

# **Meeting the Occupational Needs of Recovering Drug Addicted Adolescents**

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## DECLARATION

I, Insauf Parker hereby declare that *Meeting the Occupational Needs of Recovering Drug Addicted Adolescents* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been acknowledged by complete references.

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## DEFINITION OF TERMS

**Adolescent:** A person in the developmental stage between childhood and adulthood which usually varies from 11-13 years of age and extends to 18-21 years of age (Louw, Van Ede, & Louw, 1998).

**Barrier:** Barriers include factors which create disability and hinder function or a health condition (World Health Organisation, 2001), such as inaccessibility or lack of a health service for example. It also refers to a factor (physiological, environmental or psychological) that impedes or interferes with the attainment of a goal (Pedretti & Early, 2001).

**Client-centered:** An approach to treatment that demonstrates particular respect for and partnership with the individual or group receiving the service (Spear & Crepeau, 2003).

**Drug:** A medicine or other substance which has a physiological effect when ingested or otherwise introduced into the body, an illegal and often harmful substance (such as heroin, cocaine, LSD, or marijuana) that people take for pleasure (Merriam-Webster, 2014)

**Drug addiction:** Drug addiction is the continued compulsive use of drugs in spite of adverse health or social consequences (National Institute of Health, 2000).

**Drug merchant:** A person who sells and buys drugs for a profit (The World Book Dictionary, 1990). The term is used interchangeably with drug peddler and drug dealer.

**Drug Rehabilitation:** It refers to the process of medical or/and psychotherapy treatment for dependency of substances such as drugs or alcohol. The period usually commences only once the body is clear of the drug and the client no longer experiences withdrawal symptoms (Meier, Best, & Day, 2007).

**Drug relapse:** A sequence of emotional and mental setbacks that result in the event involving use of substances sufficient to produce a high (Boisvert, Martin, Grosek, & Clarie, 2008; Addictions and Recovery.org, 2010).

**Evidence-based practices:** Evidence-based practices are practices, interventions or programmes for which there is large body of research evidence in support of its effectiveness (Myers, Harker, Fakier, Kader, & Mazok, 2008).

**Facilitator:** A factor that encourages and enables the attainment of positive outcomes or enhances the change process (Duncan, 2005). This may include aspects in the environment which contributes towards an individual's functioning and decreases an individual's disability. This may be factors that are either present such as the existence of a health service, or absent such as the absence of negative attitudes, both of which may improve capacity (World Health Organisation, 2001).

**Occupational needs:** These refer to needs that arise when an individual encounters difficulties engaging in their occupations of daily living (Cowan, 2009). This may be as a result of a physical injury, psychosocial problem, medical condition/disease, or a mental health issue which renders the person unable to perform in a functional manner.

**Occupational therapy:** Occupational therapy is the art and sciences of helping people do the day-to-day activities that are important and meaningful to their health and well-being through engagement in valued occupations (Crepeau, Cohn, & Schell, 2003).

**Perceptions:** It refers to the process in which our brain gives meaning to information that our senses receive from the environment i.e. it involves interpretation and organisation of sensory stimuli (Louw, Van Ede, & Louw, 1998).

**Recovering addict:** A person who voluntarily maintains a lifestyle characterised by sobriety, personal health, and citizenship (Betty Ford Institute, 2007).

**Social network:** Refers to people that one associates with, hangs out with and socializes with (Mason, Malott, & Knoper, 2009) i.e. a group of friends, colleagues, or personal acquaintances with who the individual is in contact. This may extend to family members or neighbours as well.

## ACRONYMS

AA	Alcoholics Anonymous
AOD	Alcohol and Other Drug
C	Counsellor
CBO	Community Based Organisation
DARA	Drug and Alcohol Rehab Team Asia
FGM	Focus Group Member
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
MDFT	Multidimensional Family Therapy
MOHO	Model of Human Occupation
NHS	National Health Services
NIDA	National Institute on Drug Abuse
OT	Occupational Therapy
RW	Rehabilitation Worker
SANCA	South African National Council on Alcoholism (and Drug Dependence)
SACENDU	South African Community Epidemiology Network on Drug Use
TB	Tuberculosis
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
UWC	University of the Western Cape
WCYRC	Western Cape Youth Rehabilitation Centre
WHO	World Health Organisation
WMA	World Medical Association

## **ABSTRACT**

The growing phenomenon of drug abuse has alerted the attention of health professionals, addiction counsellors, school educators, the media and community members. Susceptible sub groups of the population such as adolescents have been seriously affected as addiction destroys their identities, health, daily performance, family structure and ultimately results in social disintegration. Consequently, rehabilitation facilities have been established and addicts are entering the treatment system via referrals from school principals, the judiciary court or desperate parents and family members. Despite this, after having spent a reasonable amount of time and money in rehabilitation centres, relapse rates are significantly high and addicts are returning to treatment. The question was then raised as to whether recurrent relapses were as a result of their occupational needs not being met in treatment.

To understand whether the occupational needs of these recovering adolescents are met, a true client-centred approach was employed. A descriptive approach was used within a qualitative research paradigm. The participants that were selected from four drug rehabilitation facilities in the Cape Town Metropolis, included 8 recovering drug addicted adolescents, 2 rehabilitation workers employed at two different facilities, and a sum of 26 parents of recovering addicts. Purposeful sampling was used for the adolescents and rehabilitation workers while convenient sampling was used for the parents. To access the perspectives and perceptions of the participants the researcher used individual semi-structured interviews for the recovering adolescents and drug rehabilitation workers, and focus groups for the parents. The data was analysed thematically using Lincoln & Guba's (1985) method of qualitative data analysis. All data was managed manually.

The objectives of the study explored perceptions of drug addicted adolescents with regard to relapse, to describe the barriers with regard to drug rehabilitation and their occupational needs, to reveal facilitators with reference to the recovery process, and to present suitable strategies which may improve drug treatment practice. Three themes were constructed based on the findings of the study. The themes were: 1) easy to get in, difficult to get out, 2) breakdown on life caused by drug addiction, and 3) moving forward towards recovery. Since adolescence is known as a transitional period characterised by identity development, adolescents are naturally influenced by their social and physical environment, particularly their peer groups at school and in the community. Consequently, adolescents enter treatment



with numerous physical, psychological, social, intrapersonal, and legal needs. The constant pursuit of drugs and its lifestyle leads to dysfunction and imbalance in the individual's daily performances with relapse remaining a common element in the recovery process.

The lack of knowledge from participants pertaining to the concept of relapse was perceived as a barrier to recovery. The physical and social environment such as the general availability and accessibility of drugs in adolescent's community, the unfavourable influence that peers and family relationships play, organisational challenges such as staff handling principles regarding their developmental stage and ineffective communication within the rehabilitation centre, and personal barriers including manipulative and behavioural difficulties, emerged as contra-indicative to the recovery process. Many of the recovering drug addicted adolescents were unable to cope with the array of needs and triggers, and found themselves relapsing and returning to the rehabilitation facility.

Among the many facilitators as perceived by the participants, the actual programme at the rehabilitation centre was significant in promoting progress. If it included education groups, where clients are taught about substance abuse, relapse and how to restructure their lifestyle of recovery, it was deemed as beneficial. Another facilitator highlighted by the participants was the involvement of family by incorporating parent support sessions, and an interesting factor such as including spirituality as a resource was raised as valuable in their recovery process.

Recommendations for the study included that adolescents who abuse substances need to be treated very differently to adults or children, and that maintaining communication or a connection with them via aftercare for example, will enable them to sustain their sobriety outside of the rehabilitation facility. Since addiction affects the individual's identity, roles, and habits on an occupational performance level it is paramount that treatment should be addressed from an occupation-based perspective in collaboration with existing evidence-based addiction models. Occupational therapists are uniquely equipped to deal with these components.

**Keywords:** adolescence, drug addiction, drug rehabilitation, recovering addict, occupational needs, relapse prevention, occupational performance, evidence-based practice and the Model of Human Occupation.

## CHAPTER 1: INTRODUCTION

### 1.1 Rationale

Quality of life may be defined as a comparative state of well being and functioning which includes a level of comfort and an ability to participate in meaningful tasks or activities (Spear & Crepeau, 2003). An individual who finds himself in any form of drug addiction is challenged with life-dominating difficulties which harmfully affect ones quality of life, identity and relations (The Addiction Action Campaign, 2008). The South African Community Epidemiology Network on Drug Use (SACENDU) collects data from more than 80% of treatment centres in Cape Town (Plüddemann, Myers, & Parry, 2008). As early as 2000, findings emphasised the concerns of many regarding the increase of drug use. Almost 6 out of 10 arrestees tested positive for illegal drug use during 2000 in Cape Town (Parry, 2005), and later statistics indicated that there were 10656 patients being treated for substance abuse across 65 centres in the first half of 2009 (Plüddemann, Parry, Bhana, Dada, & Fourie, 2009). With regard to age distribution, even though over half of the patients treated for methamphetamines were under 25 years of age, the proportion of patients under 20 years of age remains high across SACENDU-monitored sites (Plüddemann, Parry, Bhana, Dada, & Fourie, 2010).

The crisis situation pointed towards a great need for rehabilitation facilities and substance control programmes and individuals were entering and leaving the system by the numbers. Despite these launches to conquer the scourge of drug addiction, a plan to beat substance abuse was published by the Premier of the Western Cape in which it stated that an average relapse rate of 60% exists among addicts (Zille, 2010). Similarly, Bowen and colleagues (2009) found that relapse remain a significant problem for addicts with rates as high as 40% to 70%, after attending rehabilitation. Furthermore, according to Zille (2010) the provincial government has spent R100 million per annum on substance abuse programmes, yet the problem of substance use continues to persist.

It is of some worry that most treatment centres require commitment on behalf of the user, yet so many clients dropout of treatment (Meier & Best, 2006) and some are known to return even after having completed treatment. In a study involving 66 residential drug rehabilitation services in England, it was found that of the clients that attended treatment, one in three

dropped out before the intended completion date. Additionally, it was found that service structure of the rehabilitation centre, the therapeutic programme, and resources were predictive of treatment completion (Meier & Best, 2006).

Literature has indicated that the client has a very high risk of relapse in the period after leaving treatment, therefore adequate support should be provided to the client during this period (Gossop, Stewart & Marsden, 2007). In another study it was found that two-thirds of adolescent relapse occur in the first three months following formal rehabilitation (Brown as cited in Williams & Chang, 2000). Further, previous research studies on adolescents indicate poor follow-up outcomes as adolescents are difficult to contact and often refuse to participate in follow-up treatment.

Aftercare or follow-up treatment may be defined as attending structured visits to the rehabilitation facility which involve individual counselling sessions, support group or family sessions, meetings with counsellors, or being present at self-help groups in the community. Although they are intended to provide continued support, coping strategies, skills training and trigger stopping techniques in order to prevent relapse, in the South African context the value of aftercare has been downplayed and there has been comparatively little emphasis on aftercare in either research or practice (Myers<sup>2</sup>, Harker, Fakier, Kader, & Mazok, 2008).

There have been relatively few studies on adolescent drug treatment and earlier investigations have primarily been carried out among the adult population. This presents a gap of knowledge in the field and motivation for the study. Also, previous studies reviewed have often incorporated both drugs and alcohol in its examinations and many studies have relied on adolescent self-reports only (Williams & Chang, 2000). A number of authors have concluded their reports emphasizing that further research should examine drug treatment with participating adolescents so that their experiences are understood (Mason, Malott, & Knoper, 2009). Additionally, other reports have indicated that corroboration and perspectives by those who work closely with adolescents will ensure that a comprehensive inquiry is conducted. Moreover, according to Myers, Louw and Fakier (2008), there has been no qualitative evaluation of alcohol and other drug (AOD) treatment in the Cape Town Metropole.

Now, although this study is not an evaluation of the treatment service, listening to those who are directly involved in treatment, would provide insight into what service recipients deem as beneficial in rehabilitation programmes. Furthermore, it would advise health professionals how resources may be redistributed to improve service efficacy and service reach, so that relapse rates may be potentially reduced. This is only potentially possible if perceptions of relapse among addicts are known and understood.

It is important to explore whether service recipients' occupational needs are being met especially if so much is being spent on the establishment of these facilities. The lack of literature in this regard provided great motivation for this study. According to Parry (2005), he admits that the range of drugs used and the burden of drug use is generally greater in the Western Cape than in other provinces. The research therefore proves to be relevant for the South African context, particularly the Western Cape and could contribute significantly to the existing knowledge in the field.

## **1.2 Personal reasons for the study**

Psychiatry and mental health issues has intrigued me from an early age. Even though very little exposure was provided through my undergraduate studies at university or during community service, I always found myself reading literature on psychological concerns, things that bewildered the mind to such a degree that it affected functional performance. A snowball effect of minor experiences has lead to the nature of this study. Firstly, it was during fourth year, in a block involving psychiatric-affected patients where I was required to facilitate life skills and craft sessions that I wondered how it could be that patients from the ages of 17 up until 58 were treated in the same group with many different diagnoses. Secondly, in the neighbourhood that I resided, I pondered about individuals who were my age and similar in upbringing, made different decisions in their life and how this impacted on their overall paths as they grew older. However, as I was growing older, I was concerned about how quickly things were changing and how challenging and scary it was in fact to grow up.

By attending lectures or workshops, whether religious or academic I found myself engaging with individuals of all ages but I took a particular interest in adolescents and their decision-making processes and behaviour. Many issues would come up from joblessness, career

choices, parenting issues, teenage pregnancy etc., but the subject that was affecting youth by the numbers and destroying their functional occupations was that of drug addiction. Every newspaper had one or two, sometimes three articles about drug abuse. I attended a conference hosted by the South African National Council on Alcoholism and, in all honesty, I knew as an occupational therapist this is where I would hope to make a difference. So much emphasis verbally, is always directed on the potential of an adolescent; how youth are the future leaders, how they can shape a community, how you can change the path of a young person to lead a purposeful life, yet what is being done to attend to their concerns and their problems. We need to start somewhere and this was my somewhere. The research inquiry is as follows:

**Research question:** How are drug rehabilitation programmes meeting the occupational needs of recovering drug addicted adolescents in Cape Town?

### **Aim of the research**

The study aims to investigate how drug rehabilitation programmes are meeting the occupational needs of recovering drug addicted adolescents in Cape Town.



### **Objectives of the study**

The four objectives were as follows:

1. To explore the perceptions of recovering drug addicted adolescents with regard to drug relapse, and its effects on their daily occupations.
2. To describe the barriers that recovering drug addicted adolescents experience with regard to drug rehabilitation and their occupational needs.
3. To describe the facilitators that recovering drug addicted adolescents experience and perceive regarding their recovery process.
4. To describe suitable strategies and methods in which treatment centres or drug facilities may support recovering addicts once they have been discharged.

## **Conclusion**

In the experience of youthfulness it is inevitable and ordinary that an adolescent may have many uncertainties since they are being exposed to intellectual, psychosocial, and physical whirlpools of growth. Despite this he/she should be involved in vocations such as school, college, employment etc., all of which is capable of making him/her a sound and useful member of his/her family and of the community. The current study is therefore important for many contextual, academic and personal reasons.

This chapter elaborated on these reasons as the basis and motivation for the study. Through reading and reviewing literature and previous studies the topic was refined. The researcher aimed to investigate how drug rehabilitation programmes are meeting the occupational needs of recovering drug addicted adolescents in Cape Town. In order to understand whether their needs are being met, the researcher set out to explore whether the participants knew what it meant to relapse and in so doing obtained their perception of a being a recovering addict. The researcher needed to explore and describe their perception of barriers in the rehabilitation programme and facilitators in their recovery process. The views and opinions gained from them would elicit and enlighten possible suggestions which would inform practice. The research process and inquiry under investigation will be briefly described in the outline of chapters to follow.

## **OUTLINE OF THE CHAPTERS**

### **Chapter Two**

In chapter two literature is reviewed around which the current study is built. It contextualises drug use and abuse within the South African arena. It highlights key factors regarding drug treatment and the main aspects that previous authors and researchers have presented. Given that the area of substance use is vast, the angle from which the research study focuses on will be demarcated in the chapter.

### **Chapter Three**

In this chapter the researcher describes the methodological framework which the researcher has used. The researcher also elaborates on the reasons for using the particular research design and the research paradigm. Chapter three further presents the data collection method and analysis process employed by the researcher. It also illustrates the sampling procedures in accessing the participants for the study.

### **Chapter Four**

Chapter four is dedicated to the actual findings of the study. It summarises the main results by organising the perspectives and perceptions of the participants into themes. Each theme is discussed to elicit connections that emerged during the research process.

### **Chapter Five**

In this chapter the researcher interprets the results by drawing on previous literature reviewed. The connections of the research findings with regard to answering the four objectives of the study are described, and based on these interpretations; the researcher offers a theoretical model that demonstrates the relevance of the study in terms of expanding on the knowledge and improving practice in drug treatment with adolescents.

### **Chapter Six**

Chapter six serves to conclude the research process by highlighting the salient points reached through the analysis of the study. It recommends aspects that require further research, and proposes various suggestions, based on the findings, that need to be addressed to combat the problems related to drug addiction.



## **CHAPTER 2: LITERATURE REVIEW**

### **Introduction**

Although there is a substantial amount of literature examining various dimensions of substance use particularly alcohol, the minimal attention given to drugs especially among youth present a considerable gap in knowledge. It is gaining recognition as a topic of interest and research is necessary in order to rectify the diverse problems related to it as a matter of urgency. The huge impact drug addiction is having on the livelihoods and community functions are overwhelming and it has hence alerted many professionals in the medical, social and mental health fields. But, for purposes of this study the literature will be contextualised as follows:

- epidemiology of drugs in the South African context
- explain the developmental norms and aspects of adolescence,
- highlight drug use among the adolescent population,
- provide information of existing drug treatment models used in the Western Cape,
- explore evidence-based approaches that specifically relate to the rehabilitation of adolescent substance users,
- report on factors that focus on an occupation-based perspective of assessment and intervention.

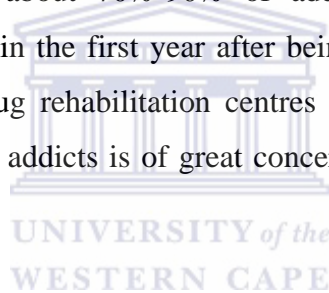
### **2.1 The South African context and illicit drugs**

A variety of explanations have been given for the high drug use and crime rate in South Africa but the period of political transition, meagre law enforcement services, inadequately patrolled transport and communication systems, and a weak criminal justice systems (Parry, Plüddemann, Louw, & Leggett, 2004), South Africa has become an easy market for the entry of drugs. As a result there is a rise in alcohol and drug related problems across diverse populations but over the last 10 years specifically, urban cities such as Johannesburg, Tshwane and Cape Town has seen a significant increase in heroin and cocaine. This has lead to an increase in the number of users and has placed established treatment facilities under pressure to expand their coverage and provision of services (Myers, Louw,& Fakier, 2008).



This is particularly evident in the Cape Town Metropole, which compared to other sites in South Africa, has a higher prevalence for drug positive arrestees (Parry, Plüddemann, Louw, & Leggett, 2004).

Useful information and the scale of drug abuse have been routinely collected by the South African Community Epidemiology Network on Drug Use (SACENDU) since 1996. According to SACENDU there are at least 30 operating drug treatment facilities in the Western Cape and over 100 community based organization (CBO) in Cape Town (Pasche, Myers, & Louw, 2008). However, the problem of substance use amongst adolescents continues to persist. According to Zille (2010) the provincial government has spent R100 million per annum on substance abuse programs yet, data collected from 27 specialist treatment centres in Cape Town over the period July 2003 to June 2007, showed that an average of 27% of the patients across the board were repeat admissions (SACENDU, 2008). Habil (2001) states that about 70%-90% of addicts who undergo rehabilitation probably return to the habit within the first year after being discharged. He adds that more than 70% of those attending drug rehabilitation centres would probably relapse. For this reason the rate of relapse among addicts is of great concern to both governmental and non-governmental bodies.



Evidence show that from 2002 to 2006 methamphetamines have replaced mandrax and with the explosion of its use in Cape Town, most staff in these facilities feel ill-equipped to cope with the psychiatric manifestations that methamphetamine patients experience particularly the symptoms of psychosis (Plüddemann, Myers, & Parry, 2008). Subsequently, the number of treatment slots in South Africa has increased from 1950 in 1994 to 2500 in 2006 and, 5800 in 2007 and the first half of 2008 (SACENDU, 2008). Many of these being private for-profit facilities which are unaffordable to the majority of the population (Myers et al., 2008) and for the remaining treatment facilities, state funding has not kept pace with the treatment demand (Myers & Parry, 2005). This demand was further manifested in the findings of a study in Cape Town where it was found that one in five clients attending a CBO have alcohol and/or drug related problems (Pasche, Myers, & Louw, 2008).

In another pilot study completed during 2009 and 2010 across the nine provinces in South Africa it was found that 65% of those surveyed admitted to having a drug user in their home. The statistics showed that the use of cannabis, cocaine and methamphetamine (tik) was twice the amount in South Africa as worldwide (Central Drug Authority, 2012). In addition, 52% of the cannabis users were under the age of twenty.

## **2.2 The rise in adolescent drug abuse**

### **2.2.1 Adolescent development**

No matter where one resides, adolescence is described as a period of experimentation, exploration and curiosity (Vourakis, 2005). A challenge facing most countries is to maintain the health status of its adolescent or youth population. Not only is this a basic human right but youth health yields immediate and long term dividends for human development and economic growth (Chimere-Dan & Makiwane, 2009). The period of adolescence, has been identified by many researchers, as one encompassing growth at levels of biological, social and cognitive development. This phase of transition into adulthood is an uncertain and risk-filled experience for most adolescents and it involves among other things psycho-somatic and social processes (Lloyd, 2005) that effect health status, health behaviours and health decision making.

The social development of an adolescent is enhanced through a mechanism of social networks. This means that the adolescent, without realising it, submits to at least some influence through a social contact. The primary influence noted by many researchers is that of the peer group. It acts as a mini-society in which the adolescent can experiment with social behaviour and relationships because it is viewed as a safe environment. The adolescents often wear the same styled clothes and use the same language as their peers (Fouché, 2005). Other than the group of friends, family members are also viewed as an important factor in the social network. They are the immediate role models and may be a major source of support. Among the most frequently identified protective processes against child and adolescent substance use and abuse are parental investment and family functioning (Vakalahi, 2002).

### **2.2.2 Illicit drug use by adolescents**

The statistics alone paint a very gloomy picture regarding this particular population and according to the National Institute on Drug Abuse (NIDA, 2003), the key risk periods for drug abuse occur during major developmental transitions. Now although it could be contended that in some societies an adolescent who did not try drugs, cigarettes or alcohol would be termed abnormal, in South Africa it was found that roughly one in six grade 11 male students have consumed cannabis (Parry, 2005). While it is established that the increase in treatment admissions for tik-related problems in Cape Town represents the most rapid increase in admission for a particular drug ever noted in the country (Plüddemann et al., 2008), it's more distressing to note that the dramatic increase of these admissions has been adolescents rather than older users.

In a study conducted by the Central Drug Authority in 2010, it was found that young people were dependent on alcohol and drugs from the early age of twelve. Drug dealers target schools in particular and drugs were disguised as lip balms, tattoos and lollipops. Even if most adolescents experience transitory problems that they can resolve, others with poor coping skills are vulnerable to intense emotional pain, and drug use can become a way to cope with both internal problems such as stress, low self-esteem and external problems like family or school (Mc Whirter, Mc Whirter, Mc Whirter, & Mc Whirter, 2007). Youth involved with alcohol and drugs pose a major problem not only to themselves but to the community as a whole. It cannot be emphasised enough that a young person who abuses drugs, his/her body does not function properly and their body structures may be damaged or destroyed. Subsequently, engagement in self care activities or participation in life situations are restricted and ultimately affect the individual's quality of life (O'Day, 2009).

### **2.2.3 Drug treatment for adolescents**

Literature does not list, nor is there a single criterion that will identify who will or will not use alcohol and drugs because adolescent substance abusers have different personality types, family histories, socio-economic levels and life experiences (Tait as cited in Stevens & Smith, 2009). However, following extensive work, researchers have fairly good knowledge about patterns in reproductive health, prevalence and trends in HIV/AIDS, but there is limited knowledge about other areas of youth health (Chimere-Dan & Makiwane, 2009). According

to the National Department of Health, many intervention programmes have been implemented to facilitate health promotion in social contexts such as family programmes so that youth can develop positive values of physical, emotional and spiritual health. But still, there have been few explorations into whether this has worked, or what method of drug treatment is best for the adolescent population. Furthermore, the active participation of youth in substance abuse treatment is not well understood (Gogel, Cavaleri, Gardin, & Wisdom, 2010) and little research has looked at perspectives that may inform understandings of these issues.

In view of important changes in the South African society in the past decade there is a need for researchers to identify critical factors that determine the health status of adolescents. There is a growing body of evidence-based treatments that have emerged in the last decade but disseminations of these trials have been slow to reach community settings. There is also little qualitative research on the experiences of adolescents receiving standardised treatments (Mason, Malott, & Knoper, 2009).

For these reasons families, communities and policy makers have become increasingly aware of the need to pay greater attention to the problem of substance use and dependence among youth. This increase of drug use in the adolescent population requires treatment services that are tailored to this population's unique needs (Vourakis, 2005). According to the United States Department of Health and Human Services (2002), the facilities that are available are not sufficiently comprehensive enough to meet the complex needs of adolescents. These include additional health services, possible psychiatric care, need for vocational training, educational services, family services and even legal advices as they may have been in trouble with the law. When these multiple needs are not addressed, the risk of relapse and poor treatment outcomes increases (Gossop, 2006; NHS, 2006).

In the South African context it is not always possible to provide the client with all services in the actual treatment facility but the services should be made available to the client in the community setting and should be met during the course of treatment. This is called integrated care pathways (Myers, 2007) and in the government plan to beat substance abuse it is identified, amongst others as a priority to implement (Zille, 2010).

In order to holistically understand whether drug treatment programmes or facilities are meeting the needs of those using the service it is crucial that core features of good-enough treatments are outlined, particularly those used in the Western Cape. A broad range of treatment services are available in the Western Cape. These include in-patient treatment that are either short term (21 to 28 days), medium term (up to 3 months) or longer term (greater than 3 months); community out-patient treatment programmes; re-integration services such as half way houses and; medical detoxification services (Myers<sup>2</sup>, Harker, Fakier, Kader, & Mazok, 2008). In-patient and out-patient drug treatment services are generally located in standalone facilities within a community while medical detoxification services are located at government hospitals, private hospitals and some specialised treatment clinics.

Out-patient treatment in the Western Cape differ in intensity, where the client may be expected to attend everyday and return to their usual living environment; these services range from attending sessions 1-2 times a week to 3-5 times a week (Myers<sup>2</sup> et al., 2008).

Myers<sup>2</sup> and colleagues (2008) argue that although there is no single treatment programme or modality that is appropriate to all individuals, target groups or community, treatment programmes should be flexible enough to adapt to the diverse needs of the community, groups and specific individuals. Some individuals are best suited for in-patient treatment, while others to out-patient treatment. Apart from this, evidence-based treatment should be culturally and age appropriate and should be adapted linguistically to meet national and local circumstances (UNODC, 2008). Whether services are high in intensity or low in intensity they are expected to possess staff that are trained and skilled in the field.

### **2.3 Evidence-based treatment modalities**

It is worth noting that the science of matching patients to treatment has progressed significantly over the past 10 years. The standard regimen of in-patient detoxification followed by aftercare, common in the 1970's and 1980's, has been replaced by attempts to tailor treatment to the patient's needs and base treatment on scientific evidence of efficacy. According to a substantial amount of drug treatment facilities, there are a few evidence-based treatment approaches being used in the Western Cape. They are applied in both the government and private sector, as separate approaches or combining one with another (Myers et al., 2008).

Globally there are at least 7 approaches being used in various treatment settings, however, the 12 Step Philosophy based on the Alcoholic Anonymous Model (AA) is most widely used in treatment facilities worldwide (Stevens & Smith, 2009). After the 12-step methods, throughout literature, three primary intervention methods were revealed. The first was brief intervention, cognitive-behavioural therapies, and motivational strategies. According to a study conducted in Pennsylvania involving 23 patients between the ages 13 to 20 years, brief intervention followed by three cognitive-behavioural sessions were reflected to be a helpful treatment experience (Mason, Malott, & Knoper, 2009). The adolescents further expressed that they became more aware of their social networks and their goals for present and future. In the Western Cape though, the 12 Step philosophy, cognitive-behavioural approaches and recently the Matrix Model are copiously employed and will therefore be briefly defined in the sections that follow.

### **2.3.1 The 12 Step Philosophy**

The AA approach is a set of 12 step guiding principles originally founded in the 1930's by members of Alcoholics Anonymous (AA). Twelve step methods have been adopted and adapted to address a wide range of substance and dependency problems. Twelve step programmes are at the heart of most treatment programmes in the USA (Burniston, Dodd, Elliot, Orr, & Watson, 2002). These are short 4-6 week programmes, typically offering a range of treatment consisting of individual counselling, group and family therapy, and recreational programmes.

Although 12 step approaches have met with considerable critique, outcome studies of clients using this approach have revealed abstinence success at 1 year follow up. But according to Doweiko (2006) research done using the AA Model is limited because the population in most studies have been composed of white middle class males. Minority groups therefore feel that the 12 step philosophy does not address ethnic related issues. Some evidence also indicates that the 12 step is not effective with individuals who are coerced into attendance like those who are sentenced to jail or to education programmes (Stevens & Smith, 2009). The outcome may be associated with either motivation or the concept of self-efficacy (Witkiewitz & Marlatt, 2004). This may present a major concern in the Western Cape as many adolescents are sent to treatment via the school system, parents or through judiciary procedures.



### **2.3.2 Relapse Prevention**

Relapse prevention is a cognitive-behavioural model based on the workings of Marlatt & Gordon in 1985. It was designed to prevent relapse in individuals who have received and who are receiving treatment for addictive behaviours. Relapse prevention strategies encompass the assessment of high risk circumstances such as people, places or events which trigger the need or crave to use drugs (Witkiewitz & Marlatt, 2004). According to Doweiko (2006) though, until recently there has been minimal research regarding relapse and relapse prevention in substance use programmes.

A review of controlled clinical trials of relapse prevention concluded that for a range of different substances of abuse, there is evidence for the effectiveness of relapse prevention but this approach is not superior to the 12 step philosophy and MET- motivational enhancement therapy (Carroll, Rounsaville, Nich, Gordon, Wirtz, & Gawin, 1994). Clients receiving relapse prevention may show sustained or continued improvement in their coping skills compared to those who did not receive relapse prevention training (Gossop, 2006).

For an adolescent though, because they feel invincible at times, it is possible that the danger exists that they would be unrealistic about their abilities and this would impact on their problem solving capacity. As the adolescent becomes more introspective however, the adolescent may begin to identify his/her own irrational thoughts and the sooner the adolescent learns the existence of them, the easier it may be to identify problems as he/she grows older (Fouché, 2005). Since the relapse prevention model is grounded on the theory that learning processes play a critical role in the development and maintenance of maladaptive patterns of behaviour (Marlatt & Gordon 1985), it has been applied successfully, and may be a positive option for the adolescent population.

### **2.3.3 The Matrix Model**

The Matrix Model of treatment was initially developed in the United States during the 1980's for the treatment of cocaine and methamphetamine dependence but has been adapted and is effective for a broad range of substance abuse (Myers<sup>2</sup> et al., 2008). It is a standalone treatment designed to be used in community out-patient settings. The treatment material include worksheets for individual sessions, family educational groups, client education

groups (information about high risk situations), participation in 12 step programmes, urine tests, social support groups and psycho education.

The provincial government of the Western Cape first replicated the use of the Matrix Model at the Helderberg Rehabilitation Care Centre in 2010, as a strategy to reduce the major increase of drug addiction (Luhanga, 2012). According to the Premier Helen Zille, the Matrix Model is successfully being run at centres in Worcester, Kraaifontein, George, Mitchell's Plain, and Khayelitsha, among other sites. To date, there are over 20 centres in the province using the Matrix Model and the City of Cape Town provides subsidised treatment to over 5200 drug addicts per year, by trained staff (Luhanga, 2012). In its approach, the Matrix Model borrows from motivational interviewing, where the therapist functions simultaneously as a teacher and coach (Rawson, Shoptaw, Obert, McCann, Hasson, Marinelli-Casey, & Ling, 1995).

A number of NIDA funded projects have demonstrated that participants treated with the Matrix Model show statistically significant reductions in drug and alcohol use (NIDA, 1999). In another study in which 8 different sites were involved, a project compared the Matrix Model of treatment with other methods available. Across sites the study found that those assigned to the Matrix Model had reductions in their drug use and better abstinence rates than individuals assigned to the treatment-as-usual groups (Galloway *et al.*, 2000).

#### **2.4 Factors influencing treatment and recovery**

According to Stevens and Smith (2009) recovery means restructuring the adolescent's entire life system regardless of the model chosen by the counsellor or rehabilitation facility. However, a number of factors highlighted in research studies may influence the treatment process of recovering addicts and the following cases are worth exploring with reference to seven factors. The first is a study examining access to substance abuse treatment of historically disadvantaged communities conducted in Cape Town. The findings indicated that there is a lack of capacity and *resources* to meet the demand of clients and that better quality services are needed (Myers, Louw, & Fakier, 2008).



The second factor is *retention*. In Oakland, California during 1995 a landmark study was done in which 3382 adolescent patients from 37 treatment programmes were involved. It was the first national study investigating the characteristics of the programme and the relationship of these characteristics with treatment outcomes (Galaif, Hser, Grella, & Joshi, 2001). Results of the investigation showed that both out-patient and in-patient treatment modalities and several risk factors such as criminal involvement, alcohol use, and existence of a psychiatric diagnosis were predictive of retention in treatment. Adolescents with high risk factors during pre-treatment periods tended to continue to be at risk during post treatment periods (Vourakis, 2005).

In another study that explored factors which facilitate ongoing participation and retention of adolescents in treatment, 28 adolescents were interviewed from three treatment facilities in two cities. It was particularly interesting to note that respondents reported more barriers than facilitators. Some of the barriers included the relevance of the programme, availability of qualified staff, and a lack of empathy portrayed by counsellors (Gogel et al., 2010). Parents and staff member were unlikely to see themselves as important in the process of treatment. More striking than the numerous barriers mentioned, was the fact that out of the 28 adolescents in the study, exactly half of them had been admitted to another in-patient treatment facility in the past. Also, 23 of them had been to an out-patient facility prior to the current in-patient facility, so it leaves room for reason as to why these adolescents are relapsing.

The third factor influencing treatment as noted in literature is debates around which *type of treatment* is better suited; in-patient treatment, residential treatment, out-patient treatment or detoxification. In a study done in England, 87 drug treatment services were involved, ranging from in-patient rehabilitation and/or detoxification services to general psychiatric units. Evidence from the study was consistent with other research indicating that better outcomes are reached for patients who attend in-patient detoxification followed by in-patient rehabilitation.

Therefore, there are grounds for assuming that if it were possible to provide detoxification and rehabilitation in the same context, it would reduce the level of treatment drop out and increase continuity of care (Meier, Best, & Day, 2007). This poses a problem for the South African context as the Department of Social Development has been made the lead department responsible for AOD (alcohol and other drug) prevention and treatment while the Department of Health remains responsible for medical detoxification (Myers et al., 2008).

Though it has been acknowledged that detoxification programmes have been implemented in recent years, *relapserates* are as high as 95% in Iran (Razzaghi et al. as cited in Golestan, Binti Abdullah, Binti Ahmad, & Anjomshoa, 2010). According to Bowen and colleagues (2009) relapse rates following substance abuse treatment are estimated at over 60%, hence substance use disorders are often being described as chronic relapsing conditions. An individual appears to be most vulnerable to relapse within the first 90 days after he or she stops the use of drugs.

But, as the concepts of dependency have changed over the years, so has the view of relapse. Stevens and Smith (2009) explain that a relapse is considered a return to uncontrolled drug use, while a lapse is usually temporary. Although AA defines a relapse as a failure in sobriety, many health practitioners believe that a relapse may be used to assist the client in learning what factors caused the relapse, and the information can be used to plan how to prevent it from occurring again. Most workers in the addiction field now view relapse as part of the recovery process and as a learning experience (Stevens & Smith, 2009).

While it may be considered a learning experience, high relapse rates are concerning and thus relapse prevention programmes have been created. More recent relapse prevention studies have compared the effectiveness of a specific approach that examine characteristics that serve as markers for its success, yet researchers have not consulted substances abuse patients regarding their perceptions of relapse needs (Walton, Blow, & Booth, 2000). However, a study in which 168 participants were recruited from a non profit agency after having completed an eight week relapse prevention programme, outcomes suggested that there were significant improvements in terms of cravings and relapse awareness compared to those who had attended standard 12 step-based programmes (Bowen, Chawla, Collins, Witkiewitz, Hsu, Grow *et al.*, 2009). In another study conducted in the United States, one hundred and eighty counsellors and patients completed a self-report questionnaire, in which it was found that

clinically both counsellors and patients provide unique information to maximize the understanding of relapse. Now although the patients were not specifically adolescents and neither was this study done in South Africa, the technique of considering both patients and counsellors' perceptions is consistent with studies of patient-centred approaches (Chewning & Sleath as cited in Walton et al., 2000) and future research should investigate whether substance abuse treatment outcomes could be improved via perceptions of counsellors and patients (Walton et al., 2000).

The fifth factor is *family*. At a place called Kerman, in Iran 226 adolescents between the ages of 13 to 20 were selected to partake in answering a self-administered questionnaire (Golestan et al., 2010). The results of this study indicated that many detoxification facilities only attend to medical needs without any consideration of important factors such as the family. The report showed a direct link between relapse and family variables. Whenever a person had an unfavourable family environment such as parental substance use, high family conflict, he or she would be placed in a relapse risk situation (Golestan et al., 2010).

Recently, studies have consistently shown the importance of parental involvement for treatment engagement, retention and outcomes (Shelef, Diamond, Diamond, & Liddle, 2005). It is essential for parents to understand how central they are to their adolescent's recovery. During a 2 year period adolescents and parents were recruited from four treatment sites across Maryland, USA. Participants were between the ages of 12-18 years and were drawn from the Cannabis Youth Treatment (Shelef et al., 2005). It was known as the largest clinical trial for adolescents conducted to date. One hundred adolescents who abused substances and their families received multidimensional family therapy (MDFT).

Of the one hundred adolescents, 89% were school going and 67% were under the juvenile justice system, while 52% were from single parent families. Results suggested that family involvement had an important contribution in the treatment outcome and in cases where the parent and therapist agreed on the same goals, parents were more likely to become engaged with their adolescent, both emotionally and in terms of day to day functioning (Shelef et al., 2005). Van der Westhuizen (2007) demonstrated that the lack of communication with parents; parental warmth and support are all aspects that could cause relapse in adolescents after treatment. Perhaps it's not surprising as to why Gordan as cited in Buddy (2008) states that relapse after treatment for drug addiction is common, predictable and preventable.

Another factor which surfaced relatively many times in adolescent literature was the *influence of peers/friends*. Having drug-using peers has been found to be one of the strongest predictors of drug use in young people. Prevention programmes designed to increase positive peer relationships focus on an individuals' relationship to peers by developing social competency skills. NIDA (2003) research found that when youth understand the negative effects of drugs and when they perceive their friends' and families' social disapproval of drug use, they tend to avoid initiating drug use. Although the common interpretation of these friendships may seem obvious, the specific nature of the relationship with adolescents and their friendships may be contested (Boys, Marsden, & Strang, 2002). One view is that young people are directly influenced by peers to use drugs (peer pressure). Alternatively some young people may report that the behaviours of their friends are consistent with their own (peer projection). The third view is that they choose friends who behave in the same manner as they do (peer selection).

Due to the various opinions regarding these peer relationships, a study carried out in Southern England involving 100 young people between the ages 16-22 years suggested that drug using fulfilled specific functions (Boys et al., 2002). Reasons and motivations for substance use could help inform the process of matching appropriate drug prevention and treatment activities to specific target groups. For example, it is possible that young people who primarily use cannabis to relieve boredom would respond better to a programme of alternative leisure pursuits. Similarly, the assumption that peer pressure is the main influence of drugs may not necessarily be correct, as prevention programmes at schools have shown few positive outcomes (Rosenbaum et al. as cited in Boys et al., 2002).

The seventh and final factor influential in the treatment process are views regarding *aftercare*. Research shows that individuals who participate in groups after treatment have lower rates of relapses overtime (Myers<sup>2</sup> et al., 2008). Furthermore, the United States Department of Health and Human Sciences (2002) states that of those who receive treatment, only a quarter receive the length of treatment time necessary to support success. Aftercare ensures that progress made during treatment is not lost and serves to further develop their skills to lead a pro-social and sober lifestyle and consequently avoid relapse (Gossop, Stewart, & Marsden, 2007). In South Africa, only recently has the importance of aftercare begun to be recognised and more

attention has been placed on its investigation (Myers<sup>2</sup>, Harker, Fakier, Kader, & Mazok, 2008).

In a study carried out in Canada, it was concluded that carefully orchestrated relapse prevention and 12 step facilitation aftercare programs yield process changes that are related positively to improved outcome. It was also found that the effectiveness of aftercare is influenced both by frequency of attendance and attainment of the targeted therapeutic objectives (Brown et al. as cited in O'Day, 2009). The study further demonstrated that clients can benefit from weekly educational sessions and that substance abuse is a chronic condition that necessitates a well thought out aftercare strategy.

### **2.5 Limitations of other studies**

Despite the many approaches available for the treatment of substance use, there are relatively few studies on adolescent substance abuse treatment outcomes and of those that exist some of them are methodologically weak (Williams & Chang, 2000). In a comparative review of 53 studies of adolescent substance abuse treatment outcomes globally, the following interesting facts were noted. Almost all the studies found were quantitative in its methodology and not qualitative ruling out valued experiences and opinions of direct recipients and providers of the drug treatment service (Mason, Malott, & Knoper, 2009).

Additionally, it is apparent that research has mainly taken place in the USA and Canada, and the results may not always be transferable to other countries. Another limitation found in literature is that adolescents are often difficult to contact and may refuse to participate in follow up outcome studies. Of the 53 studies reviewed, 48% had adolescent follow up rates of less than 75% (Williams & Chang, 2000).

Moreover, many studies have relied exclusively on adolescent self reports for determination of substance use post treatment and although self reports tend to be valid and reliable (Adair, Craddock, Miller, & Turner, 1996), it for example depends on whether parents are present at the time of the report and whether answers are given verbally. Other studies relied heavily on parental information only. It is therefore preferable to provide corroboration of the adolescent reports from parents or significant others such as educators or allied health workers (Williams & Chang, 2000). Also identified in the review of the studies, was the methodology in

evaluating the treatment outcome and how success is measured. Reduction in substance use appeared to be a more appropriate measure of success than abstinence, but it was only reported in 50% of studies (Williams & Chang, 2000).

Based on the literature reviewed, it is evident that although the prevalence rates of drugs in the Western Cape is known, such as common ages of those who use and even the destructive nature of the drug on peoples function and families, but very little information regarding feedback on these programmes or persons are described. Future qualitative research should continue to focus on the efficacy of treatments and simultaneously explore the lived experiences of adolescents (Mason et al., 2009). The undertakings of this research will therefore prove critical in providing information for the possibility of revising current approaches and give consideration to those who are directly and indirectly involved in combating substance use issues among the recovering adolescent population.

## **2.6 A need for an occupation-based approach to drug rehabilitation with adolescents**

### **2.6.1 Evidence-based practice**

Strong emphasis is placed on using evidence-based approaches, to ensure that a multifaceted response is provided to meet the complex needs of the adolescent due to their unique developmental positions (Tait as cited in Stevens & Smith, 2009) and that intervention is delivered in a planned and integrated manner (Carrick, 2004). Law (2002) suggested that evidence-based practice occurs when the clinician uses his/her expertise in conjunction with external evidence resulting in a better way to practice. Thus in recent years attention has been given to the selection of interventions and treatments suited for the needs of the patients.

Occupational therapy can provide comprehensive care, as occupational therapists are in distinctive positions to be aware of and adopt approaches espousing meaningful activities (Corvinelli, 2005) within a variety of contexts and practice settings. According to O'Day (2009) there is a need for occupational therapy services in treating patients with substance use disorders. Therefore, the Model of Human Occupation (MOHO) was selected as a suitable model in which the effect of drug use on an individual's performance may be conceptualised from the client's perspective and in this way a suitable strategy may be described to positively support and intervene within the adolescent population. An increased



understanding of the needs of those who misuse drugs may be of particular value to occupational therapists in creating a client-centred orientation for this group of individuals (Davies & Cameron, 2010).

## 2.6.2 The Model of Human Occupation

The Model of Human Occupation views an individual as an open system consisting of volition, habituation and performance capacity (see Figure 1 below). Volition involves an individual's personal causation, values and interests. Habituation refers to the individual's roles and habits while performance capacity pertains to one's skills. The person is recognised as participating in a balanced routine of work, daily living tasks and play appropriate to the person's environments, disabilities and developmental level (Kielhofner, 2002) in search of fulfilling his roles and even his needs. Cowan (2009) states that occupational needs become apparent when an individual has difficulty engaging in daily living which may be as result of physical, cultural, social or institutional environments.

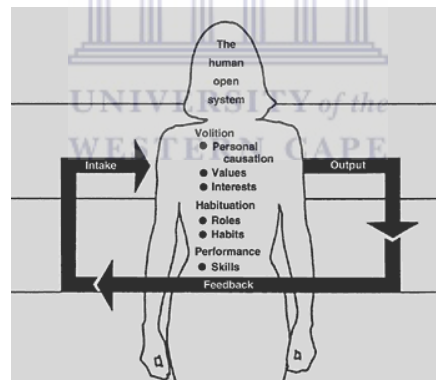


Figure 1: A depiction of the open system representing human occupation (Kielhofner, 1985)  
[Image obtained online at <http://lifeforretirement.wikispaces.com>]

As is understood, a person involved in any form of drug addiction experiences difficulties, dysfunction and disruptions in his/her occupational performance. Client occupational problems tend to be complex and deserve the careful attention of a comprehensive theoretical approach and a well-developed tool of intervention (Kielhofner, Forsyth, & Barrett, 2003).

The MOHO approach was utilized to develop occupational performance skills in persons undergoing treatment for substance use disorders and significant improvements in occupational competence, occupational identity, self esteem and quality of life were found (Boisvert, Martin, Grosek, & Clarie, 2008). Each of these areas has an important role in the development and maintenance of recovery.

The MOHO not only encourages the engagement of occupation as a treatment strategy to change maladaptive patterns of behaviour to adaptive skills (Kielhofner, 2002) but has been modified as a screening tool encompassing all components of volition, habituation and performance capacity. It is a useful tool for discussing current functioning and areas requiring change with clients. The MOHO Screening Tool influences occupational therapy practice from initial evaluation to a practical means of providing a valuable theory-based tool for goal-setting and treatment planning (Parkinson, Chester, Cratchley, & Rowbottom, 2008).

Occupational therapists utilizing the Model of Human Occupation would support clients to choose and participate in occupations that enable them to construct a positive occupational identity while ensuring that clients satisfactorily meet their occupational needs (Doble & Santha, 2008). While this construction involves multiple and simultaneous alterations to volition, habituation and performance capacity, the MOHO helps to clarify the individuals thoughts and feelings about their circumstances (Kielhofner, Forsyth, Suman, Kramer, Thomas *et al.*, 2008). In a vocational rehabilitation programme involving 20 clients with a psychiatric condition, the MOHO demonstrated that it could be used to effectively conceptualize the problems and needs of clients in the programme (Braveman, Kielhofner, & Bélanger, 2008). The results of the study further indicated that clients who used the checklists and scales developed from the MOHO theory and who received the rehabilitation services were able to identify leisure goals (Kramer, Bowyer, & Kielhofner, 2004), role choices, and had better independent living outcomes than the control group.

## **Conclusion**

Over the last few years the increase in statistics of drug use affecting the adolescent population globally and in South Africa has led to urgent research and development of drug interventions for adolescents. However, application and transference of this knowledge still



remains limited. Although existing evidence-based models of addiction treatment are known, none specifically considers the adolescent population and their needs.

In occupational therapy the intended outcome of intervention for substance use and abuse is that clients will achieve a lifestyle without the use of drugs and that the clients of the service will gain insight into their behaviour and will be equipped with relevant coping strategies and skills to improve their occupational performance. Their drug using activities will be replaced with constructive and satisfying activities (Wegner, 2005). Therefore, those that are discharged from treatment ought to seldom, if not ever be re admitted but rather become agents of change by reshaping their own life, gaining the ability to influence others positively and, encourage drug prevention in their communities.

MOHO based intervention is client-centered; the unique characteristics of the client should inform intervention and should be based on a collaborative approach with the client (Kielhofner, Forsyth, & Barrett, 2003). There is a general acceptance within literature from occupational science that an individual's health and well-being are enhanced when they orchestrate their occupational lives in ways that enable them to meet their occupational needs (Doble & Santha, 2008). The MOHO seeks to empower the adolescent by giving credence to their occupational life and issues. But, how best can one ensure that adolescents' needs are being met without consulting them directly.

A qualitative research paradigm allows for this as it permits the researcher to explore and deeply understand illnesses and therapeutic interactions in a context specific to the research participants (Johnson & Waterfield, 2004). Occupational therapy would only benefit from qualitative research as it is a profession dominated by personal interest in function of individuals and therapeutic touch. There is a need to listen to young people and allow them to influence service design and delivery. Their view can inform service representatives and providers on how to shape treatment that they are likely to see as credible (Carrick, 2004) and will go a long way towards attracting adolescents to the service, meeting their needs and avoiding their return.

## CHAPTER THREE: METHODOLOGICAL FRAMEWORK

### Introduction

In this chapter the aim and objectives of the study are stated. The researcher also provides a rationale for use of the descriptive-qualitative design within a qualitative research paradigm. In chapter three the methods of data collection, sampling, gaining access to the participants, analysis of data, procedures, establishing trustworthiness, the ethical consideration and lastly the limitations encountered during the research process are explained.

**Research question:** How are drug rehabilitation programmes meeting the occupational needs of recovering drug addicted adolescents in Cape Town?

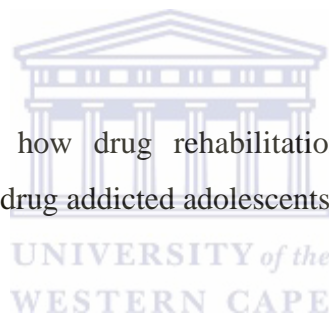
### 3.1 Aim of the research

The study aims to investigate how drug rehabilitation programmes are meeting the occupational needs of recovering drug addicted adolescents in Cape Town.

### 3.2 Objectives

The four objectives were as follows:

1. To explore the perceptions of recovering drug addicted adolescents with regard to drug relapse, and its effects on their daily occupations.
2. To describe the barriers that recovering drug addicted adolescents experience with regard to drug rehabilitation and their occupational needs.
3. To describe the facilitators that recovering drug addicted adolescents experience and perceive regarding their recovery process.
4. To describe suitable strategies and methods in which treatment centres or drug facilities may support recovering addicts once they have been discharged.



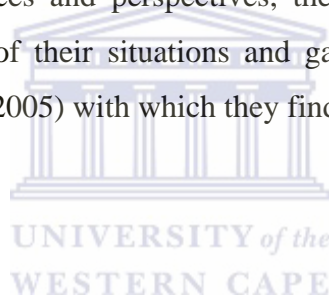
### **3.3 Research paradigm**

Occupational therapy is a service profession that has human interest and interaction at its core. The process of research should be able to explore the complexity of human behavior beyond the scope of quantitative data and a qualitative method allows the researcher to elicit meaning and experience from populations in diverse contexts (Hammell & Carpenter, 2000). It is only apt then that due to nature of inquiry; the actual research question demands that a qualitative methodology was therefore selected for the purposes of this study.

Moreover, the qualitative paradigm was undertaken for the benefit of clients with the goal of informing evidence-based theory and improving practice (Hammell, 2002). Since the inquiry focuses on the direct needs of adolescents and, it has been identified in literature that the adolescent population is very seldom afforded the opportunity to voice their direct interpretations of their experiences and perspectives, the qualitative paradigm allows the researcher to reveal the nature of their situations and gain new insights into a particular phenomenon (Leedy & Ormrod, 2005) with which they find themselves in.

### **3.4 Research approach**

Descriptive-qualitative research is used when a researcher wants to explore and then explain a phenomenon found in a real life situation (Mouton, 1996). The researcher describes the phenomenon and is given the opportunity to discover new meanings about it. Even though the researcher has a general sense of the expected parameters of the phenomenon, data may transcend what the researcher thinks he/she knows about the phenomenon (Englander, 2012). In the current study, the researcher wished to explore the perceptions and lived experiences of several individuals with regard to the phenomenon of drug rehabilitation programmes. This approach permits the researcher an opportunity to describe and document these participants' experiences and gives credence to their perceptions rather than quantifying them (Hammell, 2002). The descriptive-qualitative approach allows recognition of the adolescents' perspectives of drug rehabilitation programmes and their recovery. Furthermore, the approach affords the researcher an opportunity to explore and then describe an understanding about the research problem within the context of the study (Mouton, 1996).



For this reason the descriptive-qualitative approach was selected as it allows for the exploration of the insights of the recovering drug addicted adolescents, the parents' ideas regarding their recovering adolescents, and the knowledge of the adolescents' needs as seen through the eyes of the rehabilitation workers.

### **3.5 Sample selection**

For qualitative research it is important to select individuals that would best help the researcher to understand the research problem (Creswell, 2003). Patton (1990) views all types of sampling in qualitative research to be encompassed under the broad term purposeful sampling. In the current study the researcher decided upon a list of participant criteria prior to the research process, which the researcher believed would maximize the possibilities of obtaining information-rich data related to the purpose of the study. Coyne (1997) explains this to be the underlying principle of purposeful sampling, where the initial sample is determined and selected based on specific characteristics before the research begins. Thus, the recovering adolescent addicts were purposively selected not only based on the inclusion criteria, but according to their personal counsellors they would be able to communicate significant experiences, since they had been to a range of rehabilitation settings prior to the present one. According to the counsellors none of the adolescents were forced to participate.

With regard to the parents of recovering addicts the researcher made use of the technique convenient sampling. This involves selecting participants that are available at a time which is convenient for them and the researcher (Marshall, 1996). Even though convenient sampling is explained to be less effort (Marshall, 1996), a pre-determined list of criteria was constructed prior to the study, and the researcher ensured that the parents met this criteria.

#### **3.5.1 Sample size**

According to Leedy and Ormrod (2005) sample sizes for qualitative research are 5 to 25 individuals. For the current study the researcher selected eight recovering adolescent addicts and two rehabilitation workers. There was no doubt that the sample size was sufficient to generate depth and anymore participants would have been overwhelming, creating superficial data collection.

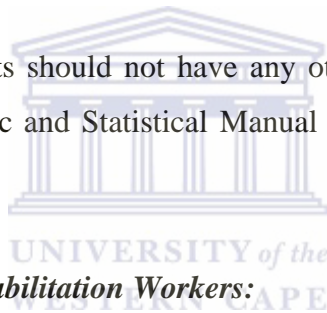
### **3.5.2 Selection criteria**

#### ***Inclusion Criteria for Recovering Adolescent Addicts:***

The eight recovering adolescent addicts (male or female) would be selected from a list of clients from the respective facility, and who has attended and received any form of inpatient or outpatient intervention from a non private rehabilitation programme. They would have experienced a drug relapse after attending a rehabilitation programme. The participants would be between the ages of 15-19 years, may be school going, volunteering, employed or unemployed. It was a requirement that the participants are able to understand English and/or Afrikaans.

#### ***Exclusion Criteria for Recovering Adolescent Addicts:***

The recovering adolescent addicts should not have any other psychiatric/medical diagnosis present (as seen in the Diagnostic and Statistical Manual of Mental Disorders-DSM iv-TR, 2000)



#### ***Inclusion Criteria for Drug Rehabilitation Workers:***

The rehabilitation workers (male or female) had to be employed or volunteering at the drug treatment facility or worked in the field of drug treatment for at least 2 years, they had to speak and understand English or Afrikaans.

#### ***Inclusion Criteria for Parents of Recovering Addicts:***

The parents (mothers or fathers) that were selected should be a parent of a recovering drug addicted adolescent, would be able to speak and understand English or Afrikaans. These parents may or may not be related or known to the recovering drug addicted adolescents that were to be interviewed in the study.

### **3.5.3 Participants**

To focus the research study on two geographical areas in the Cape Town Metropole and for transport convenience of the researcher, it was intended that the eight recovering adolescent addicts be selected from only two respective rehabilitation facilities and two workers from the same facilities. However, finding recovering adolescent addicts to interview was specifically challenging as-at the time of the interviews, not one rehabilitation centre was found that had catered solely for adolescents in the area originally demarcated for interviewing. Secondly, the rehabilitation facility did not have adolescents aged between 15-19 years available who had fitted the inclusion criteria. It was the assumption of the researcher that adolescents aged 15-19 was old enough to articulate their thoughts and experiences. Thirdly, because it was the intention to interview only those from government or semi-state funded facilities, as this was where the majority of clients ultimately sought treatment, the challenge of locating these participants was even more difficult.

Thus, eight participants from four rehabilitation centres in the Cape Town Metropole were interviewed and two rehabilitation workers who are employed at two drug rehabilitation facilities. The fact that the sample was taken from four rehabilitation facilities only contributed to gathering information-rich data through the eyes of people who have experienced drug rehabilitation programmes firsthand.

### **3.5.4 Gaining access to participants**

In the early stages of qualitative research it is suggested that the researcher begin to speak to knowledgeable persons in the field under study to locate the relevant participants that would yield a rich supply of data (Coyne, 1997). Hence, the chief counsellors or directors at the facilities were contacted telephonically in order to arrange a meeting. The meeting provided the opportunity to become familiar with the rehabilitation centres, to explain the details of the study, to identify willing participants to partake in the study, and to provide the necessary consent forms and information sheets. Specific rehabilitations workers who met the inclusion criteria at SANCA and Sultan Bahu Centre were personally asked to participate and agreed. One male and one female participated from two different rehabilitation centres.

Out of the four rehabilitation centres that was used in the current research study, only two had specific family group or support sessions. A counsellor at Sultan Bahu Centre mentioned that the researcher would be visiting, and briefly explained the intention of the visit to the parents. Those parents who were present were informed about the study and were permitted to ask questions. Englander (2012) explains that a preliminary meeting serves as an opportunity to establish trust with the participants, to review ethical issues and gives the participants a brief chance to ponder about certain experiences. All those present agreed to be part of the study and signed the consent form during this initial encounter with them (see Appendix C for Focus Group Consent Form). As this was already a scheduled time for the parents, the researcher was requested to include all those interested even though it consisted of more than 10 individuals. As mentioned previously these were open group sessions for parents and they voluntarily attended and therefore needed to be included.

SANCA Athlone also had family support sessions but the researcher was not permitted to communicate with the parents or ask them to participate as the counsellor said that the sessions are confidential and thus many parents would not want to be involved. The social worker at SANCA Boston-Belville said that locating the parents for the purpose of a focus group would be very difficult as parents were called in individually only at various times, but once a week the facility would take on new clients. The researcher was expected to be present at those times and ask any willing parents who met the inclusion criteria to participate. Only five agreed.

Consequently, three focus groups were run at one rehabilitation centre with a group of parents and two focus groups were run at another centre with different parents. Due to the nature of the first rehabilitation centre, being open group sessions, the sum of parents for the three focus groups were twenty-one parents, of which not all twenty-one attended each session. These participants were parents of recovering addicts but not the parents of the recovering adolescent addicts that partook in the current study. There were seven fathers and fourteen mothers from varying racial and religious backgrounds. Most resided in the area of the rehabilitation facility. In terms of the focus groups at the second rehabilitation centre, of the five females that participated, one was of White race, one of African race and three Coloureds. The socio-economic status of parents at both rehabilitation facilities seemed to vary between medium and low social income groups. Different parents were present at each of the focus group sessions facilitated at the second rehabilitation centre.



With regard to the recovering drug addicted adolescents, strict rules pertaining to confidentiality of clients were made apparent at the rehabilitation centres and for this reason, the researcher was not personally permitted to speak to, or ask any of the adolescents to participate. The respective counsellors at each facility identified an adolescent who fitted the criterion and provided the consent form to the client and his/her guardian, if this was necessary (see Appendix B for Consent Form). Only after consent from them, was the researcher allowed to meet and communicate with the recovering adolescent addict, further explain the nature of the study, and answer any questions that the adolescents may have had. The eight recovering adolescent addicts were between the ages of 15-19 years, of which six were male and two were female. Of the eight adolescents, six were learners and two were unemployed. Only one of them resided out of town while the others came from areas in and around the rehabilitation centres. With regard to race, two of the males were of white background while the remainder of the adolescents were classified as Coloureds (see Table 4 below for Profile of Participants).



**Table 4: Profile of Participants**

Key :

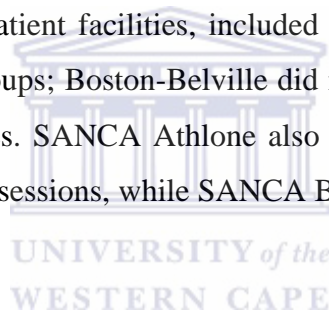
m-	male	L-	Learner at school	I-	Indian	OPF-	Out-patient facility	A-	Adolescent
f-	female	CS-	College student	W-	White	IPF-	In-patient facility	RW-	Rehabilitation Worker
E-	Employed	S-	Suspended from school	C-	Coloured	AR-	Age range	FGM-	Focus Group Member
U-	Unemployed	AB-	Absconded from school	AF-	African				

Participants	Gender	Age	Race	Occupation	Previous treatment	Current treatment
Chris	m	16	C	L (grade 10)	OPF	OPF
Kate	f	19	C	CS (2 <sup>nd</sup> year) + AB	OPF, IPF	OPF
Matthew	m	15	C	L (grade 10) + S	OPF	OPF
Tom	m	16	C	L + AB	IPF	IPF
Charlie	m	19	C	AB + U	IPF,OPF	OPF
Taara	f	16	C	L (grade 9)	OPF	OPF
Zack	m	19	W	U	IPF	IPF
Dylan	m	16	W	L (grade 9) + S	OPF	OPF
RW-Ben	m	AR 25-30	I	E + CS		
RW-Elize	f	AR 25-30	CC	E		
FGM at 1st rehabilitation centre	7×m 14×f	AR 35-55	2×W 2×I 17×C	Not known		
FGM at 2nd rehabilitation centre	5×f	AR 35-45	1×W 1×AF 3×C	5×E		

### 3.5.5 Rehabilitation facilities

The rehabilitation centres were chosen based on whether they provided treatment to adolescent clients and whether the centres in fact had recovering adolescent addicts. The facilities were also selected on grounds of their geographical location, and had to be government or semi-government affiliated. Four adolescents and one rehabilitation worker participated from the South African National Council on Alcoholism and Drug Dependence (SANCA) in Athlone and Boston-Belville. Although SANCA was initiated in 1953 servicing people facing alcohol problems only, it has expanded its service to include drug addiction.

SANCA Western Cape has six branch offices and provides accessible substance abuse prevention and equal treatment services for all South Africans. The rehabilitation programme at Athlone and Boston-Belville differed in some ways. Although they both had individual counselling sessions, were out-patient facilities, included motivational interviewing, 7 Step Philosophy, and had life skill groups; Boston-Belville did not have family support groups or high school outreach programmes. SANCA Athlone also incorporates the Matrix treatment programme and limited aftercare sessions, while SANCA Boston-Belville had not established this as yet.

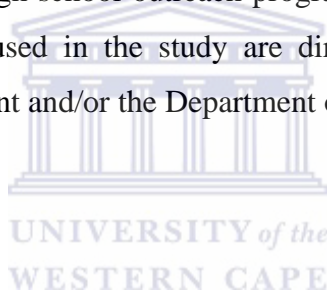


One adolescent participated from Tehillah Community Collaborative which was established 15 years ago. Tehillah is a non-profit organization in Elsiesriver rendering a holistic service to socio-economic challenged situations such as poverty or unemployment, TB and HIV/AIDS preventative programmes, and services victims of abuse especially women and children, and youth development outreach. Tehillah is an in-patient facility and the rehabilitation programme includes life skill development, family consultation sessions, education and training, entrepreneurial and work ethic skills, spirituality, and change awareness through knowledge of rights and responsibilities.

Another adolescent participated from the Western Cape Youth Rehabilitation Centre (WCYRC) in Eersterivier which was launched in 2010. The WCYRC is an in-patient facility servicing males and females with drug-related problems.

The in-patient rehabilitation programme usually runs for 8 weeks and thereafter clients are expected to return for regular out-patient sessions. The programme includes individual counselling, and group sessions in the form of life skill development, relapse prevention, education, arts, and sports.

The fourth facility where two recovering drug addicted adolescents and one rehabilitation worker came from was the Sultan Bahu Centre. The Sultan Bahu Centre was established in Johannesburg in the 1980's servicing public needs. Later it was realised that formal and specialised treatment for drug addiction is lacking in Cape Town and this led to the establishment of Sultan Bahu Centre in Cape Town in 2005. Sultan Bahu is an out-patient facility. The programme includes the Matrix treatment, relapse prevention, individual counselling sessions, group counselling, community outreach, recreation in the form of music and drama, family support sessions, knowledge and empowerment, and spirituality. The Sultan Bahu Centre also has a high school outreach programme included in its intervention. All drug rehabilitation centres used in the study are directly involved with the national Department of Social Development and/or the Department of Health.



### **3.6 Methods of data collection**

To access the perspectives and perceptions of the participants, two methods of data collection were used. For the parents, the researcher made use of focus groups and for the recovering drug addicted adolescents and drug rehabilitation workers, individual semi-structured interviews.

#### **3.6.1 Focus groups**

Occupational therapy practitioners may find the focus group method useful as it allows for discerning of a variety of client perceptions of a particular service or intervention (Hollis, Openshaw, & Goble, 2002) and for this reason, the focus group method was used. Parents from two rehabilitation centres were asked to partake in the focus groups. As mentioned earlier, the parents were different at each respective rehabilitation centre. At Sultan Bahu it was scheduled for parents to come in as they had family support sessions however, at SANCA Boston-Belville they were asked to come in especially for participation in the study

It should be noted though, that for a focus group a small number of participants, typically 6-10 people are selected and brought together for a carefully planned discussion (Hollis et al., 2002), but due to the programme-characteristic of the first rehabilitation centre, being open groups, each session contained more than 10 parents. Only five parents were present at the second rehabilitation centre. Knox and Burkard (2009) explain that the focus group method allow multiple participants to share their knowledge on a specific topic. The researcher sought to obtain the view of the parents regarding their challenges and experiences with their drug recovering children and how the rehabilitation programme has assisted them. Furthermore, the researcher wanted to obtain the parent's opinions on whether they were satisfied with the rehabilitation programme and whether the needs of their recovering children were being met.

Another advantage of using the focus group method was that this method is easily understood, reflects cultural differences and has high face validity by providing convincing findings (Hollis et al., 2002). The focus group method proved to be appropriate for the nature of this study as focus groups are generally anchored in a qualitative paradigm which reflects a person-centered, holistic perspective for achieving depth of understanding of the participants' reality. Therefore as a researcher and an occupational therapist, giving the parents an opportunity to relay their perspectives was particularly beneficial for future planning and aiding research in drug rehabilitation programmes.

### **3.6.2 Semi-structured interviews**

For a descriptive-qualitative research approach, the common method for collecting data is semi-structured interviews (Balls, 2009). Each of the eight recovering adolescent addicts and two rehabilitation workers were individually interviewed. Interviews carried out in person, as opposed to telephonic interviews were a suitable method for the qualitative paradigm as it allowed the researcher access to facial expressions, gestures and other paraverbal communications that enriched the meaning of the spoken words. Because the interviewer and the participant are in the same space they can build a rapport that will enable the participant to freely disclose experiences more effectively (Knox & Burkard, 2009).

The semi-structured open-ended questions, being more flexible in nature (Leedy & Ormrod, 2005), permits the interviewee to use whatever words he or she wants to in order to represent individual experiences. Turner (2010) explains that open-ended questions also allow for the interviewees to express their viewpoints in as much detail as they desire. Furthermore, to prevent responses from departing in just any direction, the method of semi-structured interviewing allowed the researcher to make use of an interview guide (see Appendix A for Interview Guide and Focus Group Guide). It served as a basic checklist of pre-constructed questions which ensured that the same relevant topic areas were covered but also assisted in making interviewing across a number of different adolescents more systematic. The follow-up questions or probing however as Turner (2010) describes, facilitated a degree of freedom or adaptability so that individual experiences could still emerge.

### **3.7 Data collection process**

The formal data collection process ran from May 2011 to April 2012. The researcher conducted the interviews and the focus group sessions without the use of a co-facilitator. In both the semi-structured interviews and the focus groups only an audio recorder was used. The recordings were saved on the researcher's personal audio device and computer and no one but the researcher had access to them. A personal diary was used during the interviews and focus groups to record ideas, for basic note-taking, for clarifying issues raised when necessary, and to document significant gesturing of participants.

The interview guide and focus group guide were also kept at hand to refer to. Certain points and feedback discussions with the research supervisor were documented in the notebook and field diary throughout the data collection process. The audio recordings were transcribed after each interview and focus group respectively. Thereafter the transcriptions were made available to the research supervisor with the knowledge of the participants.

#### **3.7.1 Becoming acquainted and establishing rapport with the participants**

In qualitative research the interviewer should create an environment that is safe and private (Bloom & Crabtree, 2006). On these grounds, the interviewer ensured that the interviewees were in a secured area familiar to the participants. The interviewer displayed respect at whatever information was disclosed. This indicates to the interviewee that their perspectives

are taken seriously and in turn contributes to a positive rapport (Boyle, 2007). Although there are different stages of rapport (Bloom & Crabtree, 2006), the researcher aimed to reach a stage of cooperation and participation between the interviewer and interviewee.

Furthermore, participant characteristics and values influence the actual interview process and relationship (Knox & Burkard, 2009). Therefore, with regard to the recovering adolescent addicts specifically, an interview is not a particularly comfortable experience as many adolescents feel the need to clarify their beliefs and to push boundaries of their acceptability. Moreover, if an adolescent has few social support systems and is embarrassed due to his/her lack of competence to express emotions effectively, they may be vulnerable adolescents and gaining access to them is difficult (Boyle, 2007).

Using clichés to respond to disclosures may lead the adolescent to perceive a lack of empathy which will detract from any attempt at disclosing important information (Boyle, 2007). With the above considerations in mind, the researcher ensured that genuine concern and interest were displayed and every effort to make the participants feel comfortable was exercised.

### **3.7.2 Procedure**

Most semi-structured in depth interviews are conducted once. They last between 30 minutes to several hours to complete (Bloom & Crabtree, 2006). For the current study, each semi-structured interview lasted approximately 40 minutes. Only one interview was held with each recovering drug addicted adolescent and drug rehabilitation worker. Due to the nature of semi-structured interviews, the interviews were like an informal conversation (Leedy & Ormrod, 2005) with the researcher doing most of the listening. Open-ended questions were used and it permitted the participants to express ideas in a manner that they wished.

With regard to the focus group sessions, prior to the facilitation thereof, a list of 7-9 core questions was drawn up by the researcher as guide to stimulate ideas from participants. Hollis and colleagues (2002) explain that the questions serve to direct the discussion and allow participants to interact with each other. The questions were checked by the researcher's supervisor to ensure their relevance and content-focus. Three one-hour group sessions were conducted at Sultan Bahu in Mitchells Plain while two one-hour focus group sessions were facilitated at SANCA Boston-Belville. Since the family group sessions at Sultan Bahu



occurred on a regular basis, parents seemed to be comfortable with one another during the focus groups too. However, at SANCA Boston-Belville apart from the fact that parent sessions had not existed in their programme, it was the first time that the parents had met one another and this created a concern for the researcher. The concern was soon eliminated when the parents acknowledged the purpose for the study and shared common opinions and feelings.

The need for further focus groups were evaluated based on saturation of data (Krueger, 1994) and this was achieved after three sessions with the parents at Sultan Bahu. The information expressed by the parents occurred repeatedly and the researcher could anticipate it. Onwuegbuzie and colleagues (2009) describe that at this point, the collection of more data has no additional interpretive worth. However, the researcher would have preferred a third session at SANCA Boston-Belville as this would have yielded even deeper information, but due to the parents working this was not possible.

### **3.7.3 Data collection environment**

When conducting the focus groups special consideration should be given to group dynamics as it affects data outcomes (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009). For this reason, due to the knowledge that certain parents may dominate the focus group while others may be shy to express their perspectives; the researcher afforded the opportunity for each parent on different occasions to respond to a question or to add to a comment. In addition, at the beginning of each focus group the participants were asked to identify themselves which proved useful for recognizing voices during the transcribing.

The interviews and the focus groups were conducted at the four centres. This was done as the participants were familiar with the area and actual venues. A well-recognized and socially orientated environment helps participants to feel safe and to share information (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009). Leedy and Ormrod (2005) also describe the importance of conducting the interviews and focus groups in a quiet place. Therefore, the rooms at the facilities were suitable as it was where one-on-one counseling sessions and group therapy sessions usually occurred, so the interviews and focus groups were unlikely to be interrupted or distracted.

The interviews with the rehabilitation workers were held in the respective office of the worker while the focus groups at Sultan Bahu were conducted in the group room and the focus groups at SANCA Boston-Belville took place in the social worker's office as this was the only room available that was suitable for conducting the interviews. With regard to the interviews carried out with the recovering adolescent addicts, six of them were held in a counseling room, one in a dining hall at the rehabilitation centre, and one in a conference room.

Lastly, the researcher did not have any previous experience in drug addiction treatment. Shank (2002) explains this to be advantageous at times as the researcher would then show and demonstrate authentic interest in what all participants had to say. The researcher opened up each interview and focus group session by briefly explaining who the researcher was and engaged in casual small talk. According to Leedy and Ormrod (2005) this contributes to trust, genuineness and openness of the group environment. The researcher ensured that the opinions of all participants were respected at all times.

#### **3.7.4 Incentives for participating**

The participants were notified in the information sheet that they would not be benefiting directly for participating but Onwuegbuzie and colleagues (2009) explain that arranging for refreshments creates an environment that is conducive to discussion, hence at all the focus group sessions and interview sessions, snacks and beverages were provided by the researcher. The researcher informed the counselor about the snacks as they were very strict with what the recovering adolescent addicts received. Regarding transport however, of the eight adolescents interviewed, seven were scheduled to be present at the rehabilitation centre at the given time so transport had been automatically arranged. One of the adolescents though was especially asked to come in for purposes of the interview so transport money was provided. Similarly, transport money was provided for the parents of the focus groups conducted at SANCA Boston-Belville as they were not scheduled to be present but stayed voluntarily for the purpose of the research only.

### **3.8 Bracketing**

In qualitative research the chance always exist that the researcher may have an unwanted and inevitable influence on how data is gathered, interpreted and presented (Tufford & Newman, 2010), either due to preconceived assumptions, interests or unacknowledged emotions. The method of suspending this unduly influence is known as bracketing, and for this reason any ideas or thoughts regarding the subject matter was suspended by the researcher thereby increasing rigor of the research project. Moreover, the researcher had no personal experiences in the field of drug rehabilitation or programmes, hence every perspective was recognized as noteworthy and fresh insights were being documented throughout the data gathering process.

Since it is expected that the researcher be honest about pre-existing thoughts and be vigilant about own perspectives, bracketing facilitated a deeper level of reflection across the stages of the research process (Tufford & Newman, 2010). Throughout the process, the researcher also made time to ponder and reflect on certain views or issues that may have been elicited through readings with current newspaper articles and headlines, or general encounters at the rehabilitation centres. These reflections, in the form of mind map notes were also recorded in the field diary and were discussed during meetings with the research supervisor. This allowed the researcher to obtain feedback from the supervisor and to set aside personal views from that which was gathered. It also served as a form of debriefing and venting.

### **3.9 Data management**

If data is managed appropriately at every step during the research process, it forces the researcher to correct both the direction and analysis of the study ensuring validity of the completed project (Morse, Barrett, Mayan, Olsen, & Spiers, 2002). Balls (2009) explain the benefits that the audio recordings not be delegated to someone else, rather the researcher should transcribe it. This encourages the researcher to be self-aware of own perspectives or values, and to listen to the researcher's interview skills and reflect on how this may have influenced the course or content of the spoken word. In addition, audio recordings of the interviews and focus group sessions should be processed as soon as they are saved (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). Thus, all the data was managed by the researcher and the audio recordings that were used during the focus group sessions and semi-

structured interviews were transcribed verbatim by the researcher, typed in a specific format for easy reading, and saved on the researcher's personal computer.

Each interview and focus group session transcription was titled, dated, and numbered. A space along the right hand margin was strategically provided for note-taking or comments. The researcher ensured that there was a standard convention for indentifying the researcher and participants throughout the transcript. Mack and colleagues (2005) explain that abiding to these techniques will not only avoid confusion but will save time later during the analysis process. Furthermore, they suggest that backup copies should be saved and stored at a separate location from the original recordings. For this reason individual copies were sent to the research supervisor via email. It should be noted that no personal identification of any participant was made known to the supervisor.

The first transcript was critiqued by the research supervisor for any information or questions that the research supervisor felt may be missing. Bailey (1997) confirms that this may assist the researcher to return to the setting and correct this if necessary. Consent forms, and notes made by the researcher in the field diary were kept separately from the transcripts in an equally secure location. A total of fifteen transcripts were printed for purposes of the researcher alone.

### **3.10 Data analysis**

Transcript-based analysis represents the most rigorous and time-intensive mode of analyzing data (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009). Although there are several ways of deriving meaning and making sense out of qualitative data, Moustakas (1994) states that all qualitative researchers generally employ a similar series of steps. The analysis process employed to eventually end up at some sought of a conclusion were numerous and required going over notes a few times, organizing raw data, checking patterns, and merging parts again. For the current study, Lincoln & Guba's (1985) method of data analysis was used and for purposes of explanation of the steps carried out by the researcher, the following four stages will be described.

### **3.10.1 Immersion of data and familiarization**

Immersion and familiarization of data is a structural and management process described by Patton (1980) that occurs throughout data management and data analysis. As reported earlier, fifteen transcripts were printed. The researcher initiated the familiarization process by reading the recovering drug addicted adolescents transcripts first, thereafter the rehabilitation workers and lastly the focus group transcripts. Each transcript was read multiple times to ensure complete familiarization of the texts and to get a feel of how much data there was. Sanders (2003) affirms that this gives the researcher a general sense of the whole content.

### **3.10.2 Content analysis**

In qualitative research, content analysis is fairly labour-intensive and the start of bringing meaning to the words of data (Taylor-Powell & Renner, 2003). Researchers have to remain true to the participants' words and meanings and to represent their experiences correctly (Balls, 2009). Thus, once the researcher was familiar with the transcript, units of meaningful and interesting information were identified from the transcript. The units of meaning are significant statements, phrases, or sentences that pertain to the phenomenon under study (Lincoln & Guba, 1985). Starting with the transcripts of the recovering adolescent addicts first, units were referenced and coded in the right hand margin of the transcript next to the participant's direct quote. Either the exact words were extracted as the code or a description by the researcher. This process was carried out through the entire transcript for each transcript. The transcript was then re-read to check for any omitted points or units of meaning.

Having located the unit of information, instead of placing them on index cards as suggested by Lincoln and Guba (1985), each phrase or piece of information was tabulated on the computer using Microsoft Word, without the use of a specific qualitative database programme. This was done for each transcript. In addition, accompanying each unit of information was the direct quote from the participant and the page number of the transcript. A large number of codes surfaced from the initial content analysis but as the process continued for each transcript, similar units of meaning, in fact some exact phrases became evident. According to Lincoln and Guba (1985), this is to be expected.

The codes from all fifteen transcripts were integrated and placed on the same tables with a record indicating which transcript they had come from. This was easily recognizable for the researcher and the research supervisor. On completion of this process of unitizing, the tabulations were sent to the research supervisor to ensure that the units of information were identified in a reasonably similar fashion to that of someone who was not present at the interviews or directly involved in the research. No major discrepancies were found and minor concerns were clarified.

### **3.10.3 Categorizing**

Categorizing is a step in analysis where the researcher groups and organizes codes that relate to the same content (Lincoln & Guba, 1985) or implied meaning (Taylor-Powell & Renner, 2003). Although a name is not officially given to the group of codes, a provisional description is formulated by the researcher and this becomes the provisional category. However, the researcher may adjust the description of a category or identify new categories to accommodate data (Taylor-Powell & Renner, 2003).

The researcher decided which codes should be grouped in a yet-to-be-named category and which codes should be referenced to a new category. The researcher followed this process for all the codes and the similar codes were placed together in a column. Lincoln and Guba (1985) explain that there may be codes that do not fit an emerging category and may be moved to a miscellaneous column for later reviewing. After reading each column it was evident that the column of codes had distinctive properties or meanings for its inclusion. Then, the codes were re-checked on the grounds that they are in fact coherent and at this stage certain codes were moved about to better suited columns. Ultimately, an emerging title and description encompassing the entire tabulated column/s was delineated to capture the essence of the column.

It is important that the researcher consult someone who may review the categories in order to determine the quality and effectiveness of the categorizing process (Creswell, 2007). Thus, regular meetings were held with the research supervisor to guarantee that no invented information was added and that original perspectives were not lost or misinterpreted. Furthermore, according to Lincoln and Guba (1985) the miscellaneous column should be re-

visited as the presence of applicable data may now be assigned to a category. The column was reviewed and it was noted that some of the quotes were in fact relevant to certain categories after all. Those codes that were unrelated or insignificant were discarded.

The columns which now had a category name were examined and it was evident that some of them could be sub-divided while others were subsumable. The researcher felt that the data had been exhausted and that saturation was reached as no new categories emerged (Bloom & Crabtree, 2006) or any new categories seemed redundant (Lincoln & Guba, 1985). Although there is not a clear point where categorizing begins or ends as ideas for linking and bridging categories occurs intuitively (Lincoln & Guba, 1985), towards the end of this stage, the researcher reached a state where refinement of terms and titles were established and clear patterns had emerged. In no specific manner, the provisional categories were being connected and began to enter into temporary themes.

#### **3.10.4 Inducing themes**

By nature, Patton (1980) states that qualitative data analysis is inductive as patterns and themes emerged from the data rather than being imposed on them. Additionally, when the material is worked through step by step and aspects or codes are as near as possible to the actual material or direct quotes, analysis is said to be inductive (Mayring, 2000). Therefore, the final stage of data analysis pursued was inducing themes based on connections made from and between categories. The categories, whether relating to an objective of the current study or based on construction of the researcher, was then linked together until all the categories had been sifted through to form different sets of categories.

The researcher ensured that no important perceptions and experiences from the participants were lost during this process and that perspectives were correctly captured. By re-reading through each set of categories a general theme surfaced. The set was given a theme name and description. A final number of three themes were induced, each containing categories and sub-categories. At this juncture the collecting and processing of data had stopped and the researcher felt that regularity was produced.



### **3.11 Establishing trustworthiness**

Trustworthiness in qualitative research is a broad concept referring to ways of increasing rigor of studies (Krefting, 1991) and encourages the reader to assess and be convinced that the study is worthy of confidence (Lincoln & Guba, 1985), and has value in its findings. For the purposes of ensuring trustworthiness the researcher made use of Lincoln and Guba's Model (1985) which consist of four criteria namely; **truth value, applicability, consistency and neutrality.**

The following techniques were used to ensure that implementation of the four criteria were practiced:

#### **3.11.1 Truth value**

Credibility is the strategy used to achieve truth value, and a number of activities demonstrate that the findings and interpretations arrived at by the researcher are credible.

##### ***Triangulation***

Triangulation is based on the premise that comparison of perspectives from two or more different methods of data collection or sources helps to confirm the data and examines aspects of a phenomenon (Hammell, 2002). Triangulation in this regard was achieved by using various data sources i.e. parents, recovering drug addicted adolescents, rehabilitation workers, and two data collection methods. The researcher employed semi-structured interviewing and focus groups to accommodate the different perspectives for the same research question. Moreover, in being explicit about using these methods and sources, the researcher ensured that the findings are reflective of the participants whom the researcher engaged with, and not the researcher's perspective.

##### ***Peer debriefing***

Another approach to overcome partiality and ensure credibility of the information is peer debriefing. This process exposes the researcher to uninterested peers or colleagues in a manner similar to an analytic session and for purposes of exploring aspects of the

researcher's findings (Lincoln & Guba, 1985). Although consultations were arranged with the research supervisor at regular intervals during the research process, preliminary findings were presented to lecturers at the UWC Occupational Therapy Department. This gave the researcher an opportunity to test working ideas and deal with biases. According to Krefting (1991) it also allows the researcher to clear the mind of emotions or feelings that could cloud good judgment. By being subjected to peers, it provided the researcher with new insights, and ensured that the conclusions are presented systematically and methodically.

### ***Member checking***

Member checking is technique used in which the researcher takes the interpretations and constructions of data back to the participants so that they may verify the credibility of the information (Lincoln & Guba, 1985). A meeting was arranged with the parents of the focus groups and approximately a third of the parents were present. The remainder of the parents were contacted telephonically most of which did not attend sessions at the respective rehabilitation facilities centres any longer. To those who attended, the researcher provided a copy of the provisional themes and categories after which the constructions were explained.

The parents and rehabilitation workers confirmed all interpretations and although no new data emerged, certain already constructed points were elaborated upon. With regard to the recovering adolescent addicts, the researcher had no way of contacting them except via their counselors. Numerous efforts were exercised by the researcher to contact and remind the counselors, but due to time constraints and according to the counselors, the adolescents' numbers had changed and they had not been to the rehabilitation centres since being discharged.

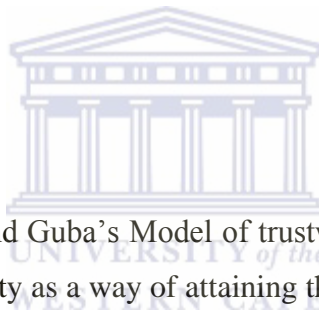
### **3.11.2 Applicability**

Transferability is the strategy used to assess applicability (Krefting, 1991). In qualitative research each setting is defined as unique and thus not open to mere generalization (Krefting, 1991). Moreover, the qualitative nature of the study dictated that the researcher explored and described perspectives of specific individuals within a specific context and time frame. But, having mentioned this, whether the perspectives of the adolescents, parents and rehabilitation workers hold the same view in other contexts is an inference which can be made by the

reader of the study. Although the findings were not meant to be generalized to other settings, the detailed inclusion of methods, purposeful and convenient sampling, and accounted procedures suggests that transferability may be likened to other contexts and hence be applicable.

### **3.11.3 Consistency**

Consistency is the third criteria to establish trustworthiness, and dependability is the strategy used to assess consistency (Lincoln & Guba, 1985). This was demonstrated by essentially replicating the face-to-face interview questions with more than one adolescent under similar conditions, thus the reliability of the research inquiry was indisputably established. Additionally, the use of credible methods of data collection (i.e. focus groups and interviews), which was managed correctly ensured that dependability of findings were achieved.



### **3.11.4 Neutrality**

The fourth criterion in Lincoln and Guba's Model of trustworthiness is neutrality. Lincoln & Guba (1985) suggest confirmability as a way of attaining this in qualitative data. To reach the strategy of confirmability, the utility of collecting, managing, and carrying out the research inquiry in a specified manner (audit trail) establishes confirmability, irrespective of whether an audit was intended (Lincoln & Guba, 1985). Two other techniques mentioned earlier, triangulation and member-checking also enhances confirmability of results.

Truth value, applicability, consistency and neutrality were employed by the researcher to ensure that trustworthiness was established and that the study was worthy of confidence. The researcher used methodological notes and consultations with the supervisor to ensure that no discrepancies existed during the data analysis process and in so doing reinforced credibility, transferability, dependability and confirmability of the constructions and interpretations of this inquiry. Although, no amount of audit or re-checking can ever compel a reader of qualitative research, it could at best persuade that the findings are indeed trustworthy (Lincoln & Guba, 1985).

### **3.12 Ethics**

The Helsinki Declaration compiled by the World Medical Association-WMA (2008) describes principles which have to be adhered to during research in order to guard participants against being harmed by the research process. It is also intended to respect human rights for dignity and privacy. Therefore, the research proposal for this study was considered by UWC Faculty Board Research and Ethics Committee, then by the UWC Senate Research Ethics Committee in October 2010. The project registration and ethical clearance was granted in November 2010.

The researcher has read and understood the ethical considerations and the following principles, as endorsed by the Helsinki Declaration (WMA, 2008), was adhered to by the researcher.

#### **3.12.1 Informed consent**

Informed consent is the ability to make a free and un-coerced decision (WMA, 2008). Children under the age of 18 are legal minors and accordingly have limited legal capacity to act independently without the assistance of an adult (Strode, Slack, & Essack, 2010). In research however, there is no clear legal statute specifying when children can independently consent but ethical norms do exist. Children under 18 years have the right to participate in matters that affect them (The Children's Act of 2005) whilst according to the National Health Act, the parent/guardian's consent is mandatory for all health research and children will consent alongside the parent if they have an understanding (Strode, Slack, & Essack, 2010).

Since the researcher was not allowed to contact the recovering adolescent addicts directly as this was the policy of the rehabilitation facility, an information sheet and consent form was emailed to each of their counselors (see Appendix E for Information Sheet). The researcher ensured that the recovering drug addicted adolescents were informed about the research study via their respective counselors. For the recovering adolescent addicts who were under 18 years of age, written consent was obtained from their parent/guardian, and verbal assent from the minor. Only once consent was obtained from the parent/guardian and assent for participation from them, was the researcher allowed to make personal contact with them.

Risks of research should always be fully disclosed at the beginning of the research relationship (Goldsmith & Joshi, 2012). Therefore, once initial contact was made, the researcher explained the process, aim of the study, predictable risks (emotional or social) and foreseeable benefits that may be imposed upon the recovering adolescent addict. Additionally, Goldsmith and Joshi (2012) explain that without the guardian/parent present, the adolescent is given the ultimate freedom to express thoughts or ideas. Thus, the recovering adolescent addicts were given the opportunity to ask questions pertaining to the study, assent to participation without the presence of significant others, and were informed that they may rescind at any time during the research process.

With regard to the parents for the focus groups, the researcher met with them personally and provided a copy of the information sheet. In addition, the researcher explained the aims and purpose for the study and asked whether they would be keen to participate. They were given the opportunity to read through the information sheet. Those who were keen agreed and once certain questions were answered by the researcher pertaining to the study, the parents signed the consent form. At the first rehabilitation facility an auxiliary counselor was present when the consent forms were signed and remained in the focus group for the duration of the session as this was a policy of the facility. For the second rehabilitation facility however, the parents were alone during the focus group session and for the signing of the consent form.

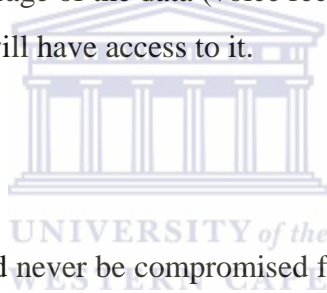
A similar procedure took place with the rehabilitation workers however verbal consent was first given telephonically as they had already received a copy of the information sheet via email. The researcher then arranged an appointment with them, and on meeting with them, explained the procedure and purpose of the study again. Both rehabilitation workers signed the consent form. All participants were made aware that their involvement should be completely voluntary and that they may withdraw from the study at any stage during the process without any consequences.

### **3.12.2 Confidentiality**

In research protocols issues pertaining to confidentiality and circumstances necessitating disclosure should be communicated with participants in a developmentally appropriate manner (Goldsmith & Joshi, 2012). With adolescents in particular, if they perceive there to be a barrier to confidentiality whether real or imagined, the interview may not be as

forthcoming and details may be omitted from any discussion (Boyle, 2007). Thus, having been informed about the nature of the study both verbally and in writing, the participants were asked whether they could be audio recorded.

Even though they preferred to be called on their first names during the actual focus group session and interview, they were assured that their names and surnames would not be used in any of the written notes, transcriptions or final document. The participants were also informed that the information obtained from them would be transcribed and this would be made available to the research supervisor. Furthermore, the participants were explicitly told that the final document would be seen by those involved in the marking and evaluation process of the document, all of whom would handle the data with respect. The participants understood the conditions and limits of confidentiality and agreed to be voice recorded only. Each participant was guaranteed that any information attained from them by the researcher will be privileged and that the storage of the data (voice recordings) would be kept in a secure place where only the researcher will have access to it.



### **3.12.3 Nonmaleficence**

The welfare of participants should never be compromised for research efforts and researchers should avoid any practice that is harmful to, or that may hinder the development of the participants (Goldsmith & Joshi, 2012). The researcher ensured that the principle of nonmaleficence was employed and every endeavor to protect the health, rights and dignity of the participants was exercised throughout the research process. The participants were made aware that by participating in the study, they would not be exposed to any known harm, neither any direct benefit. But, due to the nature of focus groups and semi-structured interviews, a referral source was made available to them if stirred emotions should be evoked during the focus group sessions or interviews. According to the Medical Research Council (2006) a referral source is a person who is able to offer professional guidance and help with problems that the participants may have experienced as a result of the study.

### **3.13 Limitations**

#### **3.13.1 Related to methodology**

An aspect which may be deemed as a limitation is the lack of prior research on this topic. Previous studies or literature lays the foundation for understanding the problem or phenomenon under investigation but due to lack of qualitative literature pertaining to relapse and adolescents, particularly in South Africa, perhaps certain challenges or methods could have been considered or made known to the researcher by previous studies. The second point relates to the sample; the majority of the recovering adolescent addicts were male while majority of the parents were female. This may have had an influence on the results.

A third perceived limitation relates to the data collection method. Because adolescents are known to value peer relationships and heterosexual relationships (Fouché, 2005), in hindsight, the researcher is aware that running an interactive focus group with the adolescents rather than individual face-to-face interviews may have yielded different information. With regard to the focus groups, the large number of parents present at the one rehabilitation facility may have also influenced the findings as conformity of group pressure could have resulted in individual opinions not being expressed or the participation of certain members may have been inhibited. Furthermore, the fact that an auxiliary counselor was present during the focus group sessions at the first rehabilitation centre may have impacted the responses from the parents and is therefore identified as a limitation.

The final methodological limitation relates to the venues for collecting the data. Although for reasons of convenience and safety the actual rehabilitation facilities were selected as venues for the interviews and focus groups, perhaps this very fact made the participants feel that they are being watched or that they cannot completely say what they would like to. It must however be noted that nothing of this sought was verbalized or observed by the researcher. Furthermore, because developmental stage, psychological factors, self-concept, and possible pressures all of which may have an influence on the research gathering process (Boyle, 2007), the researcher gave careful consideration to the participants to make them feel safe and relaxed.



### **3.13.2 Related to the researcher**

Two limitations are highlighted with regard to the researcher. The first is language fluency. Only participants who were able to understand and/or speak English and/or Afrikaans were used, as this was the languages that the researcher felt most comfortable with. The second factor pertains to access. Gaining access to the adolescents was time-consuming as the researcher had to go through their respective counsellors first. What could have easily been done in 6 months, if direct contact was allowed with the participants, was stretched to 12 months.

### **3.13.3 Related to trustworthiness**

If the participants can recognize their own experiences or words within the results, this lends credibility to the study (Balls, 2009) and therefore, it is important that the researcher go back to the participants with a summary of the main findings and interpretations to show that the results accurately demonstrate the participants' experiences. Although this process took place with the rehabilitation workers and a few of the parents, the researcher acknowledges that member checking was not done with the recovering drug addicted adolescents despite numerous messages and telephone calls to their counselors to arrange for a meeting with them. On many of these occasions the counselors were not available and they were unable to reach the adolescents. Due to policies at the rehabilitation facilities, the researcher was not allowed to contact the recovering drug addicted adolescents directly and their counselors therefore refused to provide their numbers. This was deemed as a limitation.

## **Conclusion**

The methodology used to obtain the results and achieve the aim has been outlined in the chapter and even after assessing the research paradigm, the research approach, the data collection sources, the data analysis procedures, trustworthiness, ethical considerations and the possible impact of the limitations, the researcher felt that every effort was exercised to ensure that the findings were validated and credible. The researcher learned and practiced good interview and facilitation skills, guided by the supervisor, to the best of the researcher's knowledge and ability. In addition to feeling that the purpose of the study had been accomplished, it was also felt that saturation of information was achieved with the participants that were involved. The findings will be presented in the next chapter.



## **CHAPTER FOUR: FINDINGS**

### **Introduction**

In chapter four, the main results of the research study are presented and summarised by using direct quotes from the participants to substantiate the interpretations as recognised and understood by the researcher. Three themes emerged from the data analysis process and will be described in this chapter. A summary of the findings and its relationship to the objectives will be shown at the end of this chapter, however the discussion thereof will be provided in the next chapter.

### **4.1 Background information of the participants**

The participants in the research were recovering adolescent addicts, parents of recovering addicts and drug rehabilitation workers. All the participants were meant to be selected from only two rehabilitation facilities as mentioned previously (Chapter 3) but the rehabilitation facilities did not have the participants which met the inclusion criteria, thus the participant population was extended to four rehabilitation facilities in the Cape Town Metropole. Although not equal in number, a representative from four of the racial groups was included in the study (see Appendix D for Profile of Participants).

The quotes by the participants have been referenced by making use of pseudonyms for the 8 recovering drug addicted adolescents and the 2 rehabilitation workers. For the parents, although the symbol (FGM) was used to indicate focus group member with its accompanying number, they may have originated from either of the two rehabilitation facilities. It should also be mentioned that at the focus group sessions which was held at the first rehabilitation centre, an auxiliary worker was present as a requirement by the rehabilitation centre. Quotes from these persons were indicated by (C) for counsellor.

## **4.2 Themes**

Themes are the starting point in which to report the findings of this study. Three themes emerged and for purposes of explanation each theme is divided into categories and further sectioned into sub-categories. This will be presented in a table form at each theme followed by discussions. The three themes are:

- Theme One: *Easy to get in, difficult to get out*
- Theme Two: *Breakdown on life caused by drug addiction*
- Theme Three: *Moving forward towards recovery*

At the beginning of each theme, the overall explanation of the theme will be provided before the discussion of the categories pertaining to the specific theme.

### **4.3 Theme One: *Easy to get in, difficult to get out***

Theme one is titled easy to get in, difficult to get out. This theme relates to the social, developmental and physical context of the adolescent. The theme is characterised by the circle of friends which the adolescent surrounds himself with, and the sense of fitting in which ultimately leads to the experimentation and use of drugs (see Table 1). The theme also denotes the ease with which an adolescent may fall prey to using drugs and then due to the nature of addiction, the difficulty of having to get out of this environment or condition.

The theme also makes reference to the fact that the adolescents deem themselves to be in the company of family members who are not always the best role models. Perhaps consequential to this, the adolescents then find protection with older non-family members in their residential areas which as it turns out are neither the ideal company. With regard to the physical context, the theme deals with the insurmountable accessibility and availability of drugs. Finally, theme one mentions the hindering factors that the participants have portrayed to be significant in drug rehabilitation and how it contributes to the difficulty of getting out of

the drug addiction lifestyle (see Table 1: page 56, showing categories and sub-categories related to Theme 1).

**Table 1:**

4.3 Theme One	CATEGORIES	SUB-CATEGORIES
<p><i>Easy to get in, difficult to get out</i></p>	<p>4.3.1 Pressure and sense of belonging through friends</p>	<p>a) Friends having power over you b) Experimenting together with drugs c) Drug use enhances popularity</p>
	<p>4.3.2 Adolescence is a stage of developing insight and coping skills</p>	<p>a) Curiosity and developing insight encourages drug use b) Drugs as a coping strategy</p>
	<p>4.3.3 Spending time with negative role models</p>	<p>a) Being surrounded by bad examples b) Finding guardianship in drug peddlers</p>
	<p>4.3.4 It's easy: just here on my corner</p>	<p>a) Physical environment enhances temptation of drug use b) Accessibility makes drugs easy to obtain c) Community allows drug use in plain sight</p>
	<p>4.3.5 External factors which hinder progress in drug rehabilitation</p>	<p>a) Poor handling by staff b) Lack of follow up-communication between rehabilitation facility and client base c) Lack of resources, staff and infrastructure</p>

### 4.3.1 Pressure and sense of belonging through friends

This category emphasises the value of peer relationships in the social context of an adolescent and what effect these relationships have on the adolescent's actions. It further explains the socializing agent that school represents and how adolescents would experiment with drugs to fit into a peer group. It also suggests that being involved in these very groups and partaking in the unfavourable activity of drug use, leads to popularity.

#### a) Friends having power over you

This sub-category speaks about the invisible yet significant pressure that peers have over the adolescent. The bond that they have with each other and for each other is so strong that leaving their friends can be felt as a form of betrayal. They are in each other's company everyday so much so that the adolescent recognises his group of friends as family. One adolescent described his relationship with his friends. He said:

*"I can't (leave them) I grew up from small, we do everything with each other, we come in trouble together everything (laughs) [...] almost like my brothers that [...]"*  
(Chris).

Often without realising, the adolescent places his friends in high regard. This was evident in the words of a parent:

*"I don't know but boys when when they sort of make their friends that's it [...] you don't say a bad thing about their friends and they always there for me and all of that"*  
(FGM<sup>2</sup>).

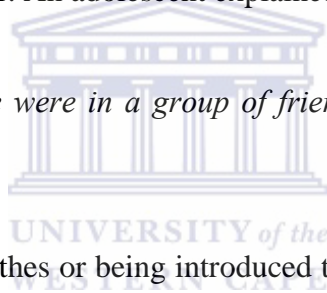
The definite sense of belonging and need for fitting in that the adolescents feel when they are around their network of friends results in them succumbing to what they do and when they do it. This is emphasised by an adolescent who said:

*“fitting in as a little English boy you know and uh there was lots of peer pressure [...] people used to make fun of me, they used to tease me a lot and [...] and I wanted to be accepted by people so eventually I started speaking like bits of Afrikaans, slang you know started trying to” (Zack).*

### **b) Experimenting together with drugs**

As an adolescent the idea of doing things together always seems more exciting. The adolescents deny being forced into the action but the mere fact that they are together demands that everyone participates together. An adolescent explained:

*“nobody force me but we were in a group of friends you see and then I wanted to experiment it” (Tom).*



Whether one is trying on new clothes or being introduced to a new drug, the circle of friends becomes the perfect arena to explore and drug experimentation becomes enticing. At that particular moment, the pressure in wanting to belong to the group of friends overpowers any restraint which may be involved in the choice to use drugs. Another adolescent said:

*“my friends slept over by my house and my parents wasn't there so we just tried everything” (Taara).*



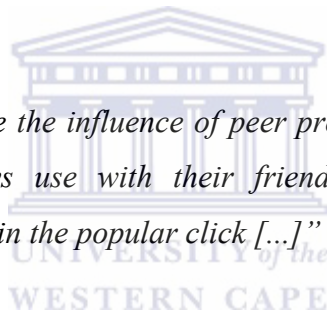
## **b) Drug use enhances popularity**

Wanting to feel recognised for something is not unheard of, and if drug use offers this esteem, it is inevitable that certain adolescents may find themselves feeding off this recognition. An adolescent described how drug use made her popular and feel important. She said:

*“so everybody knows me as that girl [...] you see the thing with the sand tools I had to teach people [...] okay people might have been doing it at home but nobody was doing it on college like I had to show them in order to sell [...]” (Kate).*

This need to be recognised and trendy specifically in the stage of adolescents is acknowledged by professionals as well and was substantiated by the quote of a rehabilitation worker:

*“we must not discount the the influence of peer pressure [...] when it comes to drug use, many of these guys use with their friends and if you don’t use drugs, unfortunately you are not in the popular click [...]” (RW-Ben).*



### **4.3.2 Adolescence is a stage of developing insight and coping skills**

This category makes reference to an aspect of the developmental stage of adolescence. The category accents that adolescents are in a significant transitional phase as they are still developing self-concept, skills, and learning to take responsibility. By nature of this growth and thought processes it influences the choices that they make.

#### **a) Curiosity and poor insight encourages drug use**

Adolescence is known as a stage characterised by curiosity. Curiosity propels teenagers to use drugs and the consequence of this curiosity is the furthest thing from their mind. The immediate satisfaction that the adolescent anticipates is what encourages the drug use.

An adolescent explained:

*“no when you do it such things, such things it’s it’s not on your mind it’s [...] do it, it’s gonna make me feel good now [...]” (Chris).*

The recovering addicts also gave accounts of past drug experiences which displayed that their intellectual insight has not fully developed. For some adolescents the outcome of their bad decisions is barred by their poor insight. This is indicative in the words of a rehabilitation worker:

*“when you dealing with an adolescent there’s [...] a sense of immortality that they portray [...] and they really feel untouchable and they don’t see their drug using as that much of an issue” (RW-Ben).*

#### **b) Drugs as a coping strategy**

In addition to poor insight and their curious nature, many of the adolescents are dealing with unresolved issues of anger; they find drugs to be the suitable defence mechanism. This was described by two adolescents. The one said:

*“why did I start [...] I dunno me and my mommy had this argument then I got so cross and she told me she’d rather have me doing drugs than having sex and so I went out to my friends and said well lets go try it [...]” (Kate).*

A few of the adolescents considered their parents to be too controlling. They felt annoyed and frustrated at being told what to do by their parents. Thus, the drug use gave them an opportunity to escape the reality of having to cope with or manage this frustration. The adolescents see the drug use as an immediate answer to their problem. This was highlighted in the views of one adolescent who stated:

*“umm my mom was carrying on with me, I was like angry the one day and she carried on with me like honest it was a random thing and yah I just thought nah I’m gonna walk around and I’m gonna buy me some and smoke” (Dylan).*

### 4.3.3 Spending time with negative role models

The adolescents described that they are not always surrounded by the best role models and this category indicates to the poor company that forms part of their social network. It further explains their perceived reasons for spending time with these negative persons and the consequences thereof.

#### a) Being surrounded by bad examples

Some of the adolescents felt that they are reprimanded at times by those who do not lead by example. One adolescent mentioned this feeling:

*“I can’t handle when, like my mommy used to tell me not to smoke cigarettes but then she’s standing with a cigarette in her hand like that thing” (Kate).*

Moreover, the adolescents said that they are accustomed to see and be in an environment not best suited for them. Two parents acknowledged this and explained:

*“die seun het gesien hoe sy pa die lolly aansteek [...] en die pa was mos nie ‘n voorbeeld vir hom gewees nie [...]” (FGM<sup>5</sup>).*

The second parent provided an example of a teenager who resides in her road. She mentioned how this particular teenager is constantly surrounded by a bad example and the effect that this has on the teenager’s behaviour. She said:

*“the other problem is, her mother is a drug addict and she’s fourteen and she’s absolutely beautiful and she ran away” (FGM<sup>19</sup>).*

Therefore, as an adolescent, being around bad company and having a perception of being controlled by parents, adolescents are drawn to older company outside of their home. A parent expressed this in the actions of her child:

*“net die skool gelos, sy het toe deel in ‘n groep wat genoem word ‘n gangster groep en umm sy het begin uithang met groterige manne wat [...] in die klasse van dertig en sy is maar nou sewentien” (FGM<sup>4</sup>).*

#### **b) Finding guardianship in drug peddlers**

The adolescents find protection and a sense of safety with older people who are often involved in immoral and perhaps illegal activities. Many of the places, sometimes of that belonging to merchants themselves, provided them with the non-judgemental environment in which they are allowed to smoke and spend time. The adolescents felt that they are part of a click and that they are taken care of by these merchants. An adolescent expressed this:

*“I went to the extent of sleeping by the merchant and everybody like knew and his been watching me since I’ve been small and I trusted him a lot and I knew he was always like a daddy [...]” (Kate).*

This comfort, trust and safety they feel and experience was spoken of by other adolescents too and emphasised in the quote:

*“I go with my friends we sit at this other man’s place, who smoke this thing [...] we grew up in that house but he’s not our family [...] he look after us” (Chris).*

#### **4.3.4 It’s easy: just here on my corner**

The physical context appeared to play a huge part in the life of a recovering addict and this is highlighted in this category. The participants relate their experiences of temptations that they face on a daily basis due to the areas that they live in. The category also makes reference to the openness of the drug trade in Cape Town.

Furthermore, the role that community members and neighbours play in contributing to the problem of drugs is featured in this category. Participants commented on their perceptions of community principles and how this impacts on those using the drugs. The category also displays the severity of the drug addiction and desperation of people in the community, which on the whole leads to its continuation.

#### **a) Physical environment enhances temptation of drug use**

Many of the adolescents considered their physical environment to be a major contributing factor for their drug use. They reported that it's effortless to obtain drugs as it is readily available in the areas that they reside. An adolescent explained:

*“well I stay in a very bad area so it's difficult to make nice friends there [...] I hang out with everyone and usually you don't know that they smoke until they actually light one in front of you” (Dylan).*

Several parents believed that the physical environment lures the adolescents into this lifestyle. One said:

*“dit is miskien die situasie en die environment waar ons bly ook, ons bly in flatse, die flats en daar is daar is baie baie daarom wat drugs gebruik” (FGM<sup>5</sup>).*

Another parent expressed a similar view with regard to the availability of drugs and further provided a reason for the significant crises of drug addiction. She said:

*“sometimes you see why is it that we have this big problem with drug abuse is that the availability of the drugs is tremendous [...] I'm now just talking about Delft ne [...] there are so many places” (FGM<sup>3</sup>).*

#### **b) Accessibility makes drugs use easy to obtain**

The accessibility of drugs seems to be a challenge impossible to escape. “Around the corner”, down my road, on my way to my friend are all ways in which the adolescents

described how drug traders surround them. An adolescent voiced the convenience of purchasing drugs:

*“I live next to a uh dinges, a merchant [...] yah it’s my uncle” (Taara).*

A different adolescent also emphasised this in the words:

*“it’s very easy...you go you go to the merchant [...] its easy yah [...] you just give him two rand or so, five rand go buy for me so they go [...]” (Chris).*

The extent to which accessibility is exercised was explained by the fact that drug traders will even come to an individual so that very little effort is needed by you to go to them. These sentiments were uttered in fury by two participants, a parent and counsellor who said:

*“no man it’s because they know where to get it and they go back to the same guy [...] it is so easy and accessible, you can just walk around the corner and you can buy it, you can phone and they deliver for you” (FGM<sup>1</sup> + C<sup>2</sup>).*

### **c) Community allows drug use in plain sight**

Drugs are used openly in the streets and yards of residents. The drug addicts display no shame or fear at the fact that someone may see them. Most of the adolescents said that no one admonishes them. This represents the decline of values and morals that exist in communities. One adolescent further described:

*“they soema stand on the corners and smoke, sometimes they just also in the yard then they smoke” (Matthew).*

A few parents mentioned that you would see the addicts smoking on the corners of roads or in drive-ways but the addicts would not even hide or move away; neither would some parents do anything about it. Another adolescent said:

*“people would rather protect you to do something wrong [...] my mother brought me up if I saw something wrong you must go and tell [...] now they don’t tell, they would say come smoke in my yard as long as you are not smoking with gangsters” (Zack).*

And although a number of adolescents expressed their involvement in such activities, they acknowledged that this was part of the drug problem.

#### **4.3.5 External factors which hinder progress in drug rehabilitation**

Drug rehabilitation centres are set up mostly so that addicts recover and maintain sobriety and therefore should include factors which promote health and wellness for the recovering addict. There were however a few obstructions to this process, specifically pertaining to the drug rehabilitation facility, which contributes to the difficulty of getting away from drug use. These aspects were mentioned by participants and they are described in this category.

##### **a) Poor handling by staff**

Although this sub-category is not meant to compare the different staff members from various facilities, it was interesting to note that the adolescents made quite a distinction between which handling methods they responded to positively and which hindered their progress. A few issues were described by the adolescents.

Firstly, one adolescent felt that at the adolescent’s previous rehabilitation centre the staff members were too unsympathetic. The adolescent felt that there should be a level of firmness but not to the extent to which some of the staff treated them. The adolescent explained:

*“not here but over there they used to push you too much it’s like a jail, they weren’t understanding to make it easier, I don’t know how else to put it” (Kate).*



Another adolescent shared a similar view in terms of handling. This adolescent described that if a fight broke out amongst addicts in the rehabilitation centre, the groups or addicts were not separated in what the addict deemed to be a healthy way or a discussion of some sort. The adolescent felt that many of them had anger problems so fighting seemed to make matters worse. Instead the adolescent reported:

*“there [...] when you fight, they the care-workers they soema moer you you see [...] and that’s where I get angry, when you moer me I moer that guy again you see [...]”*  
(Tom).

When asked about having individual sessions with specific staff members to discuss concerns, the adolescent responded that they only received group sessions or sports and as a result according to the adolescent, the rehabilitation facility was not suitable and the adolescent remarked:

*“no no but but they didn’t told us that there were counsellors you see [...] the fifth day they sent me home”* (Tom).

Many of the rehabilitation programmes involved doing a number of assignments and handing it to the counsellors. Since most of the adolescents were school-going a few felt that they were unable to manage both school tasks and rehabilitation tasks. One adolescent said that marks would be subtracted from the adolescent’s school assignments as it would be handed in late. The adolescent stated:

*“I couldn’t study like properly and I couldn’t hand in my tasks on time [...] cos they give us like tasks here almost every day [...] then I give it in late then the teachers deduct marks”* (Matthew).

#### **b) Lack of follow up-communication between rehabilitation facility and client base**

It was found that the rehabilitation facilities operate differently with regard to follow up with their clients. One adolescent said that since the adolescent had completed the programme, he had never been called by the centre either for a check up or to attend sessions.

Most of them felt that knowing that the counsellors check up on them would help keep them on their toes. The adolescent said:

*“No they don’t actually phone, this was the first time they phoned me like for the interview [...]” (Matthew).*

When parents were asked about whether they get a programme or whether counsellors follow up with the adolescent after the programme, one parent said:

*“no no not really. It’s only here that it gets checked up [...] when they come at the centre [...]” (FGM’s).*

The parents mentioned that the counsellors encourage the addicts during the rehabilitation programme to continue with the sessions after they have completed, but if they do not attend, the recovering addicts are not contacted. Another parent further added that there are too many addicts in the programme and said:

*“they can’t concentrate on the recovery (recovering addicts) so what is the recoveries (recovering addicts) doing? Relapsing again [...]” (FGM<sup>3</sup>).*

Lastly, some parents were of the opinion that the counsellors do not inform the parents about resources that may be available in the community for the recovering addict to be involved in once the formal programme is completed. Two parents said:

*“they can teach them skills or whatever [...] help them with recovery and while they are looking for jobs [...] yah but they don’t inform you and if you don’t work you don’t have experience [...] that’s the first thing they say” (FGM<sup>7+1</sup>).*

A different parent shared also this opinion and said:

*“maybe there is a lot of training colleges but the people is not aware of [...] no one makes us aware, if we are aware then we can go to these places you know” (FGM<sup>4+12</sup>).*

Another parent stated that since there were no family sessions at the centre that her adolescent attended, the parent did not always feel informed about the rehabilitation programme or role that the parent had to play. The parent added:

*“I think maybe if we knew more about what what they are doing then [...]” (FGM<sup>2</sup>).*

### **c) Lack of resources, staff and infrastructure**

A great concern was raised among many parents with regard to space and room at the drug facilities. Parents reported that the demand for drug rehabilitation was so great that space at the centres were becoming too small and often addicts had to be turned away. One parent said:

*“now the other day when I was sitting here [...] Rocklands High [...] ten children of Portlands High was sitting there and five of them was busy with drugs, where do that five children go? There’s no place for them here, now they need to get a date for next year” (FGM<sup>3</sup>).*

In terms of resources, one of the adolescents explained that skills needed to be taught during the programme in the case of the recovering addict not finding a job, but due to lack of space at the facility this was not possible. The adolescent remarked that the programme is going to come to an end for all the addicts and with no practical skill or money, the outcome would be unfavourable. The adolescent said:

*“when am I gonna get money for a bursary aww I wanna study this is my passion but I can’t, so if somehow government or whoever could sponsor these things or make ways possible or give out bursaries to [...]” (Zack).*

Separate from resources and infrastructure, there was little doubt that shortages of staff were a major concern at the rehabilitation facilities too. When asked about why more staff is not employed, a rehabilitation worker said:

*“I think it’s probably government that’s funding certain posts and things like that” (RW-Elize).*

Parents seemed to show the same concern in terms of staff shortages. One parent said:

*“they can’t handle the the [...] they don’t have staff, that’s why” (FGM<sup>4+10</sup>).*

It must be reported though, that on the other hand, due to the knowledge of shortages of staff, certain counsellors offered their time and made their contact numbers available to assist the recovering addict or parents, even out of work hours. One counsellor mentioned:

*“we would love to do more but due to lack of staff we can’t have that approach” (C<sup>2</sup>).*



**4.4 Theme Two: Breakdown on life caused by drug addiction**

Theme two underlines the apparent negative impact that drug addiction has on the adolescent’s education, family, mind, and body (see Table 2: page 70, displaying categories and sub-categories of theme two). While schooling is usually the primary occupation of a teenager, the havoc caused at this level ripples into other aspects of the adolescent’s life. Family relations are severed by bad actions towards parents and siblings and basic self-care tasks are neglected. This theme also addresses the manipulative behaviour which the adolescent has mastered to obtain drugs, to hide its use and to feed the habit. This results in strategies to deceive counsellors, parents and even the court system, which has a negative influence on the values, morals and attitude of the adolescent’s identity. Lastly, the theme presents the breakdown of life caused by the vicious cycle of relapse.

**Table 2:**

4.4 Theme Two	CATEGORIES	SUB-CATEGORIES
<i>Breakdown on life caused by drug addiction</i>	4.4.1 Negative influence on productive-related activities	a) Negative influence on school
	4.4.2 Destructive impact on family relations due to negative changes in the addict’s behaviour	a) Loss of trust by family members b) Disrespect towards parents and siblings c) Repetitive mood and attitude problems d) Repetitive stealing without consideration
	4.4.3 Harmful effect on body, mind and image	a) Negative effect on physique and diet b) Negative effect on self care c) Negative effect on consciousness and judgement

	4.4.4 Harmful effect on self concept and identity through manipulation tactics to feed the habit	<ul style="list-style-type: none"> <li>a) Manipulating the drug test</li> <li>b) Manipulating the police and court</li> <li>c) Manipulating the family</li> </ul>
	4.4.5 Relapse as a vicious cycle	<ul style="list-style-type: none"> <li>a) Unfamiliarity and different views on relapse</li> <li>b) Lack of leisure opportunity and money matters</li> <li>c) Poor support system and sense of shame due to past drug behaviour leave the adolescent unaided</li> <li>d) Getting away from the drug environment is easier said than done</li> <li>e) No plan after rehabilitation is detrimental to recovery</li> </ul>

#### **4.4.1 Negative influence on productive-related activities**

The phase of adolescents is characterised by one of many roles, for example, from being a scholar at school or college, a part-time employee, a sibling, son/daughter, a peer and a sportsman. But irrespective of what the primary productive activity may be, drug use has a harmful effect on the functioning of that role at all levels and this category is indicative of that.

##### **a) Negative influence on school**

This sub-category demonstrates that one cannot disregard the enormous, negative outcome drug use and abuse has on the adolescent's education. Their schooling has been disrupted to

the extent that they've failed a year or their grades have dropped. Some of them, due to drug use have only now realised how much of school they have missed. One adolescent said:

*“yah but I'm not passing this year, I haven't been there whole term, this is the first year I stayed out for the whole term, it really got bad, I didn't even notice it was the whole term” (Kate).*

Another adolescent said that he was caught with drugs on school and was asked to leave completely. This was detrimental to the process of learning so much so that getting in at another school became very difficult. The adolescent described that because he missed more than a term, he would probably have to repeat the year. Another adolescent mentioned her experience:

*“yah I was at school, grade 9 [...] they absconded me” (Tom).*

A parent also displayed her concern at the effect that drugs had on her child. The principle said that the child may only return on completion of a programme at a rehabilitation centre. The parent voiced her worry:

*“sy het die skool gedrop die tweede jaar in graad tien” (FGM<sup>4</sup>).*

#### **4.4.2 Destructive impact on family relations due to negative changes in the addict's behaviour**

The family is usually the primary relationship and this category draws attention to the harm done to this relationship as a result of the drug use and dependency. Broken promises and insolence towards parents and siblings by the addict places the family at a complete loss of trust towards him/her.

##### **a) Loss of trust by family members**

Apart from the major dysfunction caused at school level, the bulk of damage and complaints was attributed to the distrust and disrespect of the adolescents to that of the addict's family,



particularly parents and siblings. There is a clear loss of trust from parents due to actions and behaviour of addicts as a result of the drug use.

A parent exclaimed:

*“how must I feel? I will never trust him, I don’t trust him at all, hy het vir my seer gemaak [...] I really looked up at him, maar nou ek kan nie [...]” (FGM<sup>1</sup>).*

Most of the adolescents realised the damage they have done to their families over a period of time. One adolescent explained that as the family relationship became severed so did most of the other aspects in his life. He said:

*“yoh it affected my life alot [...] my family, the bond between my family wasn’t so good” (Tom).*

Others acknowledged that it will take time to achieve trust again and some implied regrettably that without trust there is no family bond. One said:

*“look when I was in the addiction actively I had no trust in my family I just could do whatever I pleased [...] and now I am in a relationship where I am building that bond back with them [...] you can say I forgive you but the trust won’t be there. Every time I walk near to the money they gonna think hey let me hide my bag away” (Zack).*

## **b) Disrespect towards parents and siblings**

The sheer disrespect shown by the adolescent addicts towards their parents and siblings was described as one of the most unbearable things that the parent had to go through. In a quote by a parent it was evident that she was frustrated at the disrespect shown towards her. In fact, it seemed that she was at a point of hopelessness. She exclaimed:

*“I’m sole alone. My kind het nie eers respect vir my man nie, I can [...] really man how far can you go?” (FGM<sup>1</sup>).*

Many other parents are expected to deal with the same level of disrespect. One parent said that it is as if they are treated as children while the children are dictating to them what to do. Another parent described that she had had enough, still the contempt she received from the adolescent was heartless.

She said:

*“whatever die vierteen gebeur moet die hof nou decide cos hy wys mos toe wat hy uitkom was hy meer kwaad vir my, hy sê vir my yah you can't force me to come right man, you think this that you did putting me in jail, now in the cell is gonna help me?” (FGM<sup>20</sup>).*

In another description, the effect that the drug addict has on the siblings living in the home was felt in their expressions. According to some parents, many siblings feel afraid of the adolescent addict. A mother described that her younger daughter and son gets very anxious when the older son comes home as the siblings fear his behaviour and shouting. She added:

*“sy broer moet uit die huis uit en dan sou dinge reg wees want eintlik is sy broer baie uittarterig teen aan hom [...] hy is 'n kind wat baie hy hy dinges hom baie, en hy werk op hom soos hy op my werk” (FGM<sup>5</sup>).*

### **c) Repetitive mood and attitude problems**

Many of the parents described their adolescents as displaying anger problems. One adolescent also acknowledged this and said it is something she had to work on but it is ultimately the parents and siblings at home that bear the brunt of it. An adolescent reported:

*“no like when once me and the other girl argued and so I threw her with a chair so the counsellor said I must go stand outside so I came back in and so we argued again so I threw her with my shoe [...]” (Taara).*

The extent of the anger is what most parents struggle with. It is not just shouting or screaming but the verbal behaviour turns into physical anger as well. One parent expressed:

*“die kleintjie het ‘n short temper [...] toe kom hy deur die dak skop die trap door stukken en in die huis, toe raak hy mos nou onbeskof, toe gaan sluit hy die deur oop vir die ander” (FGM<sup>20</sup>).*

Many parents find themselves in a very difficult situation. They explained that it is only since their child has been on drugs that they have displayed a very bad attitude. The parents described that the attitude problem was observed in the way the adolescents would walk, their mannerisms and even in the way they would respond to the parents.

One parent said:

*“he is like a skollie, that skollie attitude [...] you don’t tell me nothing. I walk like that and you don’t worry about nobody now” (FGM<sup>1</sup>).*

Another parent also noticed this change with her child. The parent stated:

*“haar attitude wys vir my, maar sy sy don’t care, haar attitude. Maar sy is heeltemal toe soos ‘n boek, sy praat nie [...]” (FGM<sup>4</sup>).*

#### **d) Repetitive stealing without consideration**

Another challenging behaviour trait synonymous with drug addicts is stealing. The majority of parents and adolescents described this. Parents said that their child would steal grocery items, equipment, tools and money.

One parent shamefully explained:

*“when I come back from the shops [...] the groceries is still sealed [...] so he’ll steal all those sealed packets [...] and things and go and sell them, so now I’ve learned to just open them [...]” (FGM<sup>3</sup>).*

According to many mothers, the inconsideration of the addict's stealing would be so clear because it would be at the expense of the other siblings in the house and results in the breaking of family ties and relationships. A parent sadly declared:

*“hy het al met honderd rande wegehardloop van my [...] en dan moet ek en die ander kinders sonder stukkies brood uitslaap” (FGM<sup>5</sup>).*

Another parent related her experience and said:

*“now I noticed money missing from my purse and umm one time it was eight hundred rand and [...] now my eldest daughter's getting married so I was putting money away [...]” (FGM<sup>2</sup>).*

Moreover, the impact that stealing has on the household as seen above is already hostile but having to deal with outsiders is often worse. Neighbours also had to suffer at the hand of the addict's stealing and many of them are furious by the fact that the addicts get away. One parent admitted and shared her fear when the parent said:

*“he steal gates from the other other people outside [...] for twenty rand for dagga [...] its not right because I come at home and one of the people come there at home and say your son did steal that man's dinges [...] and said he gonna go to the court” (FGM<sup>1</sup>).*

#### **4.4.3 Harmful effect on body, mind and image**

The fact that adolescence is a period of major physiological and psychological changes, many participants viewed the use of drugs to have a significant impact on their body, mind, and image. The category highlights these changes with regard to their physical appearance, the adolescents' eating habits and how drugs negatively influence their self-worth.

##### **a) Negative effect on physique and diet**

Most of the adolescents and parents described that the loss of body weight was as a result of drug use. The parents said that when their child was using drugs, they did not seem to have

appetite for ordinary foods. Two parents explained that they only noticed the differences in the dietary habits of their adolescents' once they were well into the drug abuse. They said:

*“Ek kan sien hy eet nie, hy drink my melk [...] ja hulle drink melk lyk dit vir my want melk bly nie in my huis nie. Hulle eet sagte kos en dan vir stysel lyk dit my” (FGM<sup>4+5</sup>).*

Another parent believed that her child realised the effect it had on her body and therefore wore two or three pairs of pants so that the adolescent may appear fatter. The parent described the child as flesh and bones. It appeared as though some of the adolescents were in fact aware of this physical change and recognized the effect that the drugs had on their appearance. One adolescent explained that people would notice this difference and ask about it. He stated:

*“I just feel so cos when I'm using it I'm falling down I'm getting thinner I wasn't like this before like you can see on my ID now [...] drugs, yah that's why I told myself I don't want to use it anymore” (Charlie).*

Furthermore, according to a few parents, once the adolescent stops using drugs, their weight increases tremendously. The parents seemed concerned as the adolescents would substitute drugs with food which had a direct impact on their physique and appearance. Needless to say this would not be a healthy situation for the adolescent. One parent said:

*“let me tell you, as soon as he stops the drugs then he's gotto move to something else and [...] most of the time with, I see with the majority of the drug addicts they tend to eat more [...]” (FGM<sup>2</sup>).*

Another parent shared this view and added:

*“dit is dieselfde [...] hy was nooit so uitgevreet soos hy nou eet yah [...]” (FGM<sup>1</sup>).*

## **b) Negative effect on self care**

The recovering addicts described the effect that certain drugs had on their appearance, which influenced their body image. Once in the lifestyle of searching for the next fix, they became unmindful of self care tasks. The adolescent addicts described that seeking drug money was a priority so much so that they would not care about self care tasks or healthy living. One adolescent expressed that he would wake up and not even brush his teeth.

He mentioned:

*“I don’t get dressed anymore I don’t take pride in myself, my self-esteem lowers down and I start thinking how can I make money” (Zack).*

In relation to this, one parent also noticed this change in her adolescent:

*“Sy was baie lady-like maar sy het nou so slorderig geword dat sy gee nie om hoe haar kamer lyk nie. Sy is verskriklik slorderig, sy mos met haar hare, die een kleur op die ander kleur [...]” (FGM<sup>4</sup>).*

In both quotes, the neglect of self care tasks combined with low self esteem is apparent on the adolescent. According to another adolescent she observed this first hand with her aunty and explained it to be very unpleasant:

*“I think it it it like your image [...] like the tik [...] in my aunty if you get sore, you don’t heal quickly and the teeth is is, how do you say is crumbling [...] they don’t look after themselves” (Taara).*

## **c) Negative effect on consciousness and judgement**

Already certain adolescents are known to display an attitude of invincibility, so with the inclusion of drugs and its effect, the outcome is further harmful. One adolescent reported that when you are using drugs, you don’t see its use to be damaging.

He said:

*“it’s almost like that drug they taking it make them, they don’t listen to you like like me, when they told me to stop I didn’t listen, it’s almost like it goes in but it comes out the other ear [...] it makes you almost like that drug makes you strong, you think you better than everyone” (Chris).*

An additional harmful effect as described by another adolescent is its impact on one’s reality. The adolescent would start hearing things or become unreasonably fearful of something or someone. Other adolescents also described the effect it had on sleep patterns which ultimately interfered with their judgment and awareness. This was emphasised by the quote of one adolescent who said:

*“for about eight-nine days I couldn’t sleep constantly [...] if you came to me I would look at the button on your sweater and think there’s a camera there recording me [...] I’d think you’d be wired” (Zack).*

#### **4.4.4 Harmful effect on self-concept and identity through manipulation tactics to feed the habit**

Addicts go to a great deal to get themselves out of a particular situation and this category describes how they justify and deceive various people in order to smooth over the situation so that they may return to their bad habit. The parents and surprisingly the recovering adolescents admitted and confessed to the activities and lies for survival of the drug lifestyle.

##### **a) Manipulating the drug tests**

Drug testing would be carried out once a week during the rehabilitation programme or sometimes randomly at certain schools. The adolescents would strategise and discuss with one another ways in which they could manipulate the tests. Much of these tactics involved planning, for a reason that they deemed priority; to hide their drug use.



One adolescent said:

*“I drank a bottle of vinegar and two bottles of water, that’s what my friends told me [...]. They said it works cos [...] I’ll pee all the stuff out of my system [...]. It sounded so right at the time [...]. (laughs) Yah and then I came to learn that I don’t need to do that I just need to take the water out of the toilet yah” (Kate).*

The extent to which they would plot to hide their drug use is evident of the dysfunction that they have found themselves in. Whether these methods are true is not in question but the degree to which they would attempt to hide their use is alone disturbing.

A parent said:

*“yes I heard if you on tik you must eat a whole tin of condensed milk then it will show up negative [...].” (FGM<sup>15</sup>).*

#### **b) Manipulating the police and court**

This manipulation extends to police offices or even judiciary officers in the court system. All of the adolescents had been in some way involved in trickery and manipulation of this nature. Some informed how they would buy drugs and then change their clothes as a precaution in case someone was watching them. The addicts have mastered the style and manner in which they can con the police officers. One adolescent said:

*“yah there in Manenberg its very fast to sell something and put it away, you walk, when they gone you go get it again, or put it somewhere, make a hole in here [...] put it there in so [...] they very clever there (laughs)” (Chris).*

Another adolescent added:

*“the police come there but it’s almost like he buries the stuff in, how do you say in holes [...] and in the roof and behind the paintings and stuff like that so even though they come there then [...]” (Taara).*

Furthermore, not only do they manipulate the police so confidently, another adolescent told of his experience with the court officials. The drug lifestyle that these adolescents have found themselves in leads to survival tactics simply to feed the habit. It is scary and no less difficult for the parents of these adolescent addicts. When asked about how the adolescent managed to avoid prison, despite being caught red-handed with drugs, the adolescent said:

*“cos I lied to them but they didn’t know I lied to them about the drug so that’s how I came out [...] if you know how to do it in court then you know how to survive to get out of court” (Charlie).*

### **c) Manipulating the family**

Many parents particularly the mothers expressed that their adolescents manipulate them due to their soft nature. A parent displayed her frustration:

*“the fact remains that you try so hard [...] hulle vat jou altyd vir ‘n aapie” (FGM<sup>1</sup>).*

Other adolescents manage to hide it from their parents for weeks. One said:

*“they didn’t know about it [...] still now they don’t know I’m using drugs” (Charlie).*

The deviousness of the planning that the addicts go through to manipulate various situations is frightening. The problem, as noted by the parents is almost impossible to flee from and the parents admitted that they cannot work alone to solve the crisis of their children. A different adolescent stole a ring from his mother and perhaps later realised the consequence of the action, so the adolescent decided to book himself into rehabilitation facility to avoid being arrested. A counsellor explained the manipulation:

*“he took that ring and he sold it and he knew he was in trouble so what he did hy het homself gaan in-book nogal by ‘n in-patient [...] cos hy het geweet die is tronk toe [...] en dan phone die rehab nou vir haar om te sê hy is nou daar en almal daai vir ‘n six months programme” (C<sup>2</sup>).*

#### 4.4.5 Relapse as a vicious cycle

A number of reasons surfaced as to why adolescents relapse. These views are the perceptions and experiences of those directly involved in drug addiction and this category elicits their responses. The variety of reasons for relapsing demonstrates the complexity of its occurrence.

Many parents described their frustrations at the fact that their children experienced a relapse more than once, despite the fact that they had been supportive. The rehabilitation workers however, had the view that abstinence and relapse may be part of the recovery process that they have to go through.

##### a) Unfamiliarity and different views on relapse

Almost all the adolescents had heard the term relapse but did not understand the full extent of its meaning, neither why it occurred to them. One adolescent explained:

*“it’s almost like when you did smoke ne and you did give it up, but say about the next month or so you you give in almos like you go back to it you smoke again den you relapse [...]” (Chris).*

Another adolescent had no idea what it was and asked the researcher to describe the term, despite the fact that the adolescent had been to and completed more than one rehabilitation programme. When asked about what the meaning of the term is and why the adolescent relapsed, the adolescent responded:

*“I don’t actually know what is relapse I just heard about the word [...]” (Taara).*

A few of the adolescents accepted that they had relapsed, some more than once; however most did not comprehend why and neither was it perceived as something they took seriously. When asked about relapsing, one of the older adolescents remarked:

*“on relapse [...] it’s doing something again, and for me it was like a cycle because this is not my first rehab [...]” (Kate).*

Even though the majority of the adolescents did not realise the seriousness of relapse and they did not view it as a lesson in the recovery process, two of the recovering adolescent addicts felt remorse and stated that relapse is a choice and that the addict needs to get out of the addiction lifestyle. One of the adolescent's said:

*“it's just a bad decision but I don't wanna make it again” (Dylan).*

Some parents seemed to have more knowledge about the term but also could not explain why their specific children relapsed. When the parents were asked whether they think their child knows what the term relapse means in connection with drug recovery, one parent said:

*“I think he probably would to be honest to tell you what it means but if he fully understands it I can't say” (FGM<sup>2</sup>).*

According to the rehabilitation workers, relapse was seen as a part of the process of addiction recovery. One of the rehabilitation workers mentioned that there are a few things that the addicts get taught in order to prevent it, however the worker said that they are regularly reminded that recovery is a continuous struggle. The worker said:

*“it's part of recovery but they shouldn't have it in the back of their mind [...]. I always say you should take it one day at a time [...].” (RW-Elize).*

A different worker also mentioned that because addiction is a chronic condition and should be understood in this way, relapse does not usually occur over night as there are a number of factors that contribute to it wholly. The rehabilitation worker further stated:

*“relapse is a process rather than a singular event” (RW-Ben).*

Although relapse is meant to be avoided, if it does occur counsellors were of the opinion that it should be taken as an experience to learn from. Since there are a few things that triggered the relapse, it gives for opportunity to discuss with the addict and therefore awareness is raised with the addict.

According to a rehabilitation worker, when a relapse arises, the worker said:

*“get them back into the treatment fold [...] see the events that lead up to the relapse, analyse it, put measures in place so that it does not get repeated so a relapse can be used as a learning curve” (RW-Elize).*

## **b) Lack of leisure opportunity and money matters**

A few adolescents felt that in the area they lived, there was very little opportunity to participate in leisure activities. Although some acknowledged that there were places of fun and entertainment, they said that even those have become competitive and dangerous. One adolescent remarked:

*“it’s boring now for us, there’s no sports for us like sports people making sports [...] there is a game shop but [...] the people don’t worry about that games, there’s trouble in that games [...]” (Chris).*

Another point, particularly raised by parents was the fact that when the adolescents leave the rehabilitation programme, many of those who are not schooling find it hard to secure a job, even if they make an effort to look for one. Parents said that the children end up sitting at home and before you know it they are back to their old ways. One parent mentioned that his child matriculated last year and still could not find a job. Two parents explained:

*“as die kinders klaar is met die programme [...] stuur die perfect kinders huis toe dan is daar niks om te doen nie [...]. Daar is nie werk nie” (FGM<sup>3+4</sup>).*

The final matter raised in this sub-category was the issue of finances. Some adolescents mentioned that they have interests such as studies or sports to pursue but when you leave the programme, you have no money. Moreover, those adolescents said that money is scarce at home too, so they cannot obtain money from their parents.

An adolescent stated:

*“sometimes we don’t have the opportunities [...] cos what if your programme finishes tomorrow and only a job comes or a bursary comes after two years [...]. What’s gonna happen to you in that two years? Are you really equipped?” (Zack).*

A parent also shared this view when asked about hobbies or interests to assist the adolescent in recovery after the programme. The parent expressed:

*“hy wil graag rugby speel vir die hoerskool [...] ek het met die pa gepraat al, hy makeer togs, ek het nie geld vir togs nie” (FGM<sup>5</sup>).*

### **c) Poor support system and sense of shame due to past drug behaviour leave the adolescent unaided**

Poor support by family members was strongly raised as one of the major factors as to why adolescents relapse. Two adolescents spoke about how ordinary it was for them not to have parental support in their life. When asked about support and encouragement from siblings or parents during recovery, one adolescent said:

*“for me living there where I live it’s almost like [...] I’m on my own. I live by myself like I make my own food, I wash my own school clothes, I do my homework and when I’m done I will go to my friend’s house or I’ll come sleep so” (Taara).*

On the other hand, a number of the adolescents said that their mothers were supportive while their fathers were either unaware of their situation or working out of town and therefore could not be involved. One adolescent spoke about his father:

*“yah he’s alright, he tries to do he’s thing but I don’t listen to him because he hasn’t been there so [...]” (Dylan).*

Parents who have been through this process with their child have come to realise that the support system from parents and siblings is paramount in preventing relapse. A parent mentioned that at another rehabilitation facility that the parent previously attended with his adolescent there was a visible lack of support by parents. A different parent echoed this and said:

*“that the support structure needs to be there cos there are several parents that I know [...] that is not with us whose children has gone back to where they came from [...]” (FGM<sup>3</sup>).*

The second issue raised by the adolescents was the feelings of regret that they had as a result of the things they did to family and neighbours due to the drug habit. The adolescents’ said that even though they would come out of the drug programme they would still be treated by some with a sense of rejection. One adolescent expressed:

*“people don’t like you, normal people that don’t use won’t like you cos they think you gonna steal from them or something yah [...]” (Dylan).*

Another adolescent whose uncle is a drug dealer, spoke about how neighbours in the area that she lived in, would give negative remarks and stare when passing by. The adolescent further explained that she therefore preferred to attend a rehabilitation facility where no one would know her, or her connection with her uncle. The adolescent said:

*“because if I’m somewhere else then everyone obviously knows that I’m [...] with my uncle them, the children’s parents that come buy there, they when I walk in the road then the woman will say it’s my it’s my it’s my family that is ruining their lives and [...] then they will skel and so” (Taara).*

Even though most of the adolescents accepted that they are responsible for making people think of them in a certain way, they said that they do feel regret. One adolescent felt that she would never be forgiven for things that she had done.

When asked about how she would like to be treated, the adolescent answered:

*“not to look at me with the with the thought that I do this [...] because I done alot of stuff before [...] I used to fight, I used to steal [...] and now when I’m going now by my old school again, the teachers don’t like me anymore because I was very aggressive so” (Taara).*

#### **d) Getting away from the drug environment is easier said than done**

The temptation of the environment including the presence of drug merchants and circle of friends was another significant factor that surfaced as to why adolescent’s relapse. A rehabilitation worker emphasised the difficulty that is involved in maintaining abstinence by recovering addicts. The worker said:

*“look they are changed but the it’s not like the environment changes when they do go back, it’s the same environment, so it’s really difficult for them when they are clean to maintain sobriety [...]” (RW-Elize).*

Many parents, who were regular attendees to the programme, also raised the issue that the environment is very hard to get away from. One parent spoke about the challenge of getting away from the friends as they strongly influence relapse. The parent added that the adolescent had to personally, with the help of the parent, tell the gangsters to leave him alone as the adolescent was not interested in the dealings anymore. The parent stated:

*“he didn’t want to leave them; he still went there at night. It’s very difficult to turn your back yah, you must turn you back. It’s not easy” (FGM<sup>3,4+17</sup>).*

Another parent said:

*“they are maybe locked up for a month [...] they don’t mingle with their other friends [...] but the minute they are let out...they can’t wait to get a fix but like these guys they have to pass that merchant, they have to walk pass their triggers [...] so the outside treatment I found it worked better” (FGM<sup>4</sup>).*



As for the adolescents, most of them comprehended that leaving their friends would assist them not to relapse but, also reiterated the battle it took to do so. One adolescent reported:

*“your friends you must come away from them, but I can’t (laughs) I don’t know why but I can’t, you must come away from them for a little while, I did stay away from that, from them for two weeks then I go back to them, I told them don’t influence me again [...]” (Chris).*

The adolescent further explained:

*“I see it every day [...]. Yah, I see it every time [...] where I walk I see it, they stand there they make it clean in front of me, they smoke it, the friends I have they smoke it, I just let them that’s why I keep relapse” (Chris).*

Another adolescent also mentioned that the friends know where you live and that there’s no way of escaping your friends or the area that you live in. Some said that you have to walk to school or to the shop and you end up passing them. The adolescent said:

*“my old friends [...] they are going to come back and say yah how are you? They are going to try to get me back on that path you see [...]” (Tom).*

Another adolescent also expressed his challenge and said:

*“Yah they teach you how to say no here but [...] yah it’s much harder cos people will go on with you the whole time” (Dylan).*

A third adolescent acknowledged the weakness he had and wished that he could be removed for a few months from the area that he lived in. This adolescent stated:

*“two months or three months cos I know when I’m around here I can’t stop smoking” (Charlie).*

### **e) No plan after rehabilitation is detrimental to recovery**

The final factor perceived as being a reason why relapse occurs amongst recovering adolescent addicts, was the lack of a plan after the rehabilitation programme. While many of the parents and older adolescents realised the importance of attending the aftercare sessions, quite a number of the younger adolescents in some of the rehabilitation facilities had no sense of plan for what lies ahead after rehabilitation. An adolescent stated that a schedule book was received from a previous centre but it appeared as though the adolescent was not clear of its intention or how to use it. When asked about the plan when leaving rehabilitation, the adolescent responded:

*“I don’t know umm I’ve got a book that I looked up and stuff that I got from my previous rehab and I’m just gonna maar carry on with that” (Dylan).*

Parents were of the opinion that many of their children had schedules at the facility but did not have it with them when they have completed the programme. One parent captured this by the response of the adolescent. The parent explained:

*“he said to me mummy I think why people relapse is because they don’t follow their programme once their programme is finish [...] they must stick to what they suppose to do” (FGM<sup>18</sup>).*

Similar sentiments were experienced by the rehabilitation workers who had been in the field. The workers said that many of the addicts may undergo certain changes just after rehabilitation, either they find a job or there are other things that they deem priority and then neglect follow up sessions. One rehabilitation worker expressed:

*“they do not realise the importance of aftercare I think some of them do have that mentality of I’m fine now I’ve been four months clean so I can do it on my own now” (RW-Elize).*

**4.5 Theme Three: *Moving forward towards recovery***

A number of factors are highlighted in theme four, all of which are positive to the recovery process (see Table 3: page 90). The first that will be discussed is the characteristics of the programme which allow adolescents to express their problems and needs in different ways. The theme further explains that the role education plays in the rehabilitation programme is fundamental. The adolescents felt that the manner in which their counsellors handle them has been of great benefit. In addition, while the obstructions that exist in parenthood are evident as described in the previous theme, the assistance that parent groups provide at the rehabilitation facility is appreciated as the groups teach them how to handle and deal with various problems that they are faced with.

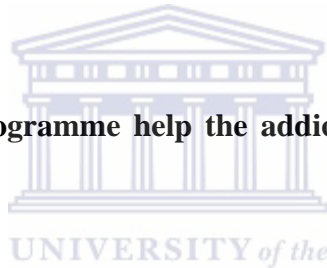
Secondly, the theme makes reference to the importance of the rehabilitation centre to consider the needs of the adolescent and how this may impact on the overall rehabilitation. The final aspects that the theme demonstrates are the self-motivation of the addict, the importance of structure, and spirituality as perhaps therapeutic. There’s great emphasis placed on the mind-set and level of commitment of the addict; whether the addict wants to be clean and recognise the danger of addiction is ultimately up to them. Furthermore, the theme concludes with many adolescents and even parents attributing progress or mere handling of the addiction situation to the element of a higher power and community members.

**Table 3:**

<u>4.5 Theme Three</u>	<b>CATEGORIES</b>	<b>SUB-CATEGORIES</b>
<i>Moving forward towards recovery</i>	4.5.1 Characteristics of the programme help the addict by providing positive options and activities to be involved in	a) Using different tools and a variety of groups in therapy b) Individualised treatment plans ensure objectives are met
	4.5.2 Education groups assist the adolescent in drug rehabilitation	a) Education leads to improved insight b) Education leads to taking responsibility for

		<p>actions</p> <p>c) Education leads to a reality check for addict</p> <p>d) Education builds skills to deal with triggers</p>
	4.5.3 Parent groups as a way of being involved in your child's recovery	<p>a) Be prepared to learn handling skills</p> <p>b) Be prepared to educate yourself</p> <p>c) Be patient</p> <p>d) Show tough love</p>
	4.5.4 Positive counsellor-handling and personal experience assists the addict	<p>a) The addict feels motivated and encouraged</p> <p>b) The addict feels comfortable and understood</p> <p>c) The addict is given the realities</p>
	4.5.5 Self motivation of the addict	<p>a) Choice to be committed</p> <p>b) Willingness to implement what has been taught</p>
	4.5.6 Importance of having structure as part of aftercare	<p>a) Establishing a routine again by following a schedule</p> <p>b) Attending aftercare sessions</p>
	4.5.7 Spirituality as a healing agent	<p>a) Spirituality is part of recovery</p> <p>b) Turning to a higher power provides relief</p> <p>c) Faith and belief helps with acceptance of</p>

		condition
	4.5.8 Considering the expressed needs and state of adolescent is crucial	<ul style="list-style-type: none"> <li>a) Need for family support</li> <li>b) Need for consideration of religious differences</li> <li>c) Need for adolescent-appropriate treatment</li> <li>d) Need for prevention of drugs at school</li> </ul>
	4.5.9 Community members contribute positively to the recovering addict	<ul style="list-style-type: none"> <li>a) Community members united against drugs</li> <li>b) Saying a word or doing an act of encouragement shows care</li> </ul>



#### **4.5.1 Characteristics of the programme help the addict by providing positive options and activities to be involved in**

To ensure that individual objectives are met, certain rehabilitation programmes make use of a treatment plan and a number of diverse activities to try to meet the needs of the variety of addicts that enter the rehabilitation facility. The category describes how different clients may require different methods or approaches in rehabilitation.

##### **a) Using different tools and a variety of groups in therapy**

The counsellors and the rehabilitation workers explained that because some adolescents are extroverts and others are more introverted, it is important to use different methods and tools in therapy. A rehabilitation worker mentioned that role-plays are useful for some while other adolescents needed motivational talks. A few parents also felt that having different techniques to get the adolescents to open up is important.

One parent said:

*“they’ve never written journals in their lives [...] which is good cos he’s a person that cannot express himself, he is putting it on paper which is also a major contributing success” (FGM<sup>18</sup>).*

The rehabilitation workers informed the researcher that a wide range of activities made the programmes work much better for the adolescents. The worker made reference to a specific model that that rehabilitation facility had recently employed. The rehabilitation worker said:

*“it’s a comprehensive model with its set objectives [...] in each and every session, so it comprises of early recovery groups, relapse prevention groups, one-on-one counselling [...]” (RW-Ben).*

In addition, another rehabilitation worker also described how different types of groups covered the needs of the recovering addict at their rehabilitation facility. The rehabilitation worker said:

*“we currently running parenting groups, anger groups, family groups on Saturdays, NA groups on Fridays so we try to keep them occupied whole week basically [...]” (RW-Elize).*

Interestingly, of the four rehabilitation facilities involved in the research, two had occupational therapists working there, but only one participant out of all, made reference to occupational therapy in drug treatment. It was surprising that the OT was only involved in the programme once a week. The rehabilitation worker said:

*“the OT is also part of the primary care, she’s involved in the groups once a week...there’s a specific guy that completed aftercare that she helped getting him into school again [...]” (RW-Elize).*

Moreover, although the worker mentioned the example above as positive, she did not understand the role of OT in drug rehabilitation and asked the researcher about this. While groups, crafts and various activities were mentioned at other centres as part of beneficial tools or forms of therapy, no reference was directly made to occupational therapy.

#### **b) Individualised treatment plans ensure objectives are met**

Apart from structuring the programme and certain activities to accommodate different addicts, individual treatment plans should, according to the rehabilitation worker, be in place. The adolescent should have the opportunity to be involved in this process. A rehabilitation worker explained:

*“there’s certain objectives which are set out [...] uh, once these objective are met, they are noted in the treatment plans [...] and we review the plans in clinical ward rounds and each and every time we sit down with a client” (RW-Ben).*

Another rehabilitation worker added that depending on the development of the addict, the necessary actions should be followed so that the objectives for the individual are achieved. The worker stated, by making reference to a model that that rehabilitation facility was implementing:

*“it’s a 6 week programme but we monitor the clients right [...] if we do see that there’s no progress whatsoever we make a referral to an in-patient facility [...]” (RW-Elize).*

#### **4.5.2 Education groups assist the adolescent in drug rehabilitation**

All the adolescents made mention of education groups as a major help during recovery. The category identifies the participants’ perceptions with regard to the function these groups have in improving their insight, in allowing them to acknowledge their errors and teaches them techniques to cope with triggers on a daily basis. Overall, the category displays the many advantages that education may have on the addict’s recovery.

### **a) Education leads to improved insight**

The role that education plays in the rehabilitation programme is fundamental. The adolescents mentioned that knowing the harmful effects of drugs encourages them to be stronger against its temptation. They have also demonstrated how education has led to improved insight into their addiction. One adolescent said:

*“I won’t go back to it because [...] when I was here now with the time also when I go back now they ask me why you not smoking, don’t you want to smoke here smoke [...] I told them no its alright [...] I’m stronger now” (Chris).*

Most of the adolescents also described that the education within the group sessions are very beneficial. They enjoy the opportunity that groups provide for debate and discussion of a specific problem that they would not otherwise get from one-on-one sessions. It also gives them the positive sense of belonging that they are not alone in this phase of recovery. An adolescent explained:

*“it reminds me that it’s an everyday struggle and it’s gonna be for the rest of my life [...]. I must keep on trying not to smoke. It basically just helped me define myself, where I stand and umm yah and just to get me and my family closer again [...]” (Dylan).*

Other adolescents, as a result of education groups, realised their personal weaknesses and said that the sessions assisted them with gaining insight into this. One adolescent said:

*“my main struggle was my anger management you see [...]. They can make you angry but it’s the way you handle it you see, that is the most important” (Tom).*

### **b) Education leads to taking responsibility for actions**

All the adolescents indicated that with education one learns to take responsibility for the things one has done in the past due to the drug use.



One adolescent said:

*“how can you blame your sins on the next person you know that’s wrong, at the end of the day I don’t want to uh I’ve been through it already I don’t want to go back to this lying and manipulating [...]” (Zack).*

The adolescents also explained that when you are a drug addict you will blame your actions or crimes on others without hesitation. So taking responsibility was something that they had to re-discover and the education groups were a way of learning that. When asked about reasons for starting to use drugs, one adolescent also said:

*“yah I think I blame it more on myself [...] it was circumstances that caused it but it was always my decision” (Dylan).*

### **c) Education leads to a reality check for the addict**

The crude awakening that the adolescent experiences in the rehabilitation centre propelled many of them to abstain from drugs. Others acknowledged, with regret the seriousness of consequences if they were to use drugs again. One mentioned that he will not be able to return to school. Therefore, education groups assisted them in understanding the reality of their drug abuse. One adolescent said:

*“I mean like for years, I didn’t even know that, I came to rehab and to find out that maybe this year or next year I can be put into Pollsmoor, yasis its a big thing” (Kate).*

Another shared the same view and said:

*“seeing myself now again as a patient I have to really you know get my act in order [...]. I told myself I even prayed about it God I’m gonna die I’m gonna die. I can’t afford to mess up my life again [...]” (Zack).*

Other adolescents also described that education groups reminded them of the negativity of using drugs and that this reminder alone helped them to steer away from its use.

#### **d) Education builds skills to deal with triggers**

The fact that counsellors taught adolescents how to deal with triggers as part of the rehabilitation programme, education on drug prevention was described as being helpful. One said:

*“they taught me triggers that influence me to relapse [...] I must have some confidence in myself” (Matthew).*

Another adolescent also felt that with the tools given, the adolescent would be equipped to cope with the outside pressures. The adolescent reported:

*“we had a session the other week about how do you say no, just avoid the whole pressure thing and I was by a party and the dudes asked me do you wanna smoke so I was like no, so they were nagging me the whole time so I just walked away” (Dylan).*

Accordingly, some parents recognized the value of the education groups. One said:

*“the programme teaches them that other rehabs that never comes so far in teaching them, the addiction, dealing with it and how to cope with it [...] you know and and educating them and that is I think part of the programme you know” (FGM<sup>18</sup>).*

#### **4.5.3 Parent groups as a way of being involved in your child’s recovery**

Not all of the rehabilitation centres used for purposes of the study had family or parent group sessions as part of their programmes and in this category the participants expressed their views regarding the benefits of those centres that did. The category also highlights how the parent sessions have assisted them to deal with and understand their recovering adolescent addict.

### **a) Be prepared to learn handling skills**

The assistance that the rehabilitation facility provides is beneficial and hopeful. The parents explained that the parent groups taught them how to approach their child, how to handle and deal with various problems that they are faced with. One parent expressed:

*“they told you ne you must have boundaries [...]. Ons het almal vir ons kinders gegee nie wat ons eerste gegee het nie, but ons vind uit hulle is op die goed [...] nou moet ons werk soos die counsellors vir ons leer [...]” (FGM<sup>9</sup>).*

Another parent also said that as the mother it is your duty to take charge. Most parents shared a common feeling of taking responsibility but acknowledged its difficulty. One parent said:

*I’m gonna face it myself so I went to the gangster and I said listen here, you know [son’s name] he is out of your gangster dinges and we support him and as you can see he went to the rehab [...] some of them said no they are glad for his part, they gonna tell the other guys to stop bothering him [...]” (FGM<sup>17</sup>).*

The parent further said that it was not easy to approach them but it was something he had to do as a parent of a recovering addict. It was also found that parents were taught skills that they had never thought of before, in terms of dealing specifically with an addict, despite the fact that they had been parents for a long time.

*“I encouraged myself to get input into whatever there is to learn how to handle my loved one, cos I never knew those things” (FGM<sup>3</sup>).*

### **b) Be prepared to educate yourself**

The parents said that having an addict in the house is not easy to manage. One counsellor advised:

*“it’s important to show support, take some time out [...] just going through the day’s notes and going through the schedule [...] what did you learn at the centre you know and how was the group and just the you know feeling and emotion” (C<sup>1</sup>).*

Parents expressed that learning the rules and listening to the advice of counsellors are helpful. They also said that being open to educating yourself proved to be useful. A parent said:

*“when she and her brother argue, I say what does your programme teach you [...] so put your programme into practice now [...] then she will laugh cos she knows what I’m talking about cos I make sure that I read all her notes” (FGM<sup>4</sup>).*

According to another parent the keenness to equip yourself is important when it comes to addicts. The parent further said:

*“diè mense wat hier is kan sê hoe was ek toe ek hier kom, I was a broken person, and he is not gonna I’m sorry [...] daar is baie dinge wat ek hier geleer het, ek het nou eerste vandag kry ek in om te implement” (FGM<sup>4</sup>).*

### **c) Be patient**

In this sub-category the strength and tolerance that parents need to endure as a result of the recovering addict, is demonstrated. The few ups and then the very many downs that parents expressed are like that of a roller coaster ride. The parents all shared the view that it is exhausting. One parent said:

*“I try, I really try hard” (FGM<sup>4</sup>).*

Another parent echoed this and said that sometimes even though you do your best the result is not immediate. The parent said:

*“is nie maklik nie [...] ek het twee seuns, daai wat aunty sê ek het worse deur gegaan [...] my man het gesê hy het nie krag vir die nie” (FGM<sup>6</sup>).*

Most of the parents realised that drug rehabilitation does not happen overnight. It takes time. Another parent added:

*“they must come back to their old behaviours because as soon as they use the drugs the behaviour automatically change you must just be patient [...]” (FGM<sup>2</sup>).*

#### **d) Show tough love**

Many of the parents indicated how hard it is to be firm with the addict because it is your own child. One parent said:

*“and for a parent to kick a child out its difficult, it’s not just the addict that go through difficulty it’s the parent also” (FGM<sup>2</sup>).*

Despite this hardship, the parents are taught at the rehabilitation centre that being strict is a requirement if you want progress for the recovering addict. Moreover, they explained that even though you cannot force your child to go to rehabilitation, but as a parent, in other ways you have to be stern. With emotion one parent explained that to show tough love is hurtful but in doing so, the adolescent will want to find help. The parent described his struggle:

*“toe sê die dokter vir my vrou jy moet [...] saam met jou man staan. As jou man gesê het so dan bly dit so want hoekom hy speel met jou sagte plek van jou hart af [...] dit gaan seer wees but laat hy voel soos jy voel [...] and it hurts her but sy het so gemaak. Toe bring hy self rehab toe en hy is vier maande skoon en ons is so close om te dink ons wil doodgemaak het [...]” (FGM<sup>17</sup>).*

Another parent described their journey of learning how to show tough love. The parent stated:

*“and I come to that decision I will not be your door mat anymore oh I’m sorry and you taking advantage all the time, ek is nou klaar” (FGM<sup>1</sup>).*

One more parent shared the same difficulty, the parent expressed that you have to stand up and step up. The parent said:

*“jy gaan nie so praat met jou pa nie [...] ek gaan dit nie tolerate nie...nou sê ek vir die pa kyk hier ek het ‘n saak gemaak teen die klonk [...] ek sê mos vir jou ek gaan vir hulle ‘n les leer [...]” (FGM<sup>20</sup>).*

It was fascinating to note that the adolescents recognised the firmness their parents showed them as positive, not initially, but they realised that it is what they needed. One remarked:

*“say like you the father in the house, don’t think ag man let my laaitie have two beers its gonna be alright [...] no tell him my son do you know what that is not the law in this house, this is the way you gonna live and if you not gonna not choose to abide by it then you hit the door you know [...] tough love has to come in but at a certain extent you know [...]” (Zack).*

#### **4.5.4 Positive counsellor-handling and personal experience assists the addict**

The stage of adolescence, as described by the rehabilitation workers, is in itself a challenging period which require specific management and conduct. This category highlights the principles, treatment and behaviour of counsellors in drug rehabilitation facilities which were perceived to be positive towards the adolescents, and encouraged positive change. Moreover, the adolescents also accredited the fact that counsellors with a personal drug history understood them and provided them with a realistic road to recovery.

##### **a) The addict feels motivated and encouraged**

Almost all the adolescents expressed that the manner in which their counsellors handled them has been of great benefit. The counsellors always encouraged them during the rehabilitation programme and made them feel like giving up drugs is possible. One adolescent said:

*“and it’s nice to people that motivate you cos they have been there man [...] some people are in high positions and I’m thinking yoh they did it and stuff like that [...] yah and I can finish college, yah they tell me all these things so [...]” (Kate).*

The adolescents also described how they appreciated the effort that counsellors made to motivate them not to smoke if they were having a craving. Another adolescent explained that after spending time at the rehabilitation centre she always felt encouraged to resist drugs. The adolescent stated:

*“no when I leave here then its umm ha uh, normally when I leave here I go home then I leave here in a good mood, I know myself if I say no then it’s no” (Taara).*

#### **b) The addict feels comfortable and understood**

Majority of the adolescents found that the rehabilitation process was beneficial if their counsellors could relate to them and understood their situation. One adolescent said:

*“my counsellor you see, he helped me, when I have problems you see in the wing as this morning before I fight I used to go to him [...] we have a nice long talk you see, then after that I feel relieved you see” (Tom).*

Some adolescents believed that if the counsellor has been through the same problems and experienced addiction, then they would give you the advice you need and they would know how to manage you. The adolescent mentioned:

*“we need this connection, someone that can relate to you and can connect with you and understand you [...]” (Zack).*

The adolescents spoke about the importance of feeling comfortable at the rehabilitation facility. One adolescent affirmed that the staff at the rehabilitation facility gave him a sense of comfort and reassurance, and this helped him. He further said:

*“this rehab is for me, this is the only rehab that I finished my programme, you see” (Tom).*

Other adolescents also expressed the significance of feeling at ease. Another said:

*“they put me in this place where I feel like [...] I’m not scared to phone them, they give their numbers out freely and they say phone me [...] no matter what time of the night it is and it makes you feel comfortable, it makes you feel like there’s someone there [...]” (Kate).*

According to a rehabilitation worker, the addict will most likely remain at the centre where the addict feels that he can be helped. The rehabilitation worker said:

*“often many of our clients have gone through SANCA, Cape Town Drug Counselling Centre [...] and umm they really had some form of counselling but it’s essentially where they comfortable coming to at the end of the day” (RW-Ben).*

### **c) The addict is given the reality**

Some adolescents reported that with the counsellors’ personal experiences they are given a touch of reality and therefore a promising glimpse of what their future could be like without the use of drugs. An adolescent said that the fact that the counsellor explained the reality of maintaining sobriety assisted the adolescent. The adolescent explained:

*“and they taught me that I’ll always be so I can’t leave it, they still get cravings and stuff, and it’s nice to know what’s install for you in the future [...] then you know you not feeling like this alone [...] it is possible man that you can stay clean [...]” (Kate).*

Another adolescent also declared this aspect by emphasising that if the counsellor is not firm and realistic, the counsellor may become an easy target to walk over. The adolescent said:

*“I don’t believe that they show you a lot of the reality over there...here they will tell you something to your face, in other places they gonna pamperlam you cos imagine I’m coming out of prison and you say, hello darling would you like to change your life? No I’m gonna think oh cool I can manipulate you, you an idiot [...]” (Zack).*



The adolescent further stated not only the importance of handling by the counsellor but the overall management of the adolescent as a helpful feature in the rehabilitation facility. The adolescent expressed:

*“you have to go to their interest right [...] let us realise the reality of what the the after effect would be [...]. Where we condemn them that’s where where they cling even harder onto what they are doing [...] but if an example can be set [...] there must come a break” (Zack).*

#### **4.5.5 Self motivation of the addict**

This category highlights the importance of drug addicts being willing to make attitudinal and behaviour changes in their lifestyle. It further signifies that recovering addicts have the choice to learn skills to maintain sobriety and implement what has been taught.

##### **a) Choice to be committed**

Since many addicts are being referred to rehabilitation centres via school or the court systems, counsellors at the facility need to ensure that the addicts are in fact committed to being assisted. The rehabilitation workers reported that this alone would give the addict the fuel to recover and would be valuable for the alliance between the counsellor and the client. One rehabilitation worker said:

*“if we make a referral, we need to see that [...] she’s committed, because in the past we’ve send people immediately umm say to Stikland [...] then, they weren’t that motivated then they signed themselves out [...] so that is why we try to keep them longer [...] motivate them, see how committed they are [...]” (RW-Elize).*

The rehabilitation worker further added that:

*“whether you go to Kenilworth or Kensington or in an out-patient programme [...] if your mindset is not right you not gonna be helped” (RW-Elize).*

Therefore, if the addict sees his/her addiction as a serious problem then being motivated and keen will only encourage the positive change of certain behaviours and actions. Many of the adolescents have identified the importance of being committed to the programme and to recovery. Quite a few of them mentioned that it is about how you want to spend the rest of your life. One stated:

*“yah at the end of the day it’s gonna boil down to a choice like I said. For me I will just have to stay focussed” (Zack).*

Parents have also found that if their addict adolescents show commitment they will be more willing to show support. One parent said:

*“he came here on his own, we threw him out, we give him hard times and [...] after that I tell my wife I think we must also support him cos he never went on his own [...]” (FGM<sup>17</sup>).*

#### **b) Willingness to implement what has been taught**

Few of the adolescents claimed to practice what they have been taught in rehabilitation. Some felt that what they did in the programme was simply just part of the programme and did not carry on with the lessons outside of the rehabilitation facility. One adolescent felt that if you have a hunger to change your lifestyle then you would automatically implement what you have been taught. The adolescent also mentioned:

*“then you get people who come to an in-patient and they don’t apply the tools so it’s also one of the choices that you have [...] do you wanna come right?” (Zack).*

Even though the willingness to apply the tools is stressed upon by the counsellors, they realise that it is ultimately the client that decides his/her fate. A rehabilitation worker said:

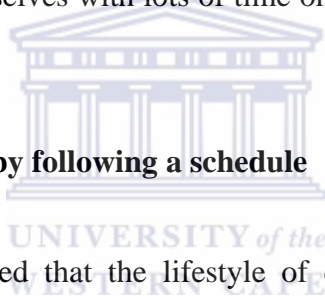
*“it’s entirely down to the client. Whether the client is willing to implement what he has picked up [...]” (RW-Ben).*

Parents have however, acknowledged the weight of applying what has been taught as critical in abstaining from drugs and the lifestyle that goes with it. A parent remarked about her adolescent:

*“he’s still managing his programme at home, whatever they have taught him here he’s implementing it” (FGM<sup>3</sup>).*

#### **4.5.6 Importance of having structure as part of aftercare**

Since many of the participants had been through the drug process more than once many emphasised the importance of having structure as part of aftercare. Leisure for them previously meant time looking for their drug of choice, using it or hiding the fact that they were using. This category therefore reinforces their perception that without these activities, recovering adolescents find themselves with lots of time on their hands hence the importance of attending aftercare sessions.



##### **a) Establishing a routine again by following a schedule**

Most of the adolescents identified that the lifestyle of drug addiction dictated a certain routine, and leaving that lifestyle would involve unlearning negative habits. While most of them said that they do not in fact follow a schedule as not all rehabilitation centres teach it, one adolescent spoke about the benefits of learning it within the rehabilitation programme:

*“everything is deurmekaar [...] all you know is getting up get a fix, eat, sleep, go to the toilet [...] you don’t know about waking up early any more so here we learn to wake up early, we go brush our teeth we go make our beds properly, there will be a room inspection done you know” (Zack).*

Another adolescent said that if you have a plan of action, then that would help structure your days after leaving the programme. The adolescent further said:

*“I’d really like to get back at school umm just finish that last year, then go study so I can get a nice job and go work cos once I start working there’s gonna be no time to vang (catch) on nonsense and what what so I know that will be the best option” (Dylan).*

The counsellors know the value of establishing a routine after leaving rehabilitation but also realised that most of the adolescents do not follow it. Some counsellors include it strictly in the rehabilitation programme. One counsellor said:

*“they have to write out or schedule their time from Monday to Sunday so by Thursday I would then ask that, so they are very active within their recovery” (RW-Elize).*

### **b) Attending aftercare sessions**

The rehabilitation workers and counsellors could not stress enough the importance of attending aftercare sessions as a means of assisting the addict in changing his/her ways and maintaining abstinence. They believed that it would be critical in recovery. One said:

*“when you dealing with substance dependency umm remember this is a chronic condition much like diabetes [...] these people need access to their medicine, the medicines quite simple, its coming to the aftercare in the long run [...]” (RW-Ben).*

Another rehabilitation worker also emphasised the significance of being present at aftercare sessions because drug addiction recovery is an ongoing process irrespective of your age. The rehabilitation worker added:

*“everybody suppose to yes, continue with aftercare once they finish with the primary care, look recovery is a a lifelong process [...]” (RW-Elize).*

It was found that this translated to the parents as well but not at all the rehabilitation centres. One counsellor asserted the importance of attending the sessions and said:

*“I emphasize that you need to walk in and out of this centre until you sixty-seventy years old” (C<sup>2</sup>).*

Most parents seemed to agree with this. The parents did however mention that it was those parents that were not present who do not take attending the sessions serious enough. One parent described the benefit of continuing to attend the sessions and said:

*“like my son next month he’ll be a year but I’m still bringing him, he still comes and I’m not forcing him, he knows he must come” (FGM<sup>3</sup>).*

#### **4.5.7 Spirituality as a healing agent**

The fact that spirituality may be incorporated in addiction treatment to positively promote change in the addict has been given attention in this category. Participants have mentioned that spiritually-orientated programmes has assisted them and their recovering addicts as it provides relief for them during the long process of rehabilitation, and allows them to accept the condition.

##### **a) Spirituality is part of recovery**

A few of the parents and adolescents spoke about how being spiritual has assisted them in the recovery process. One adolescent explained that there should be a balance between your spiritual life and your social life for recovery to be successful. Apart from having counsellors, the adolescent further explained that you sometimes need the guidance from a spiritual leader to keep you grounded during the rehabilitation process. One parent who has been through this process for a number of months said:

*“I think spirituality help alot, you can ma say what [...] if you not spiritually involved, dan gaan hy soek in die ronde, but once jy weet [...] jy sal gou result, nie ‘n problem hê” (FGM<sup>0</sup>).*

It was noticed however, that not all rehabilitation facilities included the aspect of spirituality or catered for religious diversity. One of the counsellors at a centre mentioned that not all adolescents are spiritual but providing them with the opportunity or encouragement could be helpful.

The counsellor further added:

*“part of recovery some centres say is 80% is spirituality and it’s part of your programme but I believe 100% is part of your recovery and I encourage them to [...] be part of that” (C<sup>2</sup>).*

## **b) Turning to a higher power provides relief**

The fact that a few clients have expressed that turning to higher power has assisted them in some way, have alerted certain rehabilitation centres of its importance. One adolescent indicated that the rehabilitation facility that the adolescent was currently attending had been the third facility, and none of the previous ones had included any aspect of religion. The adolescent felt that:

*“its 80% spiritual and 20% programme [...] I never went to church but the thing is that I also realised now that I have never stayed clean man and in order for me to stay clean [...] I just think I’m gonna need to go there sometime man [...] that would have to be one thing that I have to also do [...]” (Kate).*

Another adolescent reported on the experience that a higher power had in the adolescent’s rehabilitation. It made the adolescent hopeful to continue with the journey of recovery. The adolescent further mentioned:

*“for my side I do believe that it’s only through God’s grace you understand. If somebody teaches you something on a social level you know [...] God doesn’t intervene there [...] I’m not saying that the information is bad [...] but at the end of the day surrender to a higher power [...]” (Zack).*

Some parents expressed the same view in terms of acknowledging the impact it may have on the recovery of the addict as it was said that many addicts live without the consciousness of God in their life.

One parent explained:

*“and another thing the thikr (remembrance of God) spiritually. They make them more aware [...] like which other programme didn't give you that [...] they are making them more about the higher power, some children the addicts they didn't know there was a god” (FGM<sup>A+17</sup>).*

### **c) Faith and belief helps with acceptance of condition**

A number of parents expressed the difficulties that they had experienced with their child being on drugs. They could not understand why they were put through this exhausting process, from one rehabilitation centre to another, despite feeling that they were doing the best that they could for their child. The older parents of the programme discussed that it had taken a while for them to realise that you must have the belief that things will get better. A parent affirmed:

*“doen alles wat u kan doen [...] maar there's a reason why Allah (God) is taking [...] that special person that you love to bits and pieces [...] and he takes that one and he tests you with that one [...]” (FGM<sup>3</sup>).*

### **4.5.8 Considering the expressed needs and state of the adolescent is crucial**

The participants expressed common needs for adolescent drug recovery among the various rehabilitation facilities used in this study, and this category presents these views and opinions. The category also exposes some ideas for better adolescent treatment as explained by the rehabilitation workers.

#### **a) Need for family support**

Experts in a particular field may know to a certain degree what the needs of an adolescent may be in drug treatment. However, once the needs are expressed by the very clients in question, it is important to seriously consider them for treatment to be positive. In this sub-category, family support was an aspect that seemed to move forward recovery.

One adolescent said:

*“I need my family to be more supportive... spend more time with each other” (Matthew).*

Other adolescents felt that if you had people that show support, you feel encouraged to stop drugs. In addition, a parent said that it was the family support sessions that assisted with his adolescent. The parent indicated:

*“my son was at three-four rehabs and there was no what you call it [...] support group like this” (FGM<sup>17</sup>).*

#### **b) Need for consideration of religious differences**

An adolescent identified the need for taking religious backgrounds into consideration. The adolescent felt that having a spiritual leader relative to your religious need would have a positive effect on the rehabilitation process. He said:

*“it would be great you know for Muslims if there could be Islam implemented in certain rehabs you know or whatever Christianity whatever your belief you know so that there would be somebody that you can turn to” (Zack).*

Two parents stressed that although drugs should not be made out to be a religious issue, the involvement of various religious parties should be an important inclusion in rehabilitation centres. The parents said:

*“in die drugs moet daar nie wees ‘n religion storie nie [...] what government must do if they subsidise the churches with the rehabilitation centres then they must bring in that...they must make it Christian and Moslem in both parties. Die kerke sal baie help in daai” (FGM<sup>3+12</sup>).*



### c) Need for adolescent-appropriate treatment

Both the parents and rehabilitation workers acknowledged and accepted the fact that adolescents in rehabilitation have very specific needs. One rehabilitation worker said:

*“it’s essentially a combination of biological, psychological and social needs [...]”*  
(RW-Ben).

Another rehabilitation worker indicated the clear distinction in needs, since this particular rehabilitation facility had a counsellor that dealt only with adolescents. This rehabilitation worker said:

*“he’s basically just youth [...] I won’t say its general [...] they definitely have different needs”* (RW-Elize).

Treatment approaches based on theoretical models for substance abuse seemed to be practiced in all of the rehabilitation facilities. Even though it was aspects of one model combined with aspects of another perhaps, the overall treatment approach was not adolescent-specific methods. So it did not seem like too much attention had been given to this group. The rehabilitation workers emphasised the intention of work in this direction as it is a developing field. When asked about treatment for adolescents thus far, the rehabilitation worker stated:

*“there are many programmes however they seem to be very thin off the ground [...] we attempted to pilot one [...] however our target population is challenging in itself [...] we actually can’t afford to spread our resources onto that”* (RW-Ben).

Parents accordingly, over months of being involved in the rehabilitation programme found that their recovering adolescent addicts required very different handling to the older ones. In addition to the age being different, a few parents also said that no two persons are the same and therefore the manner in which the adolescent population is approached is crucial.

One parent said:

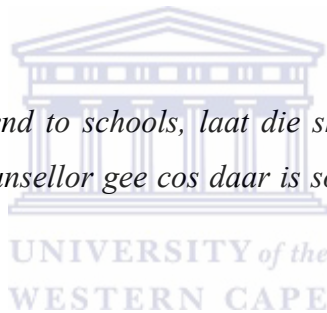
*“but it doesn’t mean its going to work for the next person [...] every loved one is different” (FGM<sup>3</sup>).*

#### **d) Need for prevention of drugs at school**

More than half of the recovering addicts that participated in the research were referred via the school principal as they were caught at school or at a school-related event. It was not surprising then, that a rehabilitation worker identified prevention and education as being a priority especially among younger users before they become drug dependent.

The rehabilitation worker further said that if these experimenting and recreational users are taught about the dangers, then this would prove to be positive in the long run. One parent also expressed:

*“hulle kan counsellors send to schools, laat die skole [...] daai geld wat hulle kan invest kan hulle vir ‘n counsellor gee cos daar is so baie kinders met issues op skool [...]” (FGM<sup>3</sup>).*



#### **4.5.9 Community members contribute positively to the recovering addict**

The final category in this theme relates to the responsibility that community members have in encouraging the recovering addict and the fight against drug addiction. Participants shared their perceptions regarding neighbours standing together and assisting the community. The category also encompasses the positive influence community members have on those attending rehabilitation centres.

##### **a) Community members united against drugs**

Although most of the parents felt strongly about standing together, being proactive and facing the problem of drugs, some admitted that there are a few in the community that do not act accordingly as they protect the merchants. Most however mentioned that they appreciate coming to support sessions as it gives them the tools to manage the problem and they felt that they are not alone in beating the crisis.

One parent said:

*“we sit here, we encourage one another [...]” (FGM<sup>3</sup>).*

Another parent also expressed that the parent would take every opportunity to talk about drugs and in that way the community can join forces to tackle it. The parent remarked:

*“but why we wanna talk about it because we wanna teach them to look out for their children cos that their children don’t get into the same boat that we are” (FGM<sup>9</sup>).*

One parent pointed out that members of the community should be aware of the drug addicts in the area so that they can stand together to assist one another in time of need. A parent explained that one of her family members was in a situation where the husband was on drugs. The parent said that the neighbours would alert the police with an anonymous call if the husband performed any misdemeanours or ill-treated the wife. The parent reported:

*“my sister het ook ‘n interdict gekry teen aan hom [...] as hy daar kom, maar haar neighbours het saam met haar gestaan” (FGM<sup>19</sup>).*

#### **b) Saying a word or doing an act of encouragement shows care**

A few of the adolescents mentioned that certain community members also had an impact on their road to recovery as they would cheer them on to keep up with the abstinence of drugs. Additionally, one adolescent said that the non-medical support staff at the facility also provided some companionship and encouragement for the adolescent. The adolescent stated:

*“yes he is actually on shift now, when I have a problem like this [...]. I used to go to him we have a nice chat and so [...] he is almost like a counsellor to me” (Tom).*

Another adolescent felt that even though the adolescent lived in an area where drugs are rife; there are neighbours who show concern and that alone motivates the adolescent to change positively.

The adolescent expressed:

*“there’s good people there by us [...] like the the people in my community they [...] tell me you a good boy [...] leave this things, your mom takes care of you, buy you clothes why you doing this and so on [...] they try to help you” (Chris).*

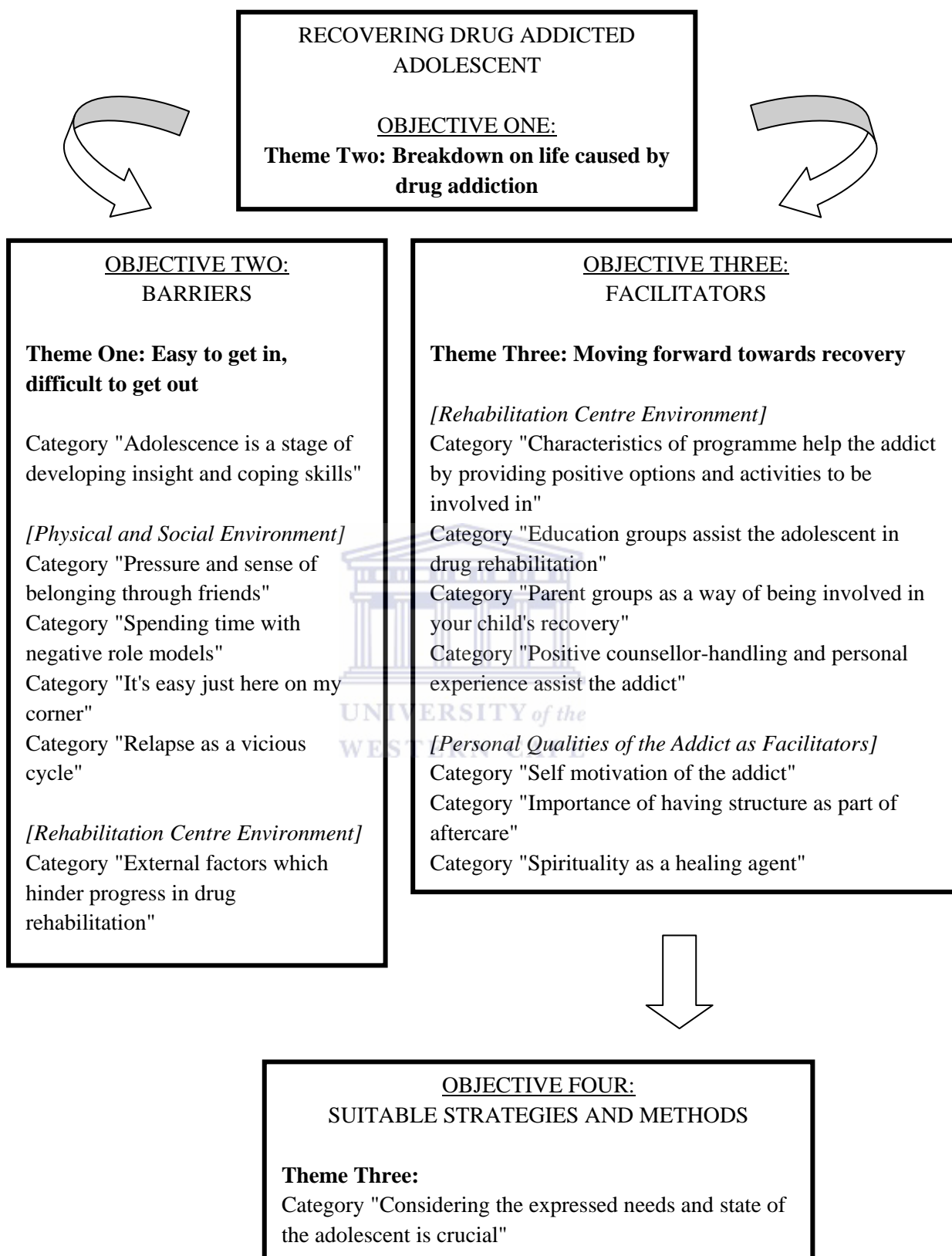
**4.6 Summary of findings** (see Figure 2: page 116 for Diagrammatic presentation of themes and categories)

The research was undertaken to answer and understand four critical objectives and by analysing the findings, the researcher has accomplished these objectives. With regard to the first objective of the study, theme two exposes the impact of the addiction lifestyle on the daily occupations of the recovering adolescent addicts. This is of particular importance as it highlights the extent to which the occupational performance of the adolescent has been affected by drug addiction and hence their susceptibility to drug relapse.

The second objective of the study related to theme one. Theme one focuses on the developmental, environmental, and social aspects of the recovering adolescent addict as contextual barriers during the rehabilitation process. This gives rise to their distinctive occupational needs that should be considered and addressed in the rehabilitation programme. The theme also reveals the barriers, external to the addicts, which hinders the recovery process.

Concerning the third objective of this investigation, theme three contains the facilitators which the participants described as being enablers in helping them prosper in drug recovery. Many of the facilitators illustrated were structural facilitators put in place by the specific rehabilitation centre to ideally combat the occurrence of relapse. Other personal attributes of the recovering adolescent addict emerged as facilitators. An example of this is the motivation of the adolescent which adds to the success of the recovery process. In relation to the fourth objective of the study, suitable strategies and methods were drawn from the facilitators in theme three. The findings highlighted ways in which to improve, develop practice, and support recovering adolescent addicts.

**Figure 2: Diagrammatic presentation of themes and categories**



## **Conclusion**

The findings, as represented in figure 2 above propose that a great consideration needs to be given to those factors which the participants deemed to be barriers and facilitators. Having this awareness could be useful and beneficial in the approach one takes to adolescent treatments and this is where the hope of occupational therapy presents itself. Through working towards eliminating and addressing the barriers and by creating and using the existing facilitators, whilst acknowledging the developmental stage of the adolescent addict, generates an opportunity for the role of occupational therapy. The interpretation and relationship of the findings to existing literature and how the rehabilitation programmes are meeting the occupational needs of recovering drug addicted adolescents will be discussed in the next chapter.



## **CHAPTER 5: DISCUSSION**

### **Introduction**

In chapter five, the interpretations of the findings are discussed with reference to literature and other research studies conducted nationally and globally. The initial discussion of this chapter clusters around the daily occupations of adolescents and how these occupations are affected by the use of drugs. Although well established and reviewed in literature, it lays a supportive foundation for the current research study. The chapter then highlights the main barriers and facilitators as perceived by the participants during their rehabilitation programme, in meeting the recovering adolescent's occupational needs and its effect on the adolescent's overall recovery process. Lastly, the chapter will expand on the role that occupational therapy and health professionals may have in adolescent drug treatment by using an occupation-based model, namely: the Model of Human Occupation.

### **5.1 The effect of drug relapse on daily occupations of adolescents**

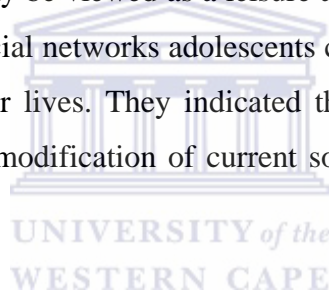
#### **5.1.1 Daily occupations of adolescents**

As described in Chapter 2, adolescence is a stage of transition and the recognition that adolescence is a period of heightened vulnerability for the development of substance use problems propels initiatives that enable the drug addicted adolescents, family and communities to act as guides that can temper their risk-taking activities (Durrant, Adamson, Todd, & Sellman, 2009). Adolescents must successfully learn to make occupational choices that bring personal satisfaction while meeting environmental expectations (Kielhofner, 2008) however, they are constantly challenged to maintain efficacy while facing new social expectations for having to master an expanding range of occupational tasks. One of the primary influences of change is the movement out of the family setting into the peer group where new interests are espoused (Kielhofner, 2008).

Daily occupations in adolescents include the functional activities of self-care, work/school and leisure pursuits (Fouché, 2005). The adolescent performs these daily occupations related to his/her role and in turn performs functions as required by these roles. Self-care tasks refer to personal activities such as dressing, eating, hygiene care, grooming etc., and more complex

ones such as caring for others, meal preparation and safety procedures. All of the adolescents in the current study were independent in their self-care tasks until they became addicted to drugs. Some experienced difficulty particularly with grooming and others due to behavioural problems lacked care and consideration for others such as siblings or neighbours. Work or school-related tasks focus on prevocational skills such as work habits, work competency, time management, academic level, and school functioning. In a study carried out in Brighton-England, thirty people participated in an in-patient drug detoxification programme (Davies & Cameron, 2010). Half of them acknowledged that drugs were the main cause of difficulties in caring for themselves.

Leisure activities are those tasks that specifically create pleasure and although adolescents tend to be passive in their leisure time (Fouché, 2005), activities such as listening to music for example can be seen as a constructive leisure activity since it is age appropriate. Spending time with friends for example may be viewed as a leisure activity but may be constructive or destructive. With reference to social networks adolescents cited peers and family members as being the main influence in their lives. They indicated that to create more positive social influences, it would require the modification of current social networks (Mason, Malott, & Knoper, 2009).



The category ‘pressure and sense of belonging through friends’ emphasises the considerable impact that peers have in the stage of adolescence. The peer group fulfils the need to belong, to fit in, to communicate with a social group whether at school or in the neighbourhood other than the family. Concurrently, epidemiological studies have noted that much of substance use among adolescents takes place at school (Swadi, 2000). For many adolescents in the study, their peers’ perceptions of them were extremely important and they endeavoured through their behaviour and actions to measure up to those expectations.

The hold that these peers have on one another is arguably more significant than their sibling relationships. It has been documented that the increase in importance of peers generally develops during adolescence (Brown & Larson, 2009), so it is not surprising then that the perception of friends being powerful influences, was highlighted in the category ‘pressure and sense of belonging through friends’. The participants expressed that disassociating with old friends was almost impossible. One adolescent suggested that even though his friends were still using, they grew up in the same neighbourhood and he regarded them as family.



In a study cited in Ibrahim and Kumar (2009), involving relapsed youth; it was found that 50% of previous friends pressured former addicts to resume the drug taking habit after treatment. The study further showed that 76% of the old peers assist recovering individuals to obtain the supply of drugs.

### **5.1.2 Drug use results in occupational dysfunction**

Addiction narrows a person's repertoire of occupations as they neglect major life roles, resulting in an inability to meet their physical, social and mental health needs (Davies & Cameron, 2010). Such an unhealthy imbalance of daily occupations leads to internal conflict and disruption. The negative impact of drugs that surfaced from the quotes of the participants was the effect on the adolescent's body, mind and image. And because the adolescent is still developing self-concept (Fouché, 2005) drug abuse and addiction affects the way they see themselves and the way they perceive the world to see them. The adolescents admitted that they would neglect themselves, often causing damage to their body and some mentioned that components of self-worth and value were diminished. The participants also account for how their occupational skills were lost or impaired as they sought to meet their addiction needs.

Thus, when an individual is unable to cope with daily stressors pooled with feeding a very bad drug habit, daily tasks are no longer positive and functional. Daily occupations are fixated around feeding the drug habit, and consequently self-care tasks, work/school and leisure activities become disrupted and disorganised. The adolescent finds himself/herself not performing as expected but in a dysfunctional cycle. This was explained by the participants of this study in theme two 'breakdown on life caused by drug addiction'.

The extent to which drug addiction negatively influences every aspect of the adolescent's occupations was explicitly stated by all participants. Many of the adolescents in this study explained how it affected their schooling. Some were asked to leave school, others suspended, a few absconded and the remainder failed. In a different study conducted in the United States, involving 23 adolescents in drug treatment, it was found that adolescents were concerned about educational and career goals as they had recognised the impact that drug use had on their college and school performances (Mason, Malott, & Knoper, 2009). They felt hopeless in relation to whether they would be accepted into a college.

Therefore, while school or student life is supposed to be the primary occupation of a teenager, drug abuse disrupts this in every way.

Evidently, one of the most significant factors was the destruction caused towards family relationships. The results of the study mentioned earlier (Mason et al., 2009) found that the main reason for the adolescents' attending treatment, was because they acknowledged the distraught caused to family and sought to improve social relationships with them. Similarly, in the category 'destructive impact on family relations due to negative changes in the addict's behaviour' of the current study, these feelings emerged too. A number of adolescents made mention of how their drug use resulted in lack of trust from family members and how they would hope to repair the rift they had caused.

Stealing from family, anger towards siblings and attitude problems experienced by parents from the recovering addicts also emerged in this category. Hurt and broken promises have been present and taking responsibility for the behaviours and mending the relationships are a large part of recovery. Some of the rehabilitation programmes in the current study integrated family support sessions to engage with parents on how to correct the mood and stealing problems of their child. Stevens and Smith (2009) explain that by involving the parents in the rehabilitation process, it will minimise the possibility of relapse. In addition, previous research has suggested that if parents are unable to assist their children in regulating their emotions, then children become dysregulated in other contexts ultimately leading to social incompetency such as stealing and risk behaviours such as aggression (Frick & Sheffield, 2005). Moreover, the parents stated that neighbours would inform the police and their already challenging domestic issue would become a legal one. These findings therefore coincide with prior literature which supports providing parenting skills as the parents have many related issues to deal with as a consequence of the adolescent being addicted to drugs (Frick & Sheffield, 2005).

Issues of dishonesty, disrespect and manipulation were highlighted as most hurtful to the parents but also as damaging to the identity of the addict. In the category 'harmful effect on self concept and identity through manipulation tactics to feed the habit' (Theme 2), the participants explain how these tactics have become part of their addiction lifestyle. They have mastered the manipulation of family, school environments, counsellors, policemen and court officials to hide their drug use and to cover their misdemeanours.

The adolescent's manipulation and lies has become part of their character that when they start recovery it is still habitual but may be unintentional. It is for this reason that efforts to enhance recovery should consist of interrelated activities that include the home, school and community. Hence, conflict resolutions skills such as anger or anxiety management, emotional coping skills, and stress management may play a vital role in aiding adolescent addicts to deal with on-going pressures and tensions in the school and other interpersonal relations rather than resorting to substance use (Lai *et al.*, 2013).

To draw on theme one in the category 'adolescence is a stage of developing insight and coping skills' the participants mentioned this as an important aspect of adolescent growth and cannot be discounted in the use and introduction of drugs. Many of the recovering addicts described that when they are taking drugs, the notion of the consequences of their actions are insignificant. Moreover, the fact that they experimented or merely took drugs in the first place was suggestive of the fact that adolescents are curious. Recent research on the adolescent brain has indicated that adolescents may be more likely and biologically determined, than any other age group, to engage in risky behaviours such as substance use, due to rapid emotional transformations occurring within the brain (Steinberg, 2008). Therefore, the predisposing characteristics which are found within the age and stage of adolescence may well be the factors that render the individual vulnerable to the condition of substance abuse and addiction.

Separate to the development of their insight, from the findings in the current study, it was evident that many of them had various feelings of anger, frustration or confusion to deal with, and personal or school issues to cope with. Literature affirms that during adolescence there is high level of emotional distress and turmoil (Crome, 2004), and in the current study, some of the adolescents were unable to manage problems effectively and drugs became a coping mechanism. In agreement, research noted that addicts are easily angered and have an inability to manage feelings (Rasmussen, 2000). Ibrahim and Kumar (2009) explain that recovering addicts are extremely sensitive individuals and easily stressed by social pressures in the environment. Therefore, it could be reasoned that the combination of these psychological concerns as experienced by the adolescents in the study could lead to greater disharmony in their daily performances. These occupational imbalances due to the addiction and inability to fill time with meaningful occupations are a trigger for relapse (Heuchemer & Josephsson, 2006).

Based on the findings on theme two ‘breakdown on life caused by drug addiction’ it appears almost impossible to detach a person’s physical, social and psychological components from each other. Neither can one ignore the fact that all of an individual’s daily occupations are in some way interrelated to their role performance and function. For this reason when drug addiction affects one aspect negatively and drastically it could affect the individual at other levels if not every other level, consequently leading to occupational dysfunction. In support, Rasmussen (2000) states that relapse therefore often occur due to a build up of additional crises in the individual’s life.

### **5.1.3 Relapse as a consequence of occupational dysfunction**

As discussed earlier, the breakdown on life caused by drug use and abuse affects body structures, participation in personal activities and behaviour, and ultimately influences an individual’s quality of life. The reward value of drugs becomes magnified to the extent that it displaces other rewards and the individual’s ability to accurately assess the adverse consequences is severely compromised (Durrant, Adamson, Todd, & Sellman, 2009). Considering that individuals who are addicted to substances are known to deny their problems and are often in treatment because of external pressure (Cournoyer, Brochu, Landry, & Bergeron, 2007), it is plausible that the clientele comes in to treatment with expectations. In fact, clients with drug addiction may often be referred or brought to the attention of health professionals and law enforcement by others due to the negative interference it has on psychosocial and behavioural aspects which leads to further dysfunction in their occupational performance (Stoffel & Moyers, 2004).

In the category ‘relapse as a vicious cycle’ (Theme 2) a number of perceptions emerged from the recovering adolescent addicts as to why they relapse. Many of the recovering drug addicted adolescents in the study, did not understand the concept of addiction and the nature of relapse even though they admitted that they returned or were referred to the rehabilitation programme after using drugs again. Yet, evidence show that poor knowledge on drug abuse is a contributing factor of relapse among drug addicts (Hadi & Herman, 1997).

Whilst treatment should go beyond helping clients simply stop the use of the drug, this may not necessarily be the case at most rehabilitation centres. Rather, treatment should allow addicts to redesign their lifestyle and rebuild occupational roles by providing meaningful activities to them at just the appropriate level to move recovering addicts to a state of well-being (Stoffel & Moyers, 2004). However, there appears to be a high degree of consensus that relapse to drug use remains a common element in the recovery process and relapse remains one of the most intricate clinical concerns in drug addiction (O'Brien, 2006).

The rehabilitation workers of the current study had a similar opinion. They were of the view that addiction is a chronic, relapsing condition and albeit preventative measures should be put in place, relapse may very well be part of the recovery process. The rehabilitation workers explained that when a relapse occurs, it could be used as a learning curve in the rehabilitation programme to inform clients on aspects that still requires work in treatment.

Furthermore, the actual event or occurrence of relapse have been described by several authors to be unpredictable and complex (Buhringer, 2000) and similarly the participants of the current study appeared to share this perception and experience with regard to drug relapse. A number of parents expressed their frustrations that even after having been supportive; they could not understand why their adolescents relapsed. Other parents said that their adolescents had been to numerous rehabilitation facilities. Correspondingly, Hser and colleagues explain that returning to drug use and associated problem behaviours resulting in multiple treatment admissions over a period of time, is quite common (Hser *et al.*, 2001). At half of the rehabilitation centres used in the study, they had incorporated stringent relapse prevention as part of the programme to teach the recovering adolescent addicts new skills to change old habits as well as advocate a balanced life so that relapse may be avoided. Such occupational interventions that address skill improvements can be seen to give meaning, purpose and supportive structures to achieve abstinence and reclaim lives (Davies & Cameron, 2010).

From an occupational intervention perspective, treatment does not occur without re-engagement in satisfying occupations to support the recovering addict's reformed identity (Stoffel & Moyers, 2004). Although early adolescent identity may be more concerned with enjoyments while late adolescent identity centres on occupational choices necessary to enter adult life (Kielhofner, 2008), addiction has resulted in a negative identity for the adolescent.

Because identity and competence are continually evolving with growth and experience, the process of occupational choice is also continuous and dynamic.

Devoid of the drug only, dysfunction in occupational identity may still exist, and research show that sustaining a sober life is significantly more challenging than eliminating the use of the drug (O'Brien, 2006). Therefore, at most of the rehabilitation programmes offered at the centres, counsellors encouraged their clients to commit to undertake a course of action, to accomplish a goal by fulfilling a new habit and to modify their lifestyle in anticipation of improving life and reforming their identities.

However, in another point as raised in the study a few adolescents said that they did not have leisure opportunities in the areas that they resided even though the rehabilitation programme encouraged them to find a substitute activity to drug taking or seeking. The parents alluded to the fact that when their children leave the rehabilitation programme they are bored and they do not have any leisure interests or goals. In a study involving four high schools in Cape Town, it was found that grade eight adolescents who experienced elevated leisure boredom were more likely to be using substances at that time (Caldwell, Smith, Wegner, Vergnani, & Mathews, 2011). Relating to this finding, literature seems to support the fact that people who are bored are also probable to experiment with drugs, which ultimately leads to substance use (Corvinelli, 2005). More importantly, an individual's potential to experience occupational well being is dependent, in part, by the available opportunities and, limited occupational choices may threaten the individual's abilities to meet their occupational needs (Doble & Santha, 2008). In a study involving young adolescents in Cape Town, it was found that adolescents participated in occupations they saw others in their communities doing. Furthermore, their occupational choices were inseparably linked to the limited range of occupations that are available and that they had been exposed to in their communities (Galvaan, 2010).

Adolescents living in low-resource communities lack the opportunity to engage in varied experiences (Verma & Larson, 2003), and since adolescents are biologically driven to seek out heightened sensations and novelty, they are more likely to involve themselves in risk-taking behaviours like substance use (Steinberg, 2008). Additionally, the participants stated that after completing the rehabilitation programme, they were unable to find a job, without the necessary finances. They have spent most of their money on feeding their habit and the



household income often just covers necessities of food and shelter, so the option to study further was non-existent. Idle time suggests that they will find themselves in the same dysfunctional environment or at the edge of a relapse.

Another major reason which emerged as to why adolescents relapse was the lack of family support, which was identified as a significant hindrance to sobriety. While it has been acknowledged that family relationships have been severed in the first place due to the addict's behaviour, this causes family members to distrust the adolescent, often breaking communication and leaving the recovering addict to fend for himself. This in turn leads to lack of support. In a study conducted in Malaysia among detained drug addicts, results showed that 57% of addicts reported that they would feel uncomfortable to express their concerns with family members (Ibrahim & Kumar, 2009).

In line with the above statements, two very strong emotions that must be dealt with in drug recovery are shame and guilt as this affects self-esteem (Marion & Coleman as cited in Stevens & Smith, 2009). A few of the adolescents in the current study shared their regret for the actions that they had done and explained how they constantly have to deal with feelings of shame. These feelings become overwhelming as the recovering addict is exposed to the very people who he/she has wronged, especially the family, and could easily lead to a relapse attempt to protect oneself from confrontation with these feelings (Marion & Coleman as cited in Stevens & Smith, 2009). Therefore, the importance of covering the areas of the adolescent's identity, self image, and emotions within the rehabilitation programme is very important, however not all the rehabilitation centres incorporated this into its programmes due to lack of staff and time constraints. In another study, it was found that 64% of recovering addicts felt that they were not received well in their communities and 66% felt that they were looked at as being the obvious suspect in the event of a robbery, and this drove them back to addiction (Ibrahim and Kumar, 2009). This often made the addicts feel uneasy to mingle freely with the community or family, and decreased their self-esteem.

Although the physical environment as a barrier will be discussed at a later point in the chapter, it was reiterated by the parents, rehabilitation workers and recovering drug addicted adolescents. In the sub-category 'getting away from the drug environment is easier said than done', the participants highlighted that the addict undergoes a change in formal rehabilitation but the environment that he/she returns to remains the same. While the participants described

that returning to their neighbourhood is a major trigger for relapsing, counter studies on adult drug use report mixed results on the impact of the neighbourhood context on substance use (Ford and Beveridge, 2006). It does however relay that negative neighbourhood effects may simply work differently or less directly for adolescents since environmental contexts do drive and reflect adolescent experimentation patterns and behaviours (Snedker, Herting, & Walton, 2009).

Still, the participants in the current study said that the routes to be travelled are the same and it is almost impossible to avoid it without actually moving to a new home. If the recovering addict was introduced to drugs at school, the challenge of returning to the same school is also something that makes maintaining sobriety difficult. According to Ibrahim and Kumar (2009) if the situation and lifestyle outside of the rehabilitation centre is not remedied, or as the recovering addict had hoped, it may lead to a relapse.

The last factor perceived by the experiences of the participants regarding relapse was the absence of a plan after formal rehabilitation. The chances of relapse are far greater without careful scheduling in terms of identifying an ambition or discussing realistic future plans with the client for the period after discharge (Wegner, 2005). Many of the younger adolescents did not realise the importance of having a plan and this may be correlated to why a number of them indicated that they were bored. Continuous attendance of the rehabilitation programme at the centre allowed the recovering adolescent addicts an opportunity to structure a weekly plan and work together with their counsellors to reorganise their roles. This gives clients a greater sense of control and responsibility for recognizing their personal strengths and weaknesses (Kielhofner, Mentrup, Miranda, Schulte, & Shepherd, 2008). Stoffel and Moyers (2004) found that clients who did not participate in any continuous aftercare group or meetings were also more likely to be unemployed. Hence, adolescents who find themselves with nothing constructive to do tend to engage in unhealthy daily occupations and appear to be prone to substance use (Caldwell et al., 2011), and therefore many of them appeared to fall back into the cycle of drug abuse.



## **5.2 Barriers experienced during adolescent drug rehabilitation**

Barriers are factors that impede or interfere with the attainment of a goal (Pedretti & Early, 2001). It therefore refers to those aspects in the adolescents' recovery path that obstructed their rehabilitation process and encompasses those features that are likely to present an opportunity for a relapse to occur, a risk factor. Among the participants in this study, a number of aspects were identified, namely: social, physical, developmental, and factors at the rehabilitation facility.

### **5.2.1 The environment and negative role models influences drug use**

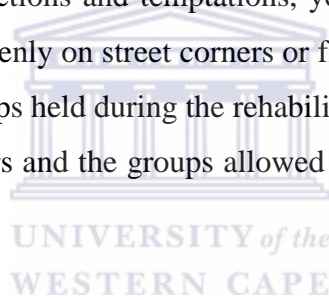
According to the United Nations Office on Drugs and Crime, price trends in South Africa over the last 15 years is one factor that has contributed to the general availability for the less customary drugs of choice. This means that a wider range of consumers is able to afford drugs escalating drug use among youth (UNODC, 2006). It needs to be recognised that drug initiation among the youth is not only shaped by the complex interaction of the psychobiological effects of drugs on the user but by the environment or social context in which they are used (Durrant et al., 2009). Environmental factors will influence occupational choices of the individual and their ability to address their occupational needs (Doble & Santha, 2008).

The impact of the physical environment, social context, and accessibility of drugs was portrayed in the category 'it's easy: just here on my corner' (Theme 1). The recovering adolescents mentioned that the physical context in which they resided influenced them on a daily basis. The adolescents said that whether on route to school or some other destination they were forced to walk pass the dealers or friends who would try to persuade them or make remarks to get them back into drug use. Apart from the luring nature of the physical environment as described by participants in this study, the ease and accessibility of obtaining drugs, due to drug dealers in the roads that they lived in, was deemed as a major risk factor for triggering a relapse, hence a barrier to their rehabilitation.

Another contextual impediment that emerged from the findings was with regard to the community members in the adolescents' respective areas and their allowance of drug use in plain sight. The recovering drug addicted adolescents and concerned parents stated that the

fact that certain community members allow addicts to be involved with drugs in their backyard, drive-ways and street corners openly, entices the youth in a negative way as they become accustomed to a poor level of moral behaviour, rules, and judgement. Other studies demonstrated a significant relationship between poor neighbourhood context and drug use behaviours (Briggs, 1997).

On the contrary, data received from a family and neighbourhood survey carried out in Los Angeles, little association between neighbourhood contexts and teenagers' substance use were reported (Musick, Seltzer, & Schwartz, 2008). In a study involving young adolescents in Cape Town, it was found that the adolescents developed an awareness for the social rules accepted in the community and how the conformity of these behavioural and social rules impacted on their occupational choices (Galvaan, 2010). Regardless of whether the adolescents are in the process of recovery, it makes it very difficult for them to maintain sobriety with these visible distractions and temptations, yet some community members still condone the actions of addicts openly on street corners or fields. Despite this, the participants explained that the education groups held during the rehabilitation programme assisted them to deal with these contextual triggers and the groups allowed them to gain valuable insight into their addiction behaviour.



Just as parents can presumably add in a positive way toward their child's development through their behaviours and values, so too can they be negative role models (Baumrind, 1991). The second barrier described in theme one was related to the category 'spending time with negative role models'. The adolescents expressed that they do not find safe and advisory environments with family, either due to the fact they are also involved with unlawful actions such as dealing with drug sellers or simply that their parents do not lead by example, such as partaking in smoking but instructing their children not to. The current findings corroborated with patients from another study conducted in Pennsylvania. It was found that many of the family members of the patients were involved in substance use and the negative support not only influenced them to use but increased their stress levels to an extent that they would use drugs as a way of coping (Mason et al., 2009).

Interestingly, in a study reviewing how economic and social changes may be linked to illicit drug use in South Africa, it was found that parents, not directly engaging in substance use, but often return home late, leaving their children with inadequate adult supervision for much

time each day (Peltzer et al., 2010). Both scenarios caused the adolescents to be surrounded by bad role models, rather than supportive parents or family members. Subsequent to this, families characterized by lack of closeness, whose members are disengaged from any emotional involvement with one another, and lack parental monitoring tend to experience greater adolescent illicit drug use (Baumrind, 1991). Thus adolescents are in some way forced to seek comfort, guardianship and interaction with older persons outside of the home who are also regarded as bad role models. Regrettably, some adolescents explained that they would spend time at the merchant's home. Therefore, weak communication with family members while in recovery and the absence of positive support and role models, highly promote addiction relapse after treatment (Ibrahim & Kumar, 2009), and for this reason is a barrier to drug rehabilitation.

From the findings above it is evident that a series of occupational needs arise due to drug addiction. Whilst many examples emerged of how the rehabilitation programme at the respective centres endeavoured to address these needs (to be discussed further at a later stage in the chapter), the rehabilitation programmes provided the recovering adolescent addicts with the tools, through groups and counselling to orchestrate their lives in a way that would enable the adolescents to consistently meet their occupational needs. Although there are certain contextual aspects that are impossible to change such as the developing stage of adolescence, resident neighbours, or lack of leisure opportunities; some of the rehabilitation programmes taught the recovering adolescent addicts skills to combat these existing challenges within the addict's environment. However, it is apparent that it is still up to the individual to be consistent in their determination of occupational balance.

### **5.2.2 Barriers within the rehabilitation centres**

Three aspects surfaced from the participants as being obstructive to the occupational needs of the recovering drug addicted adolescents. Two of them are crucial in answering the research question and will be discussed. The findings were described in the category 'external factors which hinder progress in drug rehabilitation' (Theme 1). They are handling of the addict by staff members and ineffective communication.

### **a) *Handling of the addict by staff members***

For treatment to be successful, the therapist must incorporate the adolescent's concerns and desires into the treatment process. It is only when the adolescent trusts that the counsellor understands and acknowledges his/her trials and aspirations, and therapy is transformed into personal endeavours, the treatment can be successful (Shelef, Diamond, Diamond, & Liddle, 2005). In a study done in New York in which 28 adolescents participated, the adolescents endorsed that if they had a positive relationship with staff, it would improve treatment retention and participation (Gogel, Cavaleri, Gardin, & Wisdom, 2010). Where negative relationships were perceived, such as staff not being understanding of their condition or lacking time for counselling, the adolescent believed it to be a barrier to meeting their occupational needs and hindered their treatment process.

In the current study, the adolescents spoke about how counsellors managed them and their behaviours. Some of the counsellors were unsympathetic or were too lenient and this meant that they could be easily manipulated by the addicts. Other adolescents said that the counsellors need to have a certain level of firmness with them but still be understanding of their situations. Similar findings emerged in a different study where participants involved in the technique of motivational interviewing, were appreciative of counsellors who allowed them to make many decisions on their own instead of being told what to do (Mason, Malott, & Knoper, 2009). Such a therapeutic style that allows a calculated partnership between the addict and counsellor will resolve behavioural problems which may exist and enhance the individual's readiness to change (Miller & Rollnick, 2002).

Additionally, it was mentioned by a participant that at the rehabilitation facility that he had been to previously, therapists were too strict and because he already had issues of anger and frustration, this was not beneficial. It only made matters worse and resulted in poor recovery. This finding coincided with the study done in New York where the adolescents articulated frustration with following too stringent programme rules (Gogel et al., 2010) and therefore unskilled and poor handling of the adolescents surfaced as a barrier to drug rehabilitation.

## **b) *Ineffective communication***

The second factor addressed by the participants was regarding the inadequate communication between the rehabilitation centre and the parents/clients. This was however not evident at all the rehabilitation centres but emerged as a noteworthy point. Some parents stated that the counsellors do not inform them about the programme details at the centre or resources outside of the centre, and if they were to be informed they may be more involved in the adolescent's treatment. Involvement would include among other things, regular communication with the counsellors regarding progress of the adolescent and attending family sessions. Effective referral to other team members creates familiarity with the resources, strengths and limitations of local organisations and groups outside of the rehabilitation centre (Robertson, 1998). According to Stoffel and Moyers (2004), if the therapist is to assist the addict's need of correcting social network relationships and drug abstinence, then the counsellor ought to help the client make connections with self help groups in the community.

Both the recovering drug addicted adolescents and the parents mentioned that once the client leaves the facility, no one enquires or follows up on the progress of the client. Although the recovering addicts admit that it is not the responsibility of the rehabilitation centre to ensure that the addicts maintain sobriety, without the follow up call clients can easily fall back into the drug habit, so the rehabilitation staff need to concentrate on the progress of the recovering addicts. Contrary to this, in another study it was found that staff and parents perceived each other as being responsible for causing barriers in engagement as there was lack of communication from the rehabilitation centre whilst there was poor parental involvement (Gogel et al., 2010). Therefore treatment facilities may need to adjust the ways they communicate the significance of such involvement so parents feel like valued members of the treatment team (Gogel et al., 2010).

Overall, the participants' views of barriers and its effect on their daily battles with drug addiction and their occupational requirements during recovery should be taken heed of at rehabilitation centres. In order to determine if individuals derive greater satisfaction from their occupational lives following intervention, the rehabilitation programme must be evaluated by its service users and employees to determine whether they are more consistently able to meet the needs of the recovering clients (Doble & Santha, 2008). Having discussed the barriers though, on the other hand the participants reported on various factors that have

encouraged and aided their recovery process. These positive aspects that they possess and those of the rehabilitation centre will be discussed below.

### **5.3 Facilitators in the recovery process**

Facilitators are factors that encourage and enable the attainment of positive outcomes or enhance the change process (Duncan, 2005). These factors as experienced by the participants will be discussed below in terms of contextual facilitators (external to the addict) as well as personal facilitators (internal to the addict). The contextual facilitators are aspects that the rehabilitation centre possessed and the personal facilitators are the factors of the adolescent. Both promoted their recovery process and are the essence of Theme Three.

#### **5.3.1 Contextual aspects of the rehabilitation centre**

This section will discuss selected therapeutic techniques that the rehabilitation centres have strategically or otherwise unintentionally incorporated into their rehabilitation programmes. Even though all of the rehabilitation centres in the current study may not have had all of the therapeutic methods in place, participants perceived these factors paramount in treatment of addiction.

##### ***a) Education groups facilitate drug recovery***

This therapeutic approach was with reference to the education groups that are incorporated in the rehabilitation programme for the addicts at the rehabilitation centre. It allowed specific feedback concerning the adolescent's maladaptive behaviour to be discussed with group members who are in a similar situation. Fouché (2005) states that during group sessions adolescents are given the opportunity to be exposed to a simulated peer group and can learn, experiment, and practice their social skills within a therapeutic group context.

The recovering drug addicted adolescents' expressed that the education groups helps them to become insightful and teaches them to take responsibility for their actions, something that they never had to endure in active drug addiction. This in turn contributes to the development of self-concept and autonomy. The adolescents are given the opportunity to forge new friendships and seek, as well as offer peer support, all of which may enhance their chances of

abstinence (Boisvert, Martin, Grosek, & Clarie, 2008). Furthermore, and probably the most crucial for maintaining sobriety was the fact that the groups via its counsellors assist them to deal with social and physical triggers that they are faced with on a daily basis. Education groups allow them to see the reality of the effects of drug addiction on their physical functioning and interactions with others. These findings corroborated with an earlier study which found that fourteen to nineteen year olds perceived treatment groups as a way of increasing their understanding of the effects of drug abuse and the impact it had on family members (Mason, Malott, & Knoper, 2009).

**b) *Family groups or parent sessions encourages and enables involvement***

The category 'parent groups as a way of being involved in your child's recovery' demonstrated how the participants perceived parental involvement to be a facilitator. Previous research appears to indicate that family involvement is critical, since a positive correlation exists between family involvement and treatment (Stevens & Smith, 2009). As mentioned earlier (in chapter 4) not all the rehabilitation centres in the study had parent sessions as part of their programmes. However, there were certain parents that had been to other centres with their children but realised that things did not work until they became personally involved in the sessions with other struggling parents, which provided the support they needed.

The parents also said that they are not equipped with understanding the developmental stage of adolescents and neither do they know how to handle their addicted adolescent. Even though peers and the community may loom larger among an adolescent's influences, the family and parents being a constant element usually have continuing proximity and can employ some degree of power over the actions of their adolescents (Baumrind, 1991). The education groups, via counsellors, therefore supply parents with skills to assist them in the management of their recovering addict and teach them to exercise patience whilst showing tough love.

Corresponding with the current findings, research has shown that treatment programmes which encourage involvement of parents in their child's life are a major key to making adolescents less vulnerable to drugs and assist them with maintaining sobriety. Additionally, parents need to take a more active role in their children's lives, including talking to them



about drugs, monitoring their activities, getting to know their friends and understanding their problems (Stevens & Smith, 2009). Therefore, regardless of the parent's relationship to their child, they need to be involved in the solution in order to move the client forward in recovery.

### **c) *Counsellor handling principles***

Adolescents are often self-disclosing in an environment which they are comfortable in (Fouché, 2005). In the category 'positive counsellor-handling and personal experience assist the addict' it was explained by the participants that when counsellors are caring towards the addict, the addict would feel motivated to change their bad habits. Many adolescents expressed that when their counsellors understood them and their situation, they would feel comfortable to approach the counsellor with their problems.

It is not surprising that in a separate investigation where therapists demonstrated empathy, strived to establish trust, and allowed clients to speak about positive and negative aspects of their addiction, clients acknowledged their counsellors to be understanding and accepting, and deemed the therapeutic style to be effective (Mason, Malott, & Knoper, 2009). In a study of group treatment involving 401 participants from a rehabilitation centre in Montreal, it was found that when clients believed that they and their counsellor were working towards the same goal and that there was mutual respect, the client displayed less resistance (Cournoyer, Brochu, Landry, & Bergeron, 2007). Additionally, therapeutic involvement, with reference to counsellor rapport and working alliance between client and therapist, has been identified as a key predictor in the treatment retention of clients (Gogel et al., 2010).

Another interesting point which emerged in the current study was that a few of the counsellors were ex-addicts and the adolescents felt that their advice was realistic as they knew exactly what sought of struggles and triggers the adolescents are facing. In a small body of research that examined the utility of counsellor's perceptions in determining relapse, it was found that more experienced staff were better at predicting outcomes of the clients (Walton, Blow, & Booth, 2000), and could therefore advise accordingly. Hence, if counsellors demonstrate understanding, empathy, realism, and handle their clients with an accepting temperament, counsellor handling was regarded as an essential component in the recovery process of drug addicted adolescents.

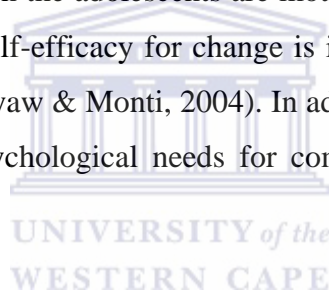


### 5.3.2 Personal qualities of the addict as facilitators

An individual may possess a number of characteristics that are facilitatory such as skills or strengths, and three emerged strongly as positively influential in drug recovery. They were motivation of the adolescent, the ability or organisational skill of scheduling, and spirituality.

#### a) *Motivation fuels the process of rehabilitation*

The category 'self motivation of the addict' surfaced as crucial in addiction recovery, and although parents and authority figures may refer adolescents to treatment because of their own concerns rather than any concerns expressed on the part of the adolescent, literature shows that it is not necessary for adolescents to admit to having a substance use problem (Tevyaw & Monti, 2004). This can be stimulated during treatment since adolescents are receptive to encouragement. When the adolescents are motivated, either personally or via the support of someone else, their self-efficacy for change is increased and they can effectively reduce their risk for relapse (Tevyaw & Monti, 2004). In addition, intrinsic motivation allows the individual to meet basic psychological needs for competence and control (Corvinelli, 2005).



According to the rehabilitation workers in the current study, the clients who choose to be committed to the programme are more willing to change their behaviours and parents felt that if their recovering addict takes rehabilitation seriously, they too will be more supportive. However, in a research involving over 900 youth from a community-based treatment programme in eastern and western United States, it was found that even if youth are not necessary motivated when they enter the treatment system as was the case with many in the current study, exposure to treatment can increase motivation and strengthen drug resistant beliefs (Schell, Orlando, & Morral, 2005). It also illustrated the importance of adolescent's perceptions and cognition with regard to motivation and the impact this may have on their treatment progress and utilization. Therefore, if the adolescents are self-motivated or inspired to be motivated, the rehabilitation workers at the centres concurred that the clients are then more willing to implement what they have been taught, and the tools and techniques that the counsellors have provided to manage their aftercare is not in vain.

**b) *To schedule and implement aftercare helps to maintain sobriety***

Once the adolescent has been discharged from formal rehabilitation, the period thereafter is often referred to as aftercare and most literature states that the highest risk for relapse is the first 60 days after being discharge (DARA, n.d.). What was a lifestyle of complete disregard for others, self-centredness, and unorganised habits with a main focus of feeding the addiction, now requires careful planning of daily routines and schedules. This could not have been emphasised more strongly by the rehabilitation workers in the current study.

Although it is primarily up to the individual to continue with abstinence, many of the adolescents mentioned that the rehabilitation centres did not teach them how to schedule, but where this did take place, the adolescents described its benefits. Also highlighted in the category 'importance of having structure as part of aftercare' (Theme 3), was the value of attending the aftercare sessions. Now, attendance and participation are defined as being physically present in treatment sessions or actively and emotionally being involved in rehabilitation activities (Gogel, Cavaleri, Gardin, & Wisdom, 2010). Since this was likely to be achieved in the formal treatment, even when the programme is over there is a requirement to be connected to the treatment centre over time.

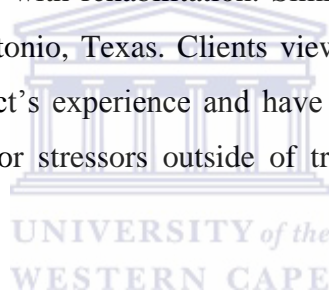
Aftercare may be in the form of counselling sessions, support groups, debriefing sessions, follow-up meetings, and serves to reinforce skills and coping strategies learned during formal rehabilitation, but many adolescents in the current study who had relapsed, and those parents who had been through the process more than once, explicitly mentioned that this was not done by them. In fact, the rehabilitation worker explained that like a chronic illness requires medication, the recovering addict requires aftercare and it was evident that it should be included in the rehabilitation programme. Further, depending on the severity of the drug addiction, where individuals have been taking drug for years, restructuring new behaviours and change will take a long time to reinforce (Stoffel & Moyers, 2004) and by learning to structure and by engaging in the daily activities, new problems will be encountered and attending a form of aftercare will assist in finding new solutions to cope with them.

Evidence also shows that having this structure may be directly linked to having goals and objectives within recovery and therefore supports the continuing implementation of them thereafter (Stoffel & Moyers, 2004). Additionally, from the findings of this study it may be

argued that there is a link between attending aftercare and being self motivated. If an individual is motivated he/she will attend aftercare and aftercare can keep an individual motivated (DARA, n.d.). Partaking in aftercare by scheduling daily tasks, and attending sessions therefore play a critical role in long time recovery (Buddy, 2008) and was identified as a facilitator in the recovery process.

### **c) *Spirituality enhances well-being***

Spirituality has been noted in literature to be helpful. Prayer for example is a spiritual activity that can be easily integrated within a typical addiction programme. In the category ‘spirituality as a healing agent’ the notion of spirituality, whether in praying, attending spiritual sessions or simply attributing faith to a higher power was described by a few participants to bring relief. Some said it was their connection with God that gave them the strength and courage to continue with rehabilitation. Similar sentiments were revealed in a case study conducted in San Antonio, Texas. Clients viewed prayer as a personal resource that can aid the recovering addict’s experience and have reported praying to be beneficial when they experience cravings or stressors outside of treatment sessions (Juhnke, Watts, Guerra, & Hsieh, 2009).



Since occupational therapists are concerned with the achievements of potential in all occupational areas, an investigation was carried out to determine whether occupational therapists considered spiritual needs to be part of their domain. The therapists explained the importance of providing holistic care but said it was often unrealistic due to time constraints (Hoyland & Mayers, 2005). They further stated that if spiritual needs were not assessed an important part of many people’s lives would be neglected and their maximum potential not achieved.

Although spirituality was not incorporated in all the rehabilitation programmes in the current study, from the participants that engaged in those that did, it was evident that spirituality was part of recovery. The parents expressed how having belief in a superior power assisted them in dealing with their current situation of having a recovering child. It also aided them in the process of rehabilitation for, and with the adolescent. In a focus group study involving 21 participants from New Haven in Connecticut, praying and belief in a higher power were most cited as coping strategies in drug recovery (Arnold, Avants, Margolin, & Marcotte, 2002).

Many participants from that study claimed that it was due to their belief in a God that they had achieved abstinence, and when asked about whether they felt the need for an intervention that would specifically integrate spirituality into their addiction treatment, most of them were supportive.

#### **5.4 Suitable ways to support recovering drug addicted adolescents**

According to the National Health Services when a client feels his needs are being met it permits and supports engagement between the client and service provider (Myers<sup>2</sup> et al., 2008). It is therefore fundamental that the first step for a therapeutic alliance is to assess and identify the domain of needs for the specific individual as a foundation for an effective treatment plan. The barriers and facilitators as discussed above emerged and were constructed from quotes of participants across the rehabilitation centres. Thus, the following strategies are drawn from the facilitators and needs perceived by the participants.

When the participants were directly asked about their needs in drug treatment and during recovery, a number of interesting points were mentioned and when considering these identified points from those involved in the intervention, it promotes successful recovery. The first was family support. Even though from the view of professionals the value of family involvement cannot be discounted, it was particularly appealing to note that the adolescents also craved their family support. There is no doubt that the family is significant in the constellation of influences, as the family touches the lives of the adolescent on a daily and profoundly personal basis (Baumrind, 1991). It is a requirement that family ought to be involved during the formal rehabilitation programme and maintain a continuous, informed, support system thereafter.

Another expressed need that emerged was the matter of considering religious differences among the population of addicts. Faith-based or spiritual sessions were raised as an important and surprising characteristic to be included in the programme. Some parents stated that the counsellors should include religious authorities in the programmes as faith-based sessions assisted a number of adolescents and their families in long term recovery. Pardini and colleagues (2000) found in a study of 237 recovering substance abusers that higher levels of faith and spirituality predicted a more optimistic life orientation, greater perceived social support and a higher resilience to stress.

In the category ‘spirituality is part of recovery’ as discussed earlier in the chapter, participants acknowledged that spirituality may be a helpful resource, but majority of the facilities in the current study had no form of spirituality or religiosity included in its programme. In a study involving 68 patients from a methadone maintenance programme, results showed that religion and spirituality appeared to be underutilized by health professionals in the field (Arnold et al., 2002). Therefore, despite the relatively few studies conducted, or programmes found that incorporates spirituality into addiction treatment and given the complexity in its definition, there is a clear interest in receiving spiritual-focused intervention as it may support addicts who are recovering.

Another need identified by the participants particularly the parents and rehabilitation workers, is for adolescent-specific approaches. Although adolescent psychiatry is a specialised field and gaining recognition (Fouché, 2005), how can one truly support addicts after they have been discharged, if firstly, the treatment programme is not designed-specific for their needs or secondly, aftercare programmes are absent. Literature emphasises that the developmental stage of adolescence is complex and diverse because of their distinguished physical, sexual and intellectual development. Yet at all the rehabilitation centres no real focus was given to the needs of adolescents or adolescent-focused drug rehabilitation programmes, even though adolescents are attributed to be markedly using substance abuse services (Schell, Orlando, & Morral, 2005).

It was attempted but according to the rehabilitation workers adolescent approaches did not work. Whether in handling principles by the counsellors(‘positive counsellor-handling and personal experience assists the addict’), or parental management (‘parent groups as a way of being involved in your child’s recovery’) there was an obvious distinction made in the way one treats adolescents, compared to any other age group. Moreover, if intervention is guided by their interests, it may prove not only to be client-centred but may very well be attractive to them for aftercare. It could be reasoned that keeping adolescents interested in treatment, will motivate them to continue even after discharge and hence may be a promising strategy in supporting their long term sobriety.

The final concern as raised by the participants was the need to have more prevention programmes at school. While it is well known that adolescents seek out experiences that offer novelty, experimentation and sensation (Caldwell, Smith, Wegner, Vergnani, & Mathews, 2011), many adolescents in the research were referred to the facilities by their school principals. Hence the school environment may well be the breeding ground for drug experimentation and addiction. It should be mentioned though that only recently has awareness programmes been run in surrounding high schools of the Cape Town Metropole as the treatment centres were overwhelmed, on a weekly basis, by educators sending learners to the centres for drug tests.

The Cape Town Metro Police also recently started random drug searches at high schools in the metropolis as part of an initiative to curb the drug problem among learners (Petersen, 2012). According to the police spokesperson the searches is one measure to prevent drug abuse at school. However, the parents in the current study explained their disbelief at the amount of grade 10 and grade 11's in the centres' rooms waiting for drug testing. The principal of a high school in Cape Town stated that grade 9 classes are most at risk and educators should monitor the progress of pupils so that a safe environment at school is attained (Petersen, 2012). Furthermore, a proactive approach at this level, perhaps in the form of a school counsellor as suggested by a parent in the study, could mean drug abuse may be prevented before it results in drug addiction. It may also serve to remind those that have returned to school after completing treatment, not to go back to the addiction lifestyle.

### **5.5 How occupational therapy can enhance current addiction intervention**

The Health and Advisory Service Report provides guidance to both commissioners and providers for the treatment of substance abuse (Carrick, 2004). In the review of Evidenced Based Intervention for the Prevention and Treatment of Substance Use Disorders (Myers<sup>2</sup>, Harker, Fakier, Kader, & Mazok, 2008) strategies and requirements on the method of implementing substance abuse services are described systematically. Overall, strong emphasis is placed on using evidence-based approaches, to ensure that a multifaceted response is provided to meet the complex needs of the adolescent and that intervention is delivered in a planned and integrated manner (Carrick, 2004).

The involvement of occupational therapists in drug-related disorders is crucial and no other health care provider is equivalently prepared to address the breakdown of occupational function caused by drug usage. Occupational therapists are uniquely prepared to deal with the intricate interactions of motivation, habits and personal causation (Boisvert et al., 2008) as the occupational therapy approach uses participation as a goal and as an intervention. During recovery, the excitement of procuring and using substances has a significant impact on relapse and it is therefore appropriate that occupational therapist assist people who used drugs to confront the experience of restructuring or boredom (Corvinelli, 2005).

However, it appeared as though the value of the role of occupational therapy in addiction treatment was absent. Only two of the four centres had an OT present, and at the one centre the occupational therapist was merely involved in the programme with clients once a week. Although in recent times, occupational therapy researchers and writers have documented the role of OT in substance-related disorders, it seems as though the greater part of practicing professionals and facilities have not embraced the benefits.

For one, since adolescents by nature of their transitional phase present with multiple challenging areas in treatment (Hser *et al.*, 2001), and occupational therapists who give significant credence to developmental norms, it seems likely that an OT should be part of the treatment team. Also, programmes were not specifically designed for adolescents, even though the counsellors acknowledged its importance. Occupational therapists are equipped to manage the dynamic interactions of roles, function of peers, and developmental processes (Hser *et al.*, 2001) so that there is not only a reduction of drug use but that complete return to occupational functioning is achieved (Stoffel & Moyers, 2004).

Thus based on the findings of the study, an occupation-based model will be used to discuss how occupational therapy may assist recovering drug addicted adolescents, and expand on the intervention of drug-related disorders. The Model of Human Occupation will be discussed primarily from a development-stage perspective and its use as an assessment or intervention tool.



### **5.5.1 Relation to the Model of Human Occupation**

The Model of Human Occupation (MOHO) considers an individual to be an open system, interacting with his or her environment; and views what the client does, thinks and feels as the mechanism of change (Kielhofner, 2008). It is through this interaction that the individual grows, regulates choice and occupational performance. The open system (as described in chapter 2) comprises of volition, habituation and performance capacity. The MOHO also takes into account the effect that tasks, social groups and culture has on the individual's behaviour.

#### **a) *Volition***

An individual views their abilities and efficacy in relation to demands and expectations of their environment (Kielhofner, Forsyth, & Barrett, 2003). This translates into how an individual feels about whether he or she is able to achieve or commit to the desired outcomes. The process of committing to something is tied to the development of an occupational identity (Kielhofner, Forsyth, 2008). In a case where a male client displayed poor recognition of his identity, feelings of inability combined with limited role involvement, the MOHO allowed him to explore a variety of interests and identify things that were meaningful to him (Kielhofner, Mentrup, Miranda, Schulte, & Shepherd, 2008). The MOHO also encourages the identification of performance challenges and occupational needs and preferences at the onset of assessment. This emphasizes volition of the individuals.

Kielhofner (1995) explains that the influence of parental styles is a major factor at this age. There is convincing evidence in literature that parental rules and involvement have a substantial impact on a recovering adolescent's progress. In the current study, not all of the parents were involved in their child's recovery. Some did not know how to be involved and the parental or family sessions offered at the rehabilitation centre taught them the correct handling skills to implement in the management of their child.



Occupational therapists, being concerned with the assessment of behaviours, meaningful roles and relationships in the client's daily living (Stoffel & Moyers, 2004), gives attention to the adolescent within his family setting so that parents may be taught new and different handling principles not only appropriate to the developmental stage, but appropriate to the phase of addiction.

Values tend to influence an individual's ideas on what occupations to choose and the proper manner in which to act (Kielhofner et al., 2003). The adolescent therefore seeks meaning either in work, school or a career field and automatically identifies leisure activities through personal explorations. It could be argued that perhaps many adolescents who become addicted to drugs do not find meaning in expected tasks; they have restricted leisure opportunities, and possibly lack a career interest. A few adolescents in the current study expressed a lack of career sense or goal-setting. Much of their time and energy had been spent on obtaining and using the drugs that identifying any other leisure activity seemed farfetched.

In the category 'it's easy: just here on my corner' (Theme 1) reference was made to the bad neighbourhoods that the adolescents resided in, leaving very little positive leisure opportunities for them to experience. Similarly, in the category 'relapse as a vicious cycle' (Theme 2), the lack of leisure activities were echoed, resulting in boredom, and drug experimentation as a consequence. If leisure activities are made available to youth, and the importance of positive leisure is reinforced in treatment, youth will have the prospect of making healthy choices that provide interest and optimal experience, but reduce the desire to seek risky activities such as substance use (Caldwell et al., 2011).

Kielhofner (1995) further explains how the adolescent slowly moves away from family-centered activities and draws towards peers and other social groups. In the category 'pressure and sense of belonging through friends' (Theme 1) and the category 'spending time with negative role models' (Theme 1), many of the adolescents alluded to their peer group that has been a major influence in their drug use, and the company of older persons in the community who may not necessary be the best social role models. A number of adolescents succumbed to this bad company as guidance was lacking or absent in other social networks such as the home. Since the adolescents have been in these negative social networks over a period of time, their values and sense of responsibility, rather the lack thereof has shaped their

decision-making. The Model of Human Occupation promotes clients to envision their lives differently. It involves reorganizing volition, reconstructing habit patterns and helps the individual to re-engage in life roles which have been previously neglected (Kielhofner, Mentrup, Miranda, Schulte, & Shepherd, 2008).

The Model of Human Occupation has a variety of assessments that focus on the client's occupational performance. It provides information about the client's volition status so that an appropriate intervention programme can be planned. Each assessment form has thematic areas covering occupational identity, environmental aspects, interests and role performance (Kielhofner, 2008). In addition, it allows the occupational therapist to be cognizant of, and assess functions of friends, volition, school environments and other social groups as they are important in understanding the context of the adolescent. Among the many reasons, the MOHO is therefore an appropriate tool to assess occupational function and dysfunction for adolescents affected by drug addiction.

#### **b) *Habituation***

Possibly the most significant subsystem for a recovering adolescent addict is that of habituation. Habits have an impact on routine performance; how people use their time and how they behave (Kielhofner et al., 2003). Although a sense of independence and responsibility is the likely path that most adolescents would tread, the adolescent that has made the poor choice of drug use, lacks even the ability to account for his behaviours, least of all those that have become habits as a result of the addiction.

In the categories 'harmful effect on self concept and identity through manipulation tactics to feed the habit' (Theme 2) and 'destructive impact on family relations due to negative changes in the addict's behaviour' (Theme 2), the participants described the extent to which they would go to maintain their addiction, from exploitation, lies and stealing all to support the drug cravings. The adolescent not only loses sight of what he hoped to achieve but becomes financially drained as he/she exhausts every avenue of obtaining money and now begins to steal. These habits, instead of relating to demands of work and other adolescent roles such as schooling, are consumed by a lifestyle of activities to obtain the drug.

Some of the adolescents in the study expressed that they were suspended from school, others mentioned failing grades and the remainder dropped out all due to the fact that they were not focused on school-related tasks but drug-related habits.

By using the MOHO, occupational therapists are distinctively equipped to take interest in evaluating the extent of bad habits and understanding those specific aspects that has become unmanageable in the addict's life. This would inform the treatment approach so that bad habits are abolished, and daily occupations and positive habits are rebuilt, organized and restored (Stoffel & Moyers, 2004). Many MOHO evaluations are also designed to be outcome measures and are appropriate to use before and after intervention and in this way the therapist can determine the effectiveness of the therapy and the achievement of short term and long time goals (Forsyth & Kielhofner, 2008).

### **c) *Performance capacity***

The final domain that Kielhofner presents in the model is performance capacity. Physically the adolescent goes through a period of rapid growth and the nervous system is at its final stage of formal operational thought (Kielhofner, 1995). However, according to the participants of the study, this naturally occurring process was to a great degree affected by the use of drugs. In the category 'harmful effect on body, mind and image' (Theme 2), the participants explained the effect that their drug use had on their eating patterns, sleeping patterns and subsequently had an impact on their self-concept, physique and thought processes. These components influenced the ability and capacity of the adolescent to perform functionally and constructively in their daily tasks. Performance capacity is therefore a critical aspect of adolescent development and the MOHO affords these psychological components to be assessed.

A few of the adolescents in the study acknowledged having anger problems and self-image concerns due to drug addiction, being active with similar individuals in facilitated group sessions for example, the adolescent finds the opportunity to evaluate their body image and physical ability. The integration of physical activity such as sport, into treatment may subsequently help in providing confidence with new body image and may allow the adolescent an arena to dissipate some bottled up emotions (Fouché, 2005).

The Model of Human Occupation has been used on diverse client groups with a number of illnesses and across specific contexts such as hospitals, rehabilitation centres and correctional facilities (Braveman, Kielhofner, & Bélanger, 2008). In a study involving 70 participants who attended a day programme; clients who received MOHO based intervention achieved significantly better independent living compared to those who received standard intervention (Kramer, Bowyer, & Kielhofner, 2005). It offers a solid theoretical view of occupation that clearly helps to provide a comprehensive picture of occupational functioning through the MOHO concepts.

Positive results were also shown in another study involving adults participating in an individual intervention programme. With the assistance of MOHO the adults were able to create an action plan to begin engagement in a new leisure activity (Kramer, Bowyer, & Kielhofner, 2005). Additionally, the MOHO as a screening tool allows for frequent re-assessment and is useful for giving feedback to multidisciplinary teams due to its unobtrusive format (Parkinson, Chester, Cratchley, & Rowbottom, 2008), and can in the many ways as mentioned above, enhance current addiction treatment. In another survey involving 259 occupational therapists using the Model of Human Occupation, it was reported that the MOHO supports holistic, client-centered and occupation-based practice (Lee, Taylor, Kielhofner, & Fisher, 2008).

## **Conclusion**

Interventions that are successful in adolescence often have long-term effects into adulthood and may in fact be life-saving (Tevyaw & Monti, 2004). The intention is to help the client develop the best performance outcomes needed to maintain abstinence and prevent relapse. Above all, it was evident following the current investigation to which extent drug use affects interpersonal relations, body functions, decision-making, leisure and school, all of which are components of daily occupational functioning and well-being. The degree and range of occupational needs discussed provide a strong rationale for the provision of occupational therapy for people who misuse drugs in terms of meeting those occupational needs and not just supporting abstinence. The barriers which surfaced from the investigation clustered around the physical, social, and rehabilitation centre context, all of which were expressed by the participants to impede their drug rehabilitation. The facilitators as experienced and

perceived by the participants encompassed primarily the rehabilitation centre context and personal attributes of the recovering addict.

Although, the facilitators expressed were convincing in demonstrating its favourable effectiveness in drug rehabilitation and meeting the occupational needs of the individual, to the researcher's knowledge not one of the rehabilitation centres in the current study possessed all the facilitators but they attempted to create an all encompassing rehabilitation programme. The consideration of the barriers and facilitators which emerged from the participants are in many ways a plausible solution to ensuring that fulfilling the needs of the clients in question, are achieved. If the drug treatment programme is beneficial, those who utilise health care have improved health status and less need (Schell, Orlando, & Morral, 2005). It is well established in psychotherapy that positive treatment is highly correlated with the individual's motivation to participate in treatment and the desire to change (Stevens & Smith, 2009). For this reason, and on the numerous accounts of the participants, the counsellor's handling and management play a purposeful role in motivating the adolescents, in showing that they care and in creating a harmonious relationship.

Whilst, research studies have suggested that health providers may consider using a combination of approaches (O'Day, 2009) in the treatment of drug addiction, the occupational therapist should select the most appropriate model and handling approach using an assortment of cognitive, behavioural, learning or developmental models. But, irrespective of which approach is used, it should be creative and ensure an element of experiential learning as adolescents learn best through experience (Fouché, 2005). Moreover, the findings of the study proved to what extent drug addiction affects occupational performance. It is therefore crucial that treatment is embedded within an occupation-based framework.

Based on the perceptions of barriers and facilitators as identified by the participants in the study, therapeutic environments that endow a sense of belonging, convey choice by characteristics of the programme, that provide a sense of control, understanding and experience from the rehabilitation team, incorporate education groups, offer family support sessions, include consistent aftercare, and are adolescent-centred, are all components which create suitable ingredients for supporting drug rehabilitation programmes among the adolescent population. In this way there is little doubt that occupational needs will be left unmet.

## CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

### Introduction

The problems related to drug addiction particularly among youth have led to an increase in research and remains a growing concern for this population. The hope is to gain an improved understanding of the predicament, and a need to find a solution to it. The findings of this research propose practical ways of how this may come to fruition. In chapter 6 certain salient findings will be further re-emphasized by drawing on literature reviewed through the research process. Lastly, based on the perspectives of the participants the chapter intends to offer strategies and methods in which treatment centres may support recovering adolescent addicts, taking an occupation-based perspective into account.

### 6.1 Conclusion

Due to high rates of relapse amongst drug addicts, the researcher reflected upon whether this was as a result of occupational needs not being met. The current research aimed to investigate how drug rehabilitation programmes are meeting the occupational needs of recovering drug addicted adolescents in Cape Town. The study explored the perceptions of those directly involved in the field of drug rehabilitation i.e. the recovering adolescent clients, the parents of recovering addicts and the rehabilitation workers. The participants relayed their views and perceptions of a world that they personally experience and struggle with on a daily basis. Through recording and documenting their reports, there remains no doubt in the negative consequence of drug use not only on the occupational performance of the addict but on the social relationships which surrounds them such as families, neighbours and school environments.

It was astounding that the findings of the study indicated the lack of knowledge from participants regarding the concept of relapse and its general relation to the recovering addict. So how do these recovering individuals remain sober if warning signs, self-defeating thoughts and effective coping responses are not taught? Although several early studies have shown that relapse prevention programmes provide sustained improvement over long periods of time while other methods show effectiveness only within a shorter duration (Carroll *et al.*,

1994), it is surprising that the magnitude of relapse prevention has not disseminated in many rehabilitation programmes.

In the current investigation, some participants did not receive relapse prevention tools either because not enough attention was given to it via the rehabilitation programme, the centre did not provide it, or adolescents and parents alike did not realise its importance. The awareness of perceived reasons for adolescent relapsing should be communicated to rehabilitation workers so that counsellors may correct incorrect ideas and teach trigger-stopping techniques to facilitate its implementation. Moreover, once the lifestyle of drug addiction has ceased it is imperative that daily occupations are restructured so that the occupational imbalance of the individual, including possibilities of boredom are to be replaced by constructive occupations.

Apart from the needs that generally arise as a result of drug addiction and occupational dysfunction, adolescents by nature of being in a transitional period have an array of social, psychological and physical needs, which requires a holistic, multidisciplinary treatment approach. By excluding developmental aspects such as the function of friends, the role of parents and their physical environment in which they live and grow, and issues pertaining to self-esteem and occupational identity, the approach in itself cannot be client-centred if it does not give attention to those social networks and personal factors which is part of their make-up. There needs to be a direct acknowledgment that understanding occupational performance of individuals requires attention to the context of that individual (Whiteford & Hocking, 2012). Some contextual barriers, such as the availability and accessibility of drugs in their places of residence proved to be factors difficult to change or remove.

The rehabilitation programmes in the current investigation however attend to recovering drug addicts based on knowledge, experience and resources in the field of addiction. The addiction models, most of which are evidence-based frameworks, did not consider the age of the individual nor cultural and/or spiritual aspects. The barriers as professed by them necessitates consideration especially when so much of what is needed by a client is dependent upon his or her developmental stage as this governs the occupational performances and roles with which the client engages.



Another critical finding that surfaced from the research, likely to be attributed to the occupational dysfunction caused by drug seeking behaviour, is the habits, attitudes, and actions of recovering drug addicted adolescents. Drugs have the capacity to alter cognitive functioning in ways that many adolescents find attractive (Durrant et al., 2009). Not only does their challenging behaviour and manipulative tactics, dictated by the drug use, call for a handling approach well thought out by counsellors, but specific handling principles need to be taught to parents or guardians of those adolescents.

In terms of facilitators, literature makes reference to the link between family involvement and drug rehabilitation outcomes. Based on the findings in the current study, the integration of family has a strong conceptual and clinical rationale. Another important facilitator that arose from the data was the benefit of education groups as part of the rehabilitation programme. Groups, if appropriately managed, is a suitable tool for adolescents as it creates a safe environment for them to behave, express themselves and learn. Furthermore, group therapy allows for the opportunity of choice, delineated expectations regarding the clients' responsibilities, and a chance to relate with like-minded others (Corvinelli, 2005). Education groups afford adolescents the opportunity to be reflective (through art or journaling), to be active (through sports or dance), and to be interactive (through role-plays or theatre).

Another key point that surfaced was the value of aftercare. Clients do not always see the value of aftercare and the MOHO can be used for building trust with the individual who is not positively motivated towards continuing with treatment (Kielhofner, Mentrup, Miranda, Schulte, & Shepherd, 2008). According to the findings, attending aftercare assisted with establishing a routine and remaining focused on the goals of occupational function and role restoration. Attending bi-weekly meetings, support groups arranged by the rehabilitation facility, and healthy social events which promote healthy choices, provide them with supports that are not available when clients are discharged into the broader community. It would be unrealistic to attend rehabilitation everyday for the remainder of your recovering life, but to uphold a link to the rehabilitation centre, offers the adolescent reminders to organise daily activities, and to sustain the techniques that has been taught to avoid drug use.

Adolescents more so are often receptive on the one hand or completely hostile depending on the approach that is taken with them by, what they reckon to be authoritative figures. From the outlook of a health service profession, there is often a need to recognize that an



individual's occupational choices are important and valued and in this way it contributes to the client's feelings of self-worth (Doble & Santha, 2008). A dominant feature in the actual retention of the recovering adolescents in treatment and their overall rehabilitation was the handling approach towards a recovering adolescent by counsellors. Whether a humanistic, cognitive-behavioural, neuro-physiological or interactive style was used, if it was free from empathy, understanding, a level of firmness and reality, it appeared as though a therapeutic alliance would not be established. The participants therefore emphasised that the counsellors' manner and management of them played a significant role with reference to their recovery.

The final factors that emerged in the current inquiry in view of facilitators are motivation and spirituality (as previously discussed in chapter 5). When clients display genuine willingness to change and they are committed to recovery, then adapting negative habits and behaviours are made less challenging. Having said that however, it in no way means that the process is not a struggle, participants simply eluded that with motivation, more support is gained and encouragement maintained.

Although minimal literature was found altogether on spirituality, in fact no articles or studies surfaced in the initial few searches on adolescent addiction, contrary to the influence of peers for example, spiritually-orientated programmes in the current study supported the contention that it is a relevant factor to include in addiction treatment. Even though it may not always be possible to address the diversity of beliefs and practices of the patient population, the option to include it is necessary. Irrespective of how it is included, be it in the form of inviting various religious organisations or leaders to the centre, or allowing for spiritual-time within a day, it should be flexible enough so that individuals may define spirituality for themselves or take part in religious-based sessions as needed.

It should be mentioned though that potential contra-indications could exist such as if the client had psychotic symptoms, does not believe in God's interest in recovery, or their perception of God to respond to a prayer for example. By and large, for a significant portion of participants in this study, belief in a higher power and spiritual activity has been seen as a helpful intervention that has augmented their overall treatment success.

In light of the overall literature reviewed throughout this research process, and the findings of this investigation, strategies specific to adolescents are needed in order to maximize therapeutic benefits. Where education groups, family support sessions, positive counsellor handling principles, structured aftercare, attention to social and physical contexts were part of the rehabilitation programme, positive responses emerged and participants felt that these facilitated the drug rehabilitation process by essentially meeting their expectations and needs. Drawing on the findings of this study to ensure that drug treatment services are accessible and that rehabilitation programmes are in fact addressing the occupational needs of recovering drug addicted adolescents, the following recommendations and suggestions call for consideration.

## **6.2 Recommendations for drug treatment services**

### **6.2.1 Recommendations for drug rehabilitation centres**

- The centre should in the very least have one qualified member from each of the community and health fields; namely a social worker, addiction counsellor, psychologist, occupational therapist, psychiatrist, nutritionist/dietician and auxiliary staff members so that the service is focused on addressing holistic needs of addicts in recovery.
- The health professionals should be competent in dealing with adolescents i.e. should be equipped to assess all the performance areas of the individual and understand the individual within his/her developmental stage.
- Drug rehabilitation facilities should, apart from working with the adolescent addict, endeavour to work within the social context of the adolescent. This includes the family, the school and the community.
- The drug rehabilitation centre should make an effort to keep up to date with current techniques or methods in drug treatment, by allowing different member/s of the multidisciplinary team, at a time to attend professional addiction courses or workshops, so that they may better advise and treat clients and their families.

- A specialist accommodation should be made for adolescents separate from adults and health members should be trained and knowledgeable in exercising adolescent-handling principles.
- The centre should offer, by means of its multidisciplinary team, a range of activities so that adolescents have an opportunity for choice within a safe treatment environment. This encompasses client-centeredness i.e. intervention should be appropriate to their age and their routines.
- It is suggested that where possible, the inclusion of an ex-addict (with positive moral characteristics, integrity and good work ethos) in the multidisciplinary team for the purpose of facilitating groups. They would bring an element of realism and benefit to service recipients.
- The centre should provide religious (spiritual) and culturally-appropriate services by integrating its programme with other community organisations, agencies and religious workers. This may be accomplished by inviting a religious representative or organisation once a week to give a talk or provide a session where the recovering addicts may discuss aspects that they may be struggling with.
- The rehabilitation facility should have knowledge of, and acquire clear network pathways for primary and secondary rehabilitation, organisations or support groups so that the correct level of treatment is administered or referred (Primary rehabilitation focuses on development and prevention programmes before substance abuse becomes a major problem. These are often social users or experimental users. Secondary rehabilitation involves planned intervention programmes that reduce the severity of consequences of drug use with high-risk groups. Tertiary care, which may include detoxification services, is needed where persons present with substance use addiction therefore comprehensive assessment and treatment should be planned with the individual and his/her social network).
- The centre should advertise its service in suitable places and be open at times where adolescents can access them without missing school, college or employment.

- Negative attitudes towards previously drug using clients should be stamped out through the provision of public talks or radio shows that focus on commonly held beliefs and pre-conceived ideas about individuals with drug problems and provide information about it. This is primarily important when recovering addicts want to return to school or places of employment.
- It is suggested that a team is created and organised at the rehabilitation facility solely for the purpose of managing discharged clients. Aftercare is seen as a major facilitator and an integral component of rehabilitation, therefore regular contact should be maintained by the rehabilitation centre and the client-base via aftercare sessions, habitual follow-up meetings, or phone calls with a supportive member in the client's social network.

### **6.2.2 Recommendations for the drug rehabilitation programme**

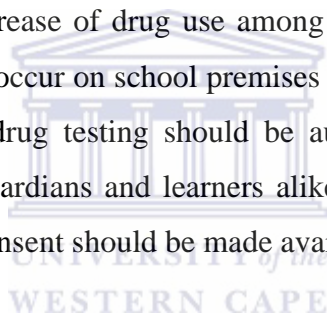
- A range of skill building groups will need to be included especially structured life skills such as problem-solving, coping skills, anger management, budgeting, career choice, CV writing, computer training etc.
- The interventions and treatment approach should be client-centred. This means that it should be customised and appropriate to adolescents and not adult interventions simply being used on younger persons.
- Education groups should be made available to clients (education on drug addiction, its damage to the body, its impact on occupational performance, relapse prevention and trigger-stopping techniques). While no single model of relapse could ever cover all individuals attempting behaviour change (Witkiewitz & Marlatt, 2004), a more thorough understanding of the determinants of relapse as underlined in this study provided added insight into the treatment of drug addiction and the prevention of relapse.
- Psychotherapy (for clients having to deal with body image, diet, and self-esteem for example) and structured one-on-one counselling should be provided.

- The programme should include family-focused interventions such as parent education (knowledge of drug addiction and relapse), handling-principle groups, individual family therapy and family support sessions.
- Drug related information in the form of posters and brochures should be accessible and be made available to individuals at the drug rehabilitation facility.
- It is suggested that during formal treatment, clients should be issued with a workbook/exercise book so that they may document lessons learned, important definitions and tools. Once discharged, clients should leave with this workbook which should assist them in self-evaluating their problems and strengths. This should motivate the desire to change. The workbook should be brought to aftercare sessions so that the new struggles may be identified and solutions may be provided.

### **6.3 Recommendations for schools as part of drug rehabilitation outreach**

- Parent-teacher meetings are generally held every term at schools. Drug treatment workers should attend and inform parents about warning signs of drug use, teach education on drugs; occupational therapist could explain the normal development of adolescents and handling principles which may be employed to better deal with them and their concerns.
- It is suggested that mentoring should be made available with supportive role players such as life orientation educators and school counsellors to address issues of peer pressure and prevention of drugs at school. Decrease in drug use is found in schools where positive climate exists (Bryant & Zimmerman as cited in Stevens & Smith, 2009). These are environments in which learners feel rewarded for achievements, they feel respected and they are given a platform to exercise opinions or thoughts surrounding school matters. In this way a drug-free school environment is encouraged.

- A number of government and private high schools engage in various festive days such as Valentine's Day, Arbour Day, Casual Day, Sports Day etc. Education and prevention sessions should be endorsed at these events where counsellors from the drug rehabilitation centres may be invited for talks on drug prevention. At this juncture the rehabilitation workers may inform schools and learners about anti-drug media programmes or campaigns.
- The drug treatment workers could inform the school mentors and educators about resources such as positive recreational programmes (craft lessons, helping with soup kitchens, clothing drives, karate classes, swimming lessons etc.) in the community or family organisations which may assist high risk adolescents (individuals with major domestic concerns), before drug addiction becomes a problem.
- Due to the disturbing increase of drug use among school learners, and the fact that experimentation of drugs occur on school premises or at school events, it is suggested that random mandatory drug testing should be authorized at schools by qualified auxiliary staff. Parents/guardians and learners alike should be informed in advance, and the opportunity for consent should be made available as part of school regulation.



#### **6.4 Recommendations for community-based education and prevention**

- Improve community collaboration with law enforcement on drug issues at police forum meetings. Use these meetings to educate community members on drug addiction and prevention, anti-drug campaigns, resources for addicts and support groups for parents.
- It is suggested that community leaders and members, by means of letters, telephone calls, assemblies, and arranged rallies stress and pressurise the South African Defence Force to be stricter at patrolling the border so that drug cartels are prevented from entering the country, and the drug supply is reduced.

- Abolishing and closing down of drug dealers and their places of trade are key in reducing availability and removing accessibility of drugs, and although toll-free numbers exist in which anonymous crime or drug tip-offs may be given by the public, it is suggested that a positive reward system be instituted by law enforcement officers for persons giving information leading to drug dealers.
- Since many high school learners frequent the community libraries for use of internet or for information gathering, it is suggested that libraries include the youth in designing and producing drug prevention phrases for bumper stickers and/or posters. This may serve as a reminder for themselves to abstain from drug experimenting, it may encourage a skill with regard to art, advertising or language, and it may enable them to be active in the fight against drug addiction among youth.

#### **6.5 Recommendations for occupational therapy practice and future research**

- The findings of the current study has supported and reiterated the breakdown that drug addiction has on the occupational performance of an individual. For this reason it is necessary and suggested that an occupation-based model be implemented at rehabilitation centres. A monitoring system, such as feedback questionnaires (relating to problems encountered, satisfaction of the intervention, whether the model has assisted, which aspects were helpful etc.), should be in place to ensure that the quality of intervention is carried out and to evaluate its outcomes with regard to meeting the needs of the service recipients.
- There is a need to test which model of addiction treatment is best suited in South Africa for adolescents. It is suggested that one treatment model be compared with another through randomised trials.
- Since many participants had mixed views regarding which type of treatment is appropriate for their child, further research should explore which type of treatment (i.e. in-patient versus out-patient) may yield better outcomes and retention rates for adolescents in the Western Cape, specifically with regard to the client's stage of addiction and the care needed (primary, secondary, tertiary).

- Given that the current study, according to researcher's knowledge, was the first qualitative research carried among adolescents and drug addiction treatment, research should be done on a larger group of adolescents, in areas outside of the Cape Town Metropole. This would not only confirm and affirm the current findings but may report on constructions to further understand the phenomenon.
- A future research area that may be explored is how the needs of recovering drug addicted adolescents interface, link and compare to the occupational needs of other adolescents in general.

### **6.6 Recommendations for occupational therapy departments**

- It is suggested that occupational therapists themselves examine and understand the role that they may play in substance use treatment within the multidisciplinary team.
- As many of the allied health workers were not knowledgeable about the role of occupational therapy in addiction treatment, occupational therapists should relay their significant function to the remainder of the team. This will ensure that the appropriate referral pathway is instituted.
- It is suggested that modules and courses focusing on substance use disorders be included as part of the occupational therapy (and social work, psychology) undergraduate programme. Students should be placed within these rehabilitation settings so that they may have the opportunity to evaluate whether this field of psychiatry and mental health is one of particular interest and attraction to them.
- Occupational therapy departments, in practice and in education, should continue to make use of platforms such as OT awareness week for example, to educate and promote occupational therapy as a profession. Students, allied health professionals and the general public in hospitals, clinics or treatment centres have the opportunity to pose questions and occupational therapists should be able to address misconceptions.



## **6.7 A future with occupational therapy**

Adolescents go through distinctive developmental stages therefore their substance abuse patterns and factors influencing their use may differ from that of adults. By accepting adolescents as individuals without telling them what to do as they are accustomed to from educators, parents and other authority figures, drug rehabilitation workers, who are equipped to deal with adolescent clients, are able to connect more easily with a rebellious adolescent and foster an atmosphere of self-directed change (Tevyaw & Monti, 2004). Additionally, by making use of evidence-based addiction frameworks and occupation-based models, substance abuse intervention for adolescents can be effective in achieving many important behavioural, psychological and occupational improvements.

This study did not compare which of the four rehabilitation centres were the best; neither did it explore the effectiveness of the types of treatment models. However, no specific mention of efficacy or higher worth was directed to a particular treatment modality or approach, by the participants. Rather, the current research study underlined how and which components necessitated meeting the occupational needs of recovering drug addicted adolescents so that a successful rehabilitation programme is offered. The service should address comprehensive needs such as influences of the school environment, psychological, recreational, vocational, medical, family, and legal concerns. The service should include experienced counsellors who are genuinely empathetic, possess intelligent and flexible thinking, and portray good interpersonal skills.

As far as the researcher's knowledge no articles were found, or qualitative studies were done in South Africa relating to adolescent drug treatment and the role of occupational therapy. The Model of Human Occupation as an assessment tool with guiding checklists, scales and theory on occupational identity, occupational choice and occupational imbalance, within a developmental framework, is different from any other addiction model. Whilst addiction models hold enormous relevance, by complimenting them with occupation-based models, it is astounding what occupational therapy service may bring to addiction intervention.

Occupational therapists are uniquely concerned with occupational performance and function; therefore they present a distinctive solution and purpose in amending the dysfunction caused by drug addiction. By no means is it being promoted that occupational therapy may exist on its own in drug treatment. The complex needs of adolescents, as expressed by them in this current study and documented by earlier authors, require a multidisciplinary approach.

It is unrealistic and unreasonable to expect that changes should occur overnight however, priority should be given to two or three specific strategies or recommendations at a time. Through collective efforts adolescent rehabilitation programmes should be made available, accessible, attractive and esteemed. Recognising that advances have been made particularly over the last few years, there is a need to show real commitment from rehabilitation centres to implement strategies. And although, this was in part achieved in the establishment of the Western Cape Youth Rehabilitation Centre in 2010, the urgency of implementing youth-centred programmes in treatment for example, or rapidly decreasing drug cartels entering the country, is far too slow.

An approach to intervention where involved parents, educators and rehabilitation workers are supported in their efforts and not condemned for failures would positively influence the individual's participation in rehabilitation, the community and the person's engagement in the occupations necessary for role functioning, health and quality of life. As a result, young people would then be encouraged to make healthy occupational choices as they experience major challenges in their environments and transition into adulthood.

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## **Appendix A: Interview Guide Plan**

### *Recovering Drug Addicted Adolescents*

- How has drug addiction affected your life with regard to school, family, or work?
- Talk about drug relapse?
  - Probe: What is your understanding of it?
  - What were your reasons for relapsing?
- Are there any barriers or difficulties that you experienced during the rehabilitation programme?
  - Probe: Barriers related to the rehabilitation facility
  - Barriers related to their socio economic circumstances e.g. community and school
- Do you think the rehabilitation programme prevents you from relapsing?
- Are there any factors at the rehabilitation centre that you feel could cause you to relapse?
- In which way/s would you say you benefitted from drug rehabilitation programmes?
  - Probe: What activities help you overcome some of the challenges you face daily?
  - Explain to me how has the drug programme assisted you to re-adapt to your role as a student/worker/family member?
- What would you describe a supportive environment to be?
  - Probe: Do you think it would matter in recovery and how so?
- From your own experience, can you describe what you feel a recovering drug addict needs from his/her family, community, the rehabilitation programme etc. to remain sober?
  - Probe: What do you consider a priority for rehabilitation workers/professionals to know or understand about drug addicts and treatment/rehab?
- Did the rehabilitation programme have the things you felt you needed?

### *Drug Rehabilitation Workers*

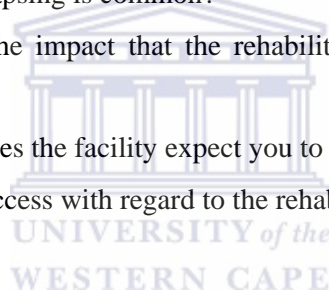
- From your experience what would you say are the needs of recovering adolescents? Are these needs addressed and how?
- Describe how you would identify whether an addict was benefitting from treatment or not?
- How involved are adolescents in their treatment programme? To what extent do they get to choose what to do?
- Being directly involved with adolescents, explain how you perceive drug relapse? Do you feel there is a way of preventing it?

- Describe the aftercare programme? What is the response like in these programmes from the attendees?
- How does the facility address integration of recovering addicts into their community or family life
- With your experience explain how you think treatment or intervention has changed regarding drug addicted adolescents compared to other aged addicts?

## **Focus Group Guide**

### *Parents of Recovering Addicts*

- Being a parent of an adolescent in treatment what are some of the challenges you face?
- Describe what are some of the challenges you feel your child faces?
- Explain to me what you believe are the reasons for drug relapse?
  - Probe: Do you think relapsing is common?
- How would you describe the impact that the rehabilitation programme is having on your child?
  - Probe: How involved does the facility expect you to be?
- How would you describe success with regard to the rehabilitation programme?



**Appendix B: Consent Form**

Title of Research: *Meeting the Occupational Needs of Recovering Drug Addicted Adolescents*

The study has been described to me by means of the Information Sheet, in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's Name: ..... Participant's Signature: .....

Witness: .....

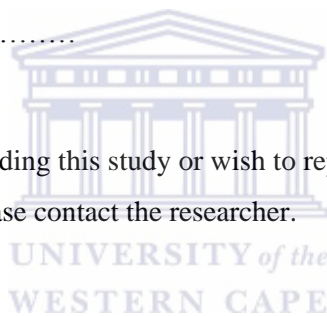
Date: .....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher.

Researcher: Miss Insauf Parker

Cell: 0793144700

Email: fairytale@webmail.co.za



**Appendix C: Consent Form-Focus Group Member**

*Title of Research: Meeting the Occupational Needs of Recovering Drug Addicted Adolescents*

**SECTION A**

The study has been described to me by means of the Information Sheet, in a language that I understand. I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study at any time during the research process and this will not negatively affect me at all.

Participant's Name: ..... Participant's Signature: .....

Witness: .....

Date: .....



**SECTION B**

In agreeing to be part of the focus group discussion, I understand that I need to respect the privacy of the other participants by not revealing the information that has been discussed in the group session/s. In addition, I will not record or document any personal, identifying information of other group members nor speculate about their identity. In so doing, I shall maintain confidentiality of their identity and the information discussed.

Participant's Signature: .....

Date: .....

Signed at: .....

**SECTION C**

To ensure that the information is obtained without omitting vital information, the sessions will be audio-taped. These tapes/recordings will be kept in a secure place where only the researcher and the researcher's supervisor will be aware of its location and will have access to its information.

**I agree** to be audio-taped during my participation in the study.

Participant's Signature: .....

Date: .....

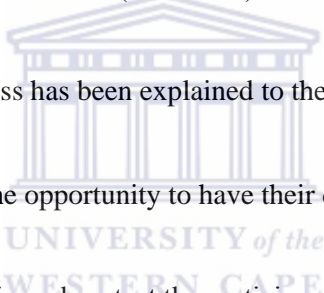
**I do not** agree to be audio-taped during my participation in the study.

Participant's Signature: .....

Date: .....

**SECTION D**

Declaration by Researcher: I ..... (first name) declare that:

- 
- The research study and process has been explained to the participants verbally and via an information sheet.
  - Each participant was given the opportunity to have their questions answered prior to partaking in the study.
  - As a researcher I will maintain and protect the participants' rights to privacy, in identity and in the information obtained.
  - The research study is for academic purposes and not for any personal gain.

Researcher Signature: .....

Date: .....

Signed at: .....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher.

Researcher: Miss Insauf Parker

Cell: 0793144700

Email: fairytale@webmail.co.za

Should you have any questions regarding your rights as a research participant, you may also contact:

Supervisor: Dr. Shaheed Soeker (Lecturer)  
Occupational Therapy Department  
Tel: 021 959 9339  
Fax: 021 959 1259  
Email: [msoeker@uwc.ac.za](mailto:msoeker@uwc.ac.za)



#### Appendix D: Profile of Participants (Table 4)

Key :

m-	male	L-	Learner at school	I-	Indian	OPF-	Out-patient facility	A-	Adolescent
f-	female	CS-	College student	W-	White	IPF-	In-patient facility	RW-	Rehabilitation Worker
E-	Employed	S-	Suspended from school	C-	Coloured	AR-	Age range	FGM-	Focus Group Member
U-	Unemployed	AB-	Absconded from school	AF-	African				

Participants	Gender	Age	Race	Occupation	Previous treatment	Current treatment
Chris	m	16	C	L (grade 10)	OPF	OPF
Kate	f	19	C	CS (2 <sup>nd</sup> year) + AB	OPF, IPF	OPF
Matthew	m	15	C	L (grade 10) + S	OPF	OPF
Tom	m	16	C	L + AB	IPF	IPF
Charlie	m	19	C	AB + U	IPF, OPF	OPF
Taara	f	16	C	L (grade 9)	OPF	OPF
Zack	m	19	W	U	IPF	IPF
Dylan	m	16	W	L (grade 9) + S	OPF	OPF
RW-Ben	m	AR 25-30	I	E + CS		
RW-Elize	f	AR 25-30	C	E		
FGM at 1st rehabilitation centre	7×m 14×f	AR 35-55	2×W 2×I 17×C	Not known		
FGM at 2nd rehabilitation centre	5×f	AR 35-45	1×W 1×AF 3×C	5×E		



## **Appendix E: Information Sheet**

*Title of Research: Meeting the Occupational Needs of Recovering Drug Addicted Adolescents*

*What is this study about?*

The use and abuse of drugs in the Cape Town Metropole has caused a great concern amongst Health professionals and researchers in the country especially since the increase has been amongst adolescence rather than older people. This resulted in the establishment of drug rehabilitation and treatment centres but despite this, relapse rates have been significantly high. The question was then raised as to whether these high relapse rates may be as a result of addicts needs not being met. But how does one best understand this without consulting them directly. The study therefore wishes to explore and describe whether rehabilitation programmes are meeting the occupational needs of recovering addicted adolescents. Their experiences, perspectives and opinions will present great insight into providing service quality and efficiency.

### **What will be asked if I agree to participate in this study?**

The proposed time frame for this study is 12 months. The researcher will invite 8 recovering drug addicted adolescents from 2 respective drug rehabilitation centres in the Cape Town area, 6 parents of recovering adolescents and 2 workers from either of the facilities to partake in this study. Two methods of data collection will be used for the purpose of obtaining their perspectives and experiences namely; focus groups for the parents and, individual in-depth interviews with each drug rehabilitation worker and each of the 8 adolescents. The participants will be informed verbally and in writing about the process they may be involved in during this research. They will also be asked to sign a consent form and will have the opportunity to ask questions prior to them giving consent.

### **What are the risks of this research?**

There are no known physical or psychological risks involved in this study but due to the nature of focus groups, interviews and the topic in question, a professional referral source will be made known to the participants if they at any time require counselling or guidance regarding personal matters that may be evoked during the research process.

### **What are the benefits of this research?**

The research study is intended to inform drug rehabilitation practice particularly amongst the youth. Moreover, there's an absence of information regarding recovering addicts who have been discharged and how they are integrating into society. This may be critical in understanding why relapse rates are so high. The study will therefore not help you personally but will inform practice to ensure that an effective rehabilitation process is being implemented.

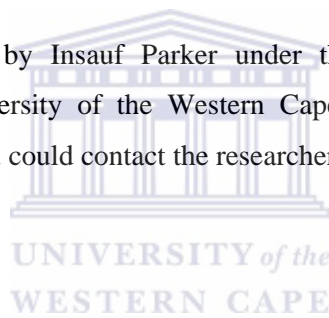
### **Do I have to be in this research and may I stop participating at any time?**

Participation in this research is voluntary. Once you've consented to partake you may withdraw your participation at any time during the process without penalty.

### **What if I have questions?**

The research is being conducted by Insauf Parker under the guidance of the Department of Occupational Therapy at the University of the Western Cape. If at any time you have queries regarding the nature of the study you could contact the researcher at the details given below:

Researcher: Miss Insauf Parker  
Email: [fairytale@webmail.co.za](mailto:fairytale@webmail.co.za)  
Cell: 0793144700



Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, you may also contact:

Supervisor: Dr. Shaheed Soeker (Lecturer)  
Occupational Therapy Department  
Tel: 021 959 9339  
Fax: 021 959 1259  
Email: [msoeker@uwc.ac.za](mailto:msoeker@uwc.ac.za)

## **INFORMASIE**

*Titel van die navorsingswerk: Die voldoening van benodighede van herstellende dwelm verslaafde jeugdiges*

### **Waaroor gaan hierdie studie?**

Die gebruik en misbruik van dwelms in die Kaapse Metropol het groot kommer tussen die gesondheids vakmanne en die navorsers in die land gewek, veral omdat die toename van gevalle meer tussen die jeugdiges voorkom as wat dit tussen die ouer mense voorkom. Dit het die stigting van rehabilitasie en behandeling sentrums veroorsaak. Ten spyte van die, is die terugvalsyfer geweldig hoog. Die vraag was toe geopper of die hoë terugvalsyfer nie dalk die gevolg is van die behoeftes van die verslaafdes nie aan voldoen word nie. Maar hoe kan 'n mens hierdie beste verstaan sonder om hulle direk te raadpleeg.

Die studie wil dus ondersoek instel en beskryf of die rehabilitasie programme wel die arbeids behoeftes van herstellende dwelm verslaafde jeugdiges bevredig. Hul ervarings, perspektiewe en opinies sal 'n geweldige insig oplewer tot die verskaffing van diens-gehalte en doeltreffendheid.

### **Wat sal aan my gevra word?**

Die voorgestelde tyd vir hierdie studie is 12 maande. Die navorser sal 8 herstellende dwelm verslaafde jeugdiges van 2 verskillende rehabilitasie sentrums in die Kaapstad se gebied, 6 ouers van herstellende jeugdiges, en 2 werkers van enigeen van die dwelm sentrums uitnooi om aan hierdie studie deel te neem.

Twee metodes van data insameling sal gebruik word met die doel om hulle perspektiewe en ervarings te verkry naamlik; fokus groepe vir die ouers en afsonderlike onderhoude met elk van die werkers van die dwelm-inrigtings en elk van die 8 jeugdiges te voer. Gedurende hierdie studie sal die deelnemers letterlik en skriftelik ingelig word oor die ontwikkeling van die navorsing waarin hulle betrokke is. Die deelnemers sal ook gevra word om 'n toestemmings vorm te teken. Hulle sal ook die geleentheid kry om vrae te stel voordat hulle hul toestemming gee.

### **Wat is die risiko's van hierdie ondersoek?**

Daar is geen fisiese of sielkundige risikos betrokke in hierdie studie nie maar as gevolg van die aard van die fokus groepe, die onderhoude en die onderwerp onder bespreking, sal die deelnemers na 'n

beroepspeleer verwys word as hulle ter enige tyd raadgeewing of leiding benodig, wat persoonlike sake betref, wat as gevolg van hierdie navorsing proses mag te voorskyn kom.

### **Wat is die voordele van hierdie ondersoek?**

Hierdie navorsingstudie is van plan om dwelm rehabilitasie praktyke veral onder die jeugdige wat in te lig. Daarenboven is daar 'n afwesigheid van inligting van herstellende verslaafdes wat ontslaan was en hoe hulle in die gemeenskap saamhang. Hierdie mag krities wees om te verstaan waarom die getalle wat terugval so hoog is. Die studie mag dus nie u persoonlik help nie, maar sal wel die praktyk inlig om te verseker dat 'n doeltreffende herstellings proses vervul word.

### **Moet ek in hierdie navorsing wees en mag ek ter enige tyd my deelname stop?**

Deelname in hierdie navorsing is vrywillig. Wanneer jy toestemming gegee het om deel te neem mag jy ter enige tyd terugtrek sonder om gestraf te word.

### **Wat as ek enige vrae het?**

Die navorsing word uitgedra deur Insauf Parker onder die toesig/leiding van die Departement van Arbeidsterapie te Universiteit van die Weskaap. As jy enige tyd vrae het in verband met die aard van die studie, kan jy met die navorser in aanraking kom by die besonderhede wat onder gegee is:

Navorser: Miss Insauf Parker

Email: fairytale@webmail.co.za

Tel: (021) 6922597

Cell: 0793144700

As jy enige probleme ondervind met betrekking tot die studie, jy mag ook die navorsing oorsieners kontakkeer:

Supervisor: Dr. Shaheed Soeker (Lecturer)  
Occupational Therapy Department  
Tel: 021 959 9339  
Fax: 021 959 1259  
Email: msoeker@uwc.ac.za