rate amongst CAAs and lack of commitment to after-care services; difficulties experienced by CAAs in internalising new behaviour; a lack of time to render after-care services as a result of a lack of human resources and funds; and frustration when there is a lack of resources.

Current services, in line with the key components described in the literature, do focus on identification and dealing with other social needs that impact on the recovery potential, the development of new behaviour, the use of resources and support systems, development of life skills and the involvement of family and peers. However, the literature also places emphasis on the following aspects to include when planning and executing after-care services: motivational enhancement training; management of cravings and withdrawal; dealing with emotions of guilt and failure; dealing with relapses; the integration of preparation for treatment, treatment and after-care as a whole; linking after-care with the content of treatment programmes; the development of an ongoing treatment plan; and addressing organisational factors that influence service delivery.

In conclusion, focus areas that are recommended for the planning and execution of further services include the following:

- The recovery from chemical addiction is a life-long process. The provision of after-care 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;

- Aftercare to CAAs should be a mandatory part of treatment services;

- Aftercare services to CAAs are perceived to be a "specialised field" of service delivery, but in practice this is not currently the case. In order to ensure the availability and accessibility of after-care, this field should be acknowledged as a specialised field;

- A sound knowledge base regarding addiction and recovery is needed for social workers who render after-care services. There seems to be a lack of information amongst social workers about the "what" and the "know-how" relating to the after-care component of the treatment of CAAs;

- The focus of after-care services should include life skills that would enable CAAs to complete adolescent life tasks and to develop resilience;

- Aftercare services should place emphasis on the importance of internalising new behaviour that would contribute to efforts to remain sober following treatment;

- The reintegration into the family following treatment is seen as a focus area in after-care services to CAAs;

- Resources (including human resources and funding) should be available to assist social workers with their efforts to deliver after-care services, as well as to support CAAs following treatment;

- Treatment and after-care services to CAAs should be coordinated and well managed, and linking and networking between resources should take place.

REFERENCES

ALBERTA ADOLESCENT RECOVERY CENTRE. 2007. [Online] Available: **Error! Hyperlink reference not valid.** [Accessed: 29/08/2007].

ALSTON, M. & BOWLES, W. 2003. **Research for social workers** (2nd ed). London: Routledge.

ARTERBURN, S. & BURNS, J. 2007. **How to talk to your kids about drugs**. Oregon: Harvest House.

BABBIE, E. & MOUTON, J. 2007. **The practice of social research**. Cape Town: Oxford University Press.

BLESS, C., HIGSON-SMITH, C. & KAGEE, A. 2006. **Fundamentals of social research methods – an African perspective** (4th ed). Cape Town: Paarl Printers.

BOZALEK, V., HENDERSON, N., LAMBERT, W., COLLINS, K. & GREEN, S. 2007. Social services in Cape Town: an analysis using the political ethics of care. **Social Work/Maatskaplike Werk**, 43(1):28-40.

BRAIG, S., BEUTEL, M., TOEPLER, E. & PETER, R. 2008. Client satisfaction with substance abuse treatment. **International Journal of Public Health**, 53:104-110.

BRANDT, C.J. & DELPORT, C.S.L. 2005. Theories of adolescent substance use and abuse. **Professional Journal for Social Work**, 41(2):163-175.

BUTTS, J.A. & ROMAN, J. 2004. **Juvenile drug courts and teen substance abuse**. Washington: The Urban Institute Press.

CAELERS, D. 2005. Tik addiction soars at an alarming rate. **Cape Argus**, 7 April 2005:9.

CAROUFEK, J. 2007. Breaking free from addictions. **The Good News**, 12(6):4-7.

CRESWELL, J.W. 2009. **Research design: qualitative, quantitative and mixed approaches**. (3rd ed). Thousand Oaks: Sage Publications.

DEPARTMENT OF HEALTH/MEDICAL RESEARCH. 2003. **Umthente Uhlaba Usamite – the first South African national youth risk behaviour survey**. Pretoria: Government Printer.

DIMOFF, T. 2007. **How substance abuse starts** [Online] Available: http://www.sacs-consulting.com/book/chapter 1.htm [Accessed on 02/05/2007].

FALKOWSKI, C.L. 2003. **Dangerous drugs** (2nd ed). Minnesota: Hazelden Foundation.

FISHER, G.L. & HARRISON, T.C. 2005. **Substance abuse** (3rd ed). Boston: Pearson Education.

FOX, W. & BAYAT, M.S. 2007. **A guide to managing research**. Cape Town: Juta and Co. Ltd.

GORDON, S.M. 2003. **Relapse – removing the taboos on the topic and promoting honest efforts to address it**. Wernersville: Caron Foundation.

GORSKI, T.T. 1988. **The staying sober workbook: a serious solution for the problem of relapse**. Independence, MO: Independence Press.

GORSKI, T.T. 2001. **Adolescent relapse prevention**. [Online] Available: **Error! Hyperlink reference not valid.** [Accessed: 05/04/2006].

GRUBER, K.J. & TAYLOR, M.F. 2006. A family perspective for substance abuse: implications from the literature. **In**: STRAUSSNER, S.L.A. & FEWELL, C.H. (ed) **Impact of substance abuse of children and families: research and practice implications.** New York: Harworth Press.

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HEALTH RESOURCES. 2004. [Online] Available: http://www.everettclinic.com.html [Accessed: 02/05/2007].

KEEGAN, K. & MOSS, H.B. 2008. **Chasing the high**. Pennsylvania: Oxford University Press.

KERWIN, M.L., WALKER-SMITH, K. & KIRBY, K.C. 2006. Comparative analysis of state requirement for the training of substance abuse treatment counsellors. **Journal of Substance Abuse Treatment**, 30:173-181.

KREFTING, L. 1991. Rigor in qualitative research: The assessment of trustworthiness. **American Journal of Occupational Therapy**, 45(3):214-222.

KUMAR, R. 2005. **Research methodology. A step by step guide for beginners** (2nd ed). Thousand Oaks: Sage Publications.

LESSA, N.R. & SCANLON, W.F. 2006. **Concise guide to mental health: substance use disorders**. New Jersey: John Wiley and Sons Ltd.

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

MALHOTRA, A., BASU, D. & GUPTRA, N. 2007. Psychosocial treatment of substance use disorders in adolescents. **JIACAM**, 1(1).

MANGRUM, L.F. & SPENCE, R.T. 2008. Counsellor and client characteristics in mental health versus substance abuse treatment settings providing services for co-occurring disorders. **Community Mental Health Journal**, 44:155-169.

MARLATT, G.A. & GORDON, J.R. 1985. Relapse prevention: maintenance strategies in the treatment of addictive behaviours. New York: Guilford Press.

MATRIX INSTITUTE ON ADDICTION. 2008. **Roadmap to recovery**. Minnesota: Hazelden Foundation.

MATZOUPOLOS, R. 2005. **Profile of fatal injuries in South Africa sixth annual report**. Cape Town: Medical Research Council.

McWHIRTER, J.J., McWHIRTER, B.T., McWHIRTER, E.H. & McWHIRTER, R.J. 2004. **At-risk youth. A comprehensive response** (3rd ed). Canada: Brooks/Cole Publishing Company. [Accessed: http://www.drugabuse.gov/infofacts/HSYouthtrends.html. 2006].

MEYER, R. 2005. Towards a rational approach to substance abuse behaviour, **CME**, 23(6):290-293.

MILLER, J.C. 2008. Twelve-Step treatment for alcohol and substance abuse revisited: best available evidence suggests lack of effectiveness or harm. **International Journal of Mental Health Addiction**, 6:146-160.

MYERS, B., LOUW, J. & FAKIER, N. 2007. **Access to South African treatment facilities in the Cape Town metropole**. Cape Town: South African Medical Research Counsel.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA, USA). 2006. [Online] Available: http://www.drugabuse.gov/infofacts/HSYouthtrends.html [Accessed: 0504/2006].

NOYOO, N., PATEL, L. & LOFFELL, J. 2006. The human development situation of Johannesburg's youth. **Social Work/Maatskaplike Werk**, 42(1):93-100.

PAGE, R.M. & PAGE, T.S. 2003. **Fostering emotional well-being in the classroom** (3rd ed). Sudbury: Jones and Bartlett.

PLŰDDEMAN, A., PARRY, C., CERFF, P., BHANA, A., PEREIRA, T., POTGIETER, H., GERBER, W., NZINI, T. & PETERSON, P. 2007. Monitoring alcohol and drug abuse trends in South Africa. **South African Community Epidemiology Network on Drug Abuse,** 10(1).

POWIS, P. 2005. Substance dependency. **In**: BECKER, L. (ed) **Working with groups**. Cape Town: Oxford University Press.

PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, No. 70 of 2008. Pretoria: Government Printer.

ROSENBERG, L. 2008. To preserve, strengthen and expand America's mental health and addictions treatment capacity. **Journal of Behavioural Health Services and Research**, 35(3):237-239.

SALEEBEY, D. 2006. **Strengths perspective in social work practice** (4th ed). Boston: Allyn and Bacon.

SATRE, D.D., MERTENS, J.R., AREAN, P.A. & WEISNER, C. 2004. Five-year alcohol and drug treatment outcome of older adults versus middle-aged and younger adults in a managed care programme. **Addiction**, 99(10):1286-1297.

SCHLEBUSH, L. 2005. **Suicidal behaviour in South Africa**. Scottsville: University of KwaZulu-Natal Press.

SIMPSON, D.D. 2005. **An integrated approach to treatment for addiction**. Texas: Institute of Behavioural Research at the Texas Christian University.

SUSSMAN, S. & AMES, S.L. 2001. **The social psychology of drug abuse**. Buckingham: Open University Press.

SMITH, M. 2006. Medpage. **Pure "Ice" fuelling Methamphetamine epidemic**. [Online] Available: http://www.medpagetoday.com [Accessed: 01/06/2006].

SOUTH AFRICAN COMMUNITY EPIDEMIOLOGY NETWORK ON DRUG USE. 2007. **News update**. Medical Research Council, South Africa.

TALEFF, M.J. 2006. **Critical thinking for addiction professionals**. New York: Springer Publishing Company.

UNITED NATIONS. 2003. Economic and social commission for Asia and the Pacific United Nations: office on drugs and crime. New York: United Nations Publications.

UNITED NATIONS OFFICE ON DRUGS AND CRIME. 2002. **Ke-Moya-I'm fine without drugs**. Pretoria: Miles and Associates International.

VAN DEN BERG, H. 2003. '**n Nasorgprogram vir maatskaplike werkers vir die behandeling van substansafhanklike adolessente**. Pretoria: University of Pretoria. (Unpublished MA Dissertation)

VAN DER WESTHUIZEN, M.A. & DE JAGER, M.S. 2009. Relapsing after treatment: exploring the experiences of chemically addicted adolescents. **Social Work/Maatskaplike Werk**, 45(1):76-90.

WALLIMAN, N. 2001. **Your research project**. Thousand Oaks: Sage Publications.

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WESTERN CAPE DEPARTMENT OF SOCIAL SERVICES AND POVERTY ALLEVIATION. 2006. **Transformation plan 2006**. Pretoria: Government Printer.

WESTERN CAPE DEPARTEMENT OF SOCIAL DEVELOPMENT. 2007. **Service delivery plan 2007-2017**. Pretoria: Government Printer.

WESTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT. 2008. **Draft systems model for prevention and after-care**. Cape Town: Department of Social Development.

WESTERN CAPE DRUG FORUM. 2005. **Treatment and after-care portfolio: business plan**. Cape Town.

WORLD HEALTH ORGANISATION. 2004. **Neuroscience of psychoactive substance use and dependence: summary**. Geneva: WHO.

YOUTH AT THE UNITED NATIONS. 2006. **United Nations: world programme of action for youth**. [Online] Available: http://www.un.org/esa/socdev/unyin/wpaydrug.html [Accessed: 01/06/2006].

ZULU, X. 2006. Health Systems Trust. **Youth turns to drugs as sales at schools soar**. [Online] Available: http://www.hst.org.za/news [Accessed: 02/06/2006].

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