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Appendix 3: Project Skills Development

A substance abuse prevention programme for early adolescents in KwaZulu Natal

The following programme is a comprehensive school-based substance abuse prevention programme for children between the ages of 11 - 14 years old. Grounded in the development of personal and social skills, to address: (a) Interpersonal risk factors (i.e. adolescent attitudes towards substance use and peer influences); and (b) individual protective factors (i.e. communication skills and social problem-solving skills). And accordingly based on the underlying rationale that the strengthening of these skills will ultimately reduce the prevalence of substance abuse among these individuals as they become older.

The programme is primarily developed for social workers and largely based on the work of authors, such as Lindenfield (1990), Louw and Amorim (1999), MacDonald and Patterson (1991), Perkinson (1998), Sancho (1994) and Stoppard (2000).

The programme is not meant to be prescriptive; rather its purpose is to stimulate ideas and indeed can and should be adapted, abridged and expanded according to your needs.

The content of Project Skills Development is thus set out in terms of the next 10 consecutive sessions.

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Session 1 - 2

Adolescent attitudes to Drugs and Drug users

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Adolescent attitudes to Drugs and Drug users

1. Introduction

This section will look at what the participants, irrespective of their personal background and experiences will bring to the learning situation – their attitudes to drugs and drug users. According to MacDonald and Patterson (1991: 16) you do not need to be a drug user, know a drug user personally or work with drug users to have formed a set off attitudes. Saturation media coverage of "drug problems" over the past decade, for example, has ensured that most people will have quite firm ideas about drugs, drug users, and what should be done about the "drug problem", however biased, stereotyped or misinformed they may be.

The adolescent's attitude to substances and substance users is thus the starting point of this programme. Aspects that will be covered, include:

- The importance of examining adolescent attitudes,
- The origin of attitudes,
- The media as an attitude source, and
- Attitude exercises.

Table 1 provides the planned course for Sessions 1 and 2.

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Table 1: Adolescent attitudes to Drugs and Drug users

Session 1		Session 2	
09:00- 09:05 *(5 minutes)*	Introduction Exercise 1: "What I'd like to learn"	09:00 –09:05 *(5 minutes)*	Recap
09:05 –09:15 *(10 minutes)*	Why is it important to examine attitudes?	09:05 –09:35 *(30 minutes)*	The media Exercise 4: Perceptions of illegal drug users Exercise 5: Perceptions of drug users
09:15 – 10:00 *(45 minutes)*	Where do attitudes come from? Exercise 2: Origin of attitudes Exercise 3: Circle of harmfulness	09:35 –10:05 *(30 minutes)*	Exercise 6: Dependency exercise
		10:05 – 10:10 *(5 minutes)*	Feedback

Following the introductions, both to the programme and to the other participants, the following exercise is a method to focus participants' thinking.

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Exercise 1: "What I'd like to learn"

Ask participants, individually, to write down what they want to learn about the topic, i.e. attitudes to drugs and drug users.

Then participants brainstorm their answers. All the answers are written on a blackboard or flipchart, and referred back to during the two sessions on attitudes.

2. Why is it important to examine attitudes?

There are several reasons why it is important to include adolescent's attitudes towards drugs and drug users in the prevention programme, particularly at the beginning:

- It is a good way for participants to become actively involved in the learning process from the onset. It enables them to look at their own attitudes and beliefs before the social worker introduces ideas and examples that may contradict, challenge or criticise those attitudes and beliefs.
- It is a good way of testing participant's factual knowledge.
- It enables the social worker to gauge the standard of drug-related knowledge of the group she is working with.
- It can normalise ideas of "sick", "deviant" or " criminal" behaviour. Suffice it to say here, that adherence to the narrow view that addiction is something that relates to illicit drugs only has permitted us to maintain the myth that addicts are different. Only "they" – an alien, deviant, shiftless, nasty and rather

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dangerous group – use addictive drugs like heroin, and addiction is someone else's problem.

The attitude exercise on dependency (Session 2) specifically looks at commonalities, shared between (a) underlying processes and dynamics, and (b) the drug user and other people. By breaking down barriers between them and us, the social worker demystify and encourage participants understanding of substance users.

3. Where do attitudes come from?

Based on sets of beliefs, including stereotypes that people have about drugs and drug users, attitudes are about feelings and are relatively stable and resistant to change. This means that this part of the session might be quite challenging to participants who have personal investments in maintaining and defending their "own" attitudes.

Exercise 2: Origin of Attitudes

To determine where the participants' information and attitudes about drugs come from, the social worker will:

- Ask participants to pick a substance they have chosen or decided not to use; and
- Ask them what information led them to make that decision and from where that information came.

Keep the three components of attitudes in mind:

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- Attitudes are descriptive, e.g. "Drug users look dirty, have long hair and wear earrings."
- Attitudes are evaluative, e.g. "Drug users are sick/bad people." and
- Attitudes are prescriptive, e.g. "Drug users should be given long prison sentences."

People's attitudes, are thus constructed around a complex set of beliefs and values, acquired from early childhood onwards. Subsequently they are part of the way that adolescents experience and react to their world. Yet, when discussing the sources of a participant's attitudes, the social worker needs to (and can) question reliability and validity by exploring underlying facts/theories/ideas.

There are four specific sources of attitudes:

- The mass media and other public information systems,
- The education system,
- Personal contacts like friends, neighbours or relatives, and
- Personal (acquired) experience.

3.1 Exercise 3: Circle of harmfulness

The following exercise will give the participants a chance to explore the origins of their own attitudes to several drugs, both legal and illegal. Do they base their ideas on media information, personal experience or drug taking, or talks with friends and family? It also tests participants' factual knowledge about drugs and their effects and what is meant by the notion, "harmful" drug.

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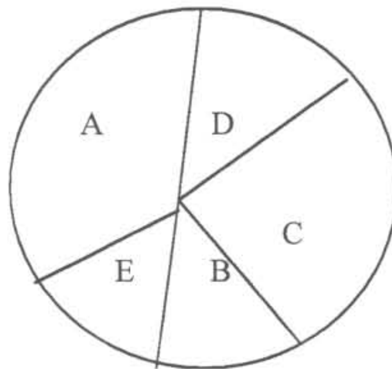
Circle of harmfulness

Each participant has to segment off the large circle as to their perception of the relative harmfulness of each substance listed on the right-hand side. The small circle is an example.

Ten minutes is the optimum time for completion of the exercise although some participants may take longer/shorter time.

Figure 1: Pie chart: "The circle of harmfulness"

A	=	Stick your finger in an electric socket
B	=	Watch TV until two in the morning
C	=	Windsurf if you can hardly swim
D	=	Ride your bike without a helmet
E	=	Over-indulge in sweets and cake



Using the substances beneath, segment the big circle to illustrate your opinion of their level of harmfulness. (The small circle is an example.)

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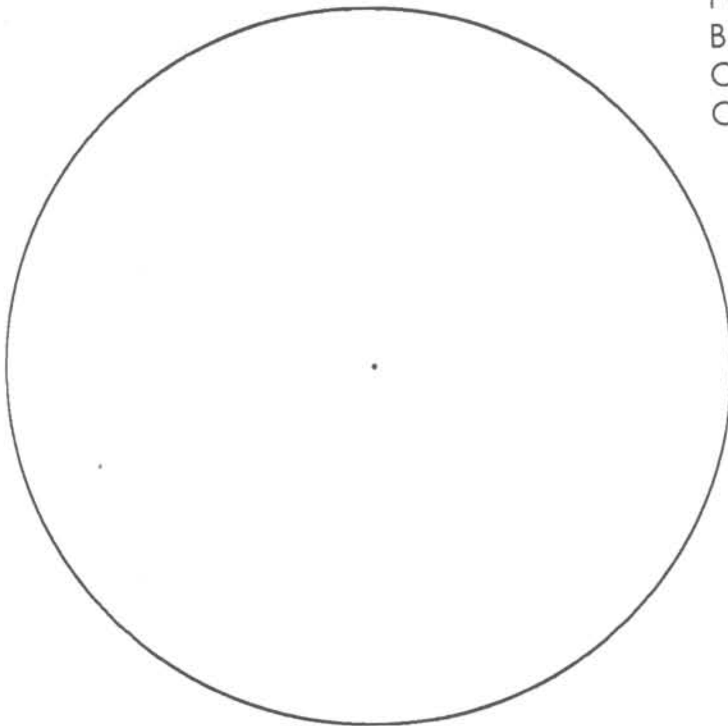

Paracetamol (pain pill)
Beer / Wine
Cigarettes
Cannabis (dagga)

Participants, either in pairs or small groups, will then compare and discuss their segments, and the ideas and attitudes on which the segments are based. The following questions will be discussed:

- Do these ideas/attitudes come from the media, personal experience or that of a close friend or relative, talks with other people, or other sources?
- What are the consequences of holding these ideas/attitudes?
- What do people mean by "harm?" Is it based on medical, moral, legal or social criteria? Is it harm to the individual, the family, the community or society in general?

Hereafter participants return to the plenary for feedback from each pair or small group. Feedback is discussed, then written on a flipchart

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by the social worker, pinned to the wall, and can be referred to throughout the programme.

4. The media as attitude source

There are several key issues and questions to explore, for example, around the ways that the media presents and portrays illegal drugs and drug users which in turn informs and help to shape people's opinions and attitudes.

The following issues and questions are thus identified for discussion in small groups within the framework of Figure 2 (page 426). As Figure 2 illustrates several conflicting and overlapping ways of perceiving illegal drug users and therefore the "type" of problem we are dealing with. The issues and questions are:

(i) Does the mass media help to create a "moral panic"?

- By presenting a particular case as universal, e.g. reporting that a 13-year-old has died following injecting drugs; implying that all teenagers who are injecting drugs and are at risk are also likely to die?
- By presenting misinformation as the truth, e.g. that experimentation with a drug like cocaine automatically leads to addiction.

(ii) Does the media over-emphasis and exaggerate the dangers of illegal drugs to the exclusion of the danger of alcohol, nicotine, over-the-counter and prescription drugs? As Stoppard (2000: 11) points out:

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" It is truly a paradox that the greatest drug problems of any society invariably relate to those substances which are most widely accepted and used. In South Africa, approximately 7 million adults are smokers. An estimated 11,000 – 15,000 deaths are attributable to alcohol (including the innocent victims of road traffic accidents that are caused by drunk-driving), whereas 500 - 600 deaths a year are attributable to the misuse of all types of illegal drugs."

(iii) What is the effect of describing drug problems in war-like terms, e.g. " the war on drugs"; society's fight against the drug pusher"? How far does this promote and support a prohibitionist and law-enforcement stance as the solution to the drug problem, and therefore the area in which resources should be concentrated?

"There is little doubt that the perception that the war on drugs is a failure has spread significantly. It also appears that people are beginning to understand that a war on drugs necessarily breeds violence and corruption" (MacDonald & Patterson, 1991: 20).

(iv) What is the effect of describing drug problems in terms of medical imagery, e.g. " drug abuse is an epidemic"; "drug addiction is a disease?

As Gossop (in MacDonald & Patterson, 1991: 21) suggests: "In some respects this view of addiction as a sickness may even be positively harmful. In so far as it

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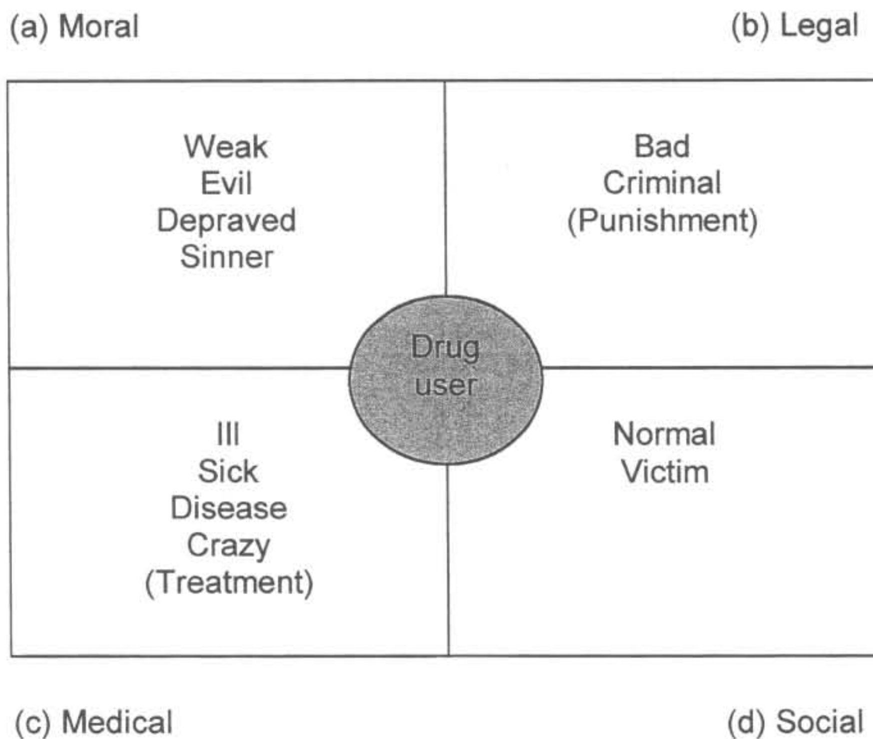
perpetuates the myth that the drug addict is a passive and helpless victim of his addiction it contradicts any expectations that the addict can, through his own efforts, learn to live without drugs."

Issues and questions discussed using Figure 2 as outline.

Figure 2: Perceptions of illegal drug users



There is a story from India that further illustrates Figure 2.

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Four blind men were confronted with an elephant. Being blind, they obviously did not know what this object was. The first blind man approached the elephant, touched its side, and said, "This is the wall of a house." The second blind man approached, touched the elephant's leg and said, "No it's not, it is a large tree." At that, the third blind man went up to the elephant touched its truck, sprang back and exclaimed, "It's a big snake!" The fourth blind man approached and touched the elephant's tail and said, " You are all wrong, it's simply a length of rope." What they all did, of course, was to mistake part of the elephant for the whole elephant.

Similarly, with the drug problem, it is all too easy to mistake part of the problem for the whole problem.

At this stage, go over the diagram (Figure 2, page 426) on a black board or flipchart and explain what each category means, pointing out the contradictions and complexities.

(a) <u>Moral</u>

Here the drug user is seen as, basically a "weak" person who may even be acting in a "depraved" or "evil" manner, especially if they are selling drugs. This latter view is one quite often favoured by the tabloid press and may engender feelings of shock, anger or moral outrage. The social worker should check with the participants what their feelings are towards any

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particular type of drug user, pointing out that it is often not the drug itself that causes this response but the lifestyle of the user or method by which the drug is taken, particularly intravenous use.

Exercise 4: Perceptions of illegal drug users

To illustrate this point more clearly, the participants are asked to close their eyes and imagine a world where the only way to take heroin is to drink it and the only way to take alcohol is to inject it. Which do you think would be seen as the more serious drug problem?

(b) Legal

Here the drug user is perceived as a "bad" or "wicked" person engaged in rational criminal activity, involved with dangerous commodities – drugs. Such a person is, by definition, a criminal who is responsible for their own actions and who may engender fear, mistrust and other such uncomfortable feelings. Punishment, as opposed to treatment, is seen as the solution for dealing with this type of problem.

(c) Medical

Here the drug user is seen as someone who is "sick" or "ill" (physically and/or mentally) who has a disease, and therefore needs medical treatment. People may feel familiar and more comfortable with this approach because historically there has

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been a dominance of the medical profession in the treatment and rehabilitation of "drug addicts". However, it has its own problems, e.g. how does the "sick" model reconcile itself with the "criminal" model? If someone has a disease or is sick, how far can they be held criminally accountable and responsible for their own behaviour? Also, as Bakalaar and Grinspoon point out (in MacDonald & Patterson, 1991: 23): "It becomes part of the definition of this illness that the patients may have no right to decide whether they want treatment for it... the treatment need not even be for the drug user's own good if drug abuse is regarded as an epidemic".

(d) Social and political

Here there are several perceptions of the drug user, e.g. as a "normal" person who has developed a strategy, albeit an illegal and potentially dangerous one, for coping with the strains and pressures of everyday life: as a "victim" of a particular social environment, for example, someone who lives in a situation characterised by high social, economic or emotional deprivation. There is also the notion of the "normalisation" of drug taking as an enjoyable recreational human activity within certain social groups.

Adolescents holding these or similar, views may be less judgemental and prejudiced towards drug users and consequently be more at risk for experimentation with substances of abuse.

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Exercise 5: Perceptions of drug users

After explaining the diagram (see Figure 2) in plenary session the social worker will ask participants which of the perceptions they most agree with and why.

4. Final attitude exercise

4.1 Exercise 6: Dependency – Self-completion questionnaire

This exercise will enable participants to understand the concept of "dependence" (as well as others such as "withdrawal" and "tolerance") by evaluating their own dependent behaviour.

The social worker introduces this exercise by suggesting that in order to understand the reasons behind drug users' use and dependency on substances we first need to understand our own dependency on substances, things, activities or people. For example a specific TV programme, jogging, chocolate, frequent cups of coffee or the first cigarette of the day.

The individual participants have 10 minutes to fill in the following sheet, and then put into pairs or threes for 10 minutes to compare notes.

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Dependency exercise: Self-completion questionnaire

Think about one or two things, which you use, or have used, on a regular basis and on which you think you, are dependent. (These can be legal, illegal or prescribed substances, objects, people or activities. In fact, anything you would miss if it no longer existed tomorrow.) Then answer these questions:

1. List your dependency/dependencies.
2. Why do you think you are dependent upon these things? In fact why do you need them, what do they do for you?
3. If you had to give up your dependency tomorrow, how do you think you would feel? Would it be easy of difficult? Would you have withdrawal symptoms?

On a flipchart or blackboard, the social worker will then list the answers to questions 2 and 3 separately, asking for brief responses from each pair/three. Out of this should come material, which can be related to the reasons why people use and are dependent upon illegal drugs and the problems they face in giving up drugs.

For the second part of the exercise, question two, the social worker will have available her own list of why people use illegal drugs. The following list represents a compilation of reasons given by drug users themselves. This can act as a comparison to the material produced by the exercise, as it is likely that there will be many similarities.

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Table 2: List of reasons why people use illegal drugs

Good reasons why I take drugs	
My friends do it	Status
It is exciting/fun	Pleasure
Tastes good	Raises self-esteem
Smells good	Risky
Feels good	Acceptable
Makes me high (life and soul of the party)	Gives me a feeling of well-being
Relieves boredom	Spiritual
Relieves pain	It's like a career when you're unemployed
Alters my perceptions of reality	Instant gratification
Cost-effective	Sociable
"Up yours!"	Gives me confidence/ makes me feel brave
It'll never happen to me	Spiritual

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Question three can be dealt with in the same way, but if you are looking for similarities it will tend to be from the point of view of the emotional and psychological withdrawals people experience, e.g. anxiety, unhappiness, pain, loss, etc.

5. Final comment

Although attitudes may not be an accurate indicator of actual behaviour, holding particular attitudes will have real consequences in the practical world. Sessions one and two thus enable and encourage participants to explore, assess and evaluate their attitudes to substances and substance users, whilst providing the social worker and participants themselves, with a clearer idea of their current level of knowledge. Invaluable information for the social worker's move to the next stage of the learning process about substances, i.e. drugs and their effects.

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Session 3 - 4

Understanding Drugs and their Effects

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Understanding Drugs and their Effects

1. Introduction

Drugs and their effects are positioned as the third and fourth sessions of Project Skills Development, as drug knowledge is approached as an integral part of (a) shaping the participants attitudes to drugs and drug users, and (b) the development of personal and social skills within which to apply that knowledge.

In addition, however, the researcher concurs with Dielman (1995: 125) who indicates, "Changes in attitudes or knowledge do not correlate with subsequent behavioural changes." Yet, the underlying premises is not to establish negative attitudes concerning substance use/abuse, or similarly, pair such behaviour with fear arousal, but rather to empower, i.e. increase participants' personal and interpersonal power, by (a) shaping attitudes, (b) enhancing substance specific knowledge, and (c) improving their skills to prevent the adoption of substance abuse.

The aim of this session is thus to inform and educate participants on "Drugs and their effects" by offering them a basic grounding in the topic.

Aspects that will be covered, include:

- What I need to know about drugs and their effects,
- What are drugs?
- Types of drugs,
- Drugs and their effects,
- What affects the effect,
- Costs and benefits of drugs, and
- Will you or won't you take drugs?

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The following Table provides the planned course for Sessions three and four.

Table 3: Drugs and their effects

Session 3		Session 4	
09:00- 09:10 *(10 minutes)*	Introduction Exercise 1: "What I need to know about drugs and their effects"	09:00 –09:05 *(5 minutes)*	Recap
09:10 –09:30 *(20 minutes)*	What are drugs? Exercise 2: "What are drugs?" Exercise 3: Key questions on drugs	09:05 –09:15 *(10 minutes)*	What affects the effect
09:30 – 09:50 *(20 minutes)*	Types of drugs Exercise 4: The windows of four squares	09:15 – 09:55 *(40 minutes)*	The costs and benefits of drugs Exercise 5: Costs and benefits of drugs
09:50 –10:10 *20minutes)*	Drugs and their effects Transparency presentation	09:55 – 10:05 *(10 minutes)*	Will you or won't you take drugs?
		10:05 – 10:10 *(5 minutes)*	Feedback

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2. What I need to know about drugs and their effects

The first step to take is to attempt to discover what it is participants need to know, or think they need to know about drugs and their effects.

Exercise 1: "What I need to know about drugs and their effects"

The participants should brainstorm the question, "What I need to know about drugs and their effects" for 5 – 10 minutes. All the answers are written on a blackboard or flipchart, and referred back to during the session to ensure these needs are met.

This exercise is used to develop the flow of the session in line with the participants' identified needs. This is also a useful way of gaining information which can be returned to at the end of the session to establish whether people wanted to learn what has been covered and, if not, what more needs to be done.

3. What are drugs?

Drugs are not new. Man has been experimenting with them for thousands of years for escapism and fun as well as for healing purposes, spiritual enlightenment and ritualistic ceremonies. People today are looking for exactly the same form of escape, but now there is a '90s twist with new refinements of time-honoured, mind-altering chemicals. Nowadays when most people use the word "drug," they are thinking of illegal substances like cannabis, cocaine, crack or acid. Some use the word "poisons" to describe illegal drugs in order to

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demonise them, but then alcohol, aspirin and nicotine are poisons too. Even water "poisons" the body when drunk to excess.

Exercise 2: "What are drugs?"

Participants are asked to individually formulate a definition for the term "drug(s)," by describing it in written form on a piece of paper. They are then asked to brainstorm their answers in small groups, and agree on one definition per small group, which is written up on a flipchart/blackboard. The small group definitions are then compared with the social worker's definition. A mutually acceptable definition will finally be formulated and can be referred to throughout the programme.

The social worker has available her own list of definitions for drugs. The following list represents a compilation of three descriptions of the term "drugs" that will act as comparison to the material produced by the participants.

Table 4: Drug definitions

Drug definitions	
1.	Substances used in medicine or as a stimulant or narcotic (Stoppard, 2000:10).
2.	All chemical substances that have biological and psychological/neurological effects on human beings. The term, is therefore used for licit substances (e.g.

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Drug definitions	
	alcohol, nicotine, aspirin, cough mixtures, appetite suppressants, sedatives, tranquillisers) and illicit substances (e.g. cannabis, cocaine, heroin, LSD.) (Compare World drug Report, 1997:10; Rocha-Silva, 1998:1.)
3.	A dependence producing substance, i.e. a substance that: • readily enter the brain and spinal cord, i.e. the central nervous system (CNS), • act upon the central nervous system to cause alterations in mood and/or level of consciousness and/or perceptions. The so-called uppers tend to cause stimulation, alertness, self-confidence, appetite suppression and euphoria. Conversely, the so-called downers tend to cause sedation, reduced anxiety, flattening of emotions, drowsiness and withdrawal from the surroundings. Hallucinogens may possess stimulant or sedative properties, but their chief effect is to markedly distort perceptions. The hallucinating individual therefore loses contact with reality by losing his sense of time and position, by seeing, hearing and feeling things which do not exist and by losing his ability to visualise his own body. • possess the ability, because of mood and mind-altering properties, to alleviate unpleasant feelings, induce pleasant feelings and consequently, to cause psychological dependence (Roper & Bartlett, 1994:5).

Next, participants have a chance to explore several key questions regarding drugs and thereby test their factual knowledge on this subject.

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Exercise 3: Key questions on drugs

Ask participants, in either pairs or small groups, to discuss the following questions:

(a) What do people mean by legal drug use?
(b) How did drugs become street drugs?
(c) How long have drugs been around?
(d) Why do people take drugs?
(e) What is the problem with drug use?

Hereafter participants return to the plenary for feedback from each pair or small group. Feedback is discussed, then written on a flipchart by the social worker, pinned to the wall, and can be referred to throughout the programme.

It is important that the social worker will explain and point out:

(a) What is meant by legal drug use

- You do not have to use the so-called "street" drugs in order to be a drug user. Tea drinkers and smokers are drug users too. Alcohol, the caffeine in tea and coffee and the nicotine in cigarettes are all drugs – and they are legal substances.

- Drinking alcohol and smoking cigarettes cause far more deaths than the use of illegal drugs. In South Africa, approximately 7 million adults are smokers. The Department of Health is currently conducting research to establish how many smoking-related

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deaths occur annually. About 11,000 – 15,000 deaths are attributable to alcohol, whereas 500 – 600 deaths a year is attributable to the misuse of illegal drugs.

(b) How drugs became street drugs

- The traditional use of the word "drug" refers to substances taken for medicinal reasons. In fact, it was not until the 19th century that a distinction began to grow between "medical" and "recreational" drug use.

- Some medicines prescribed by doctors, for example, barbiturates and tranquillizers, are just as harmful and/or addictive as some of the illegal street drugs and indeed find their way into the streets. Various plants and household substances are also being tucked under the drugs umbrella if they are used in certain ways. A common wild fungus called the Liberty Cap (one of the "magic mushrooms") contains a chemical that causes hallucinations when eaten, and butane gas lighter refills and paint thinners give a quick, cheap, but dangerous buzz when sniffed.

- Most illegal street drugs started life in the laboratory as legitimate, respectable medicines; the medical profession developed them as possible remedies for various conditions:
    - Ecstasy started life as an appetite suppressant;
    - LSD (acid) was discovered by mistake by a Swiss chemist in 1943; and
    - It was hoped that heroin would prove to be a powerful non-addictive painkiller when it was discovered in 1874.

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(c) How long drugs have been around

- It's a safe bet that ancient man began to smoke plants as soon as he had discovered fire; and long before the invention of modern mind-altering chemicals like acid and ecstasy, he had certainly discovered some natural alternatives of his own. Historical evidence suggests that people have been using cannabis for 8000 years; it was used by many early civilizations as a medicine for anything from anxiety to digestive problems, even period pains. Ancient Sumerian texts (from the Middle East) hailed the opium poppy as a "joy plant" 6000 years ago. Herewith the chewing of coca leaves by natives of South America dates back to at least 2500 BC. Bolivians still use coca leaves as a remedy for altitude sickness. Finally, mescaline (from a Mexican cactus plant) and magic mushrooms – both of which can be hallucinogenic- were used thousands of years ago in an attempt to raise the consciousness and spark of some kind of cosmic "inner journey". Both substances are as central to mystical tribal rituals as ecstasy is to the rave experience.

(d) Why people take drugs

- Whether people are using fire, drums, chanting, flickering lights or music, their aims are the same – to escape feelings of isolation, and to feel a sense of unity with everything and everyone around them. The appeal of drugs has always been that they change the way people feel and how they perceive the world around them. People take drugs to:

  - Have fun and feel happy

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- Loosen up and be free of inhibitions
- Feel confident and good about themselves
- Be accepted by a group of friends
- Feel sociable and enjoy people more
- Forget ordinary life and relieve boredom
- Forget problems and escape from worries
- Enjoy music more
- Enjoy dancing more
- Stay up all night
- Experiment and feel the thrill
- Be rebellious
- Relax and chill out
- Reduce the effects of other drugs
- Speed up the effects of other drugs
- Ease "coming down," and
- Get some sleep

(e) What the problem is with drug use

- A substance that is sufficiently active to change your brain chemistry, so that your perception is altered and you see the world differently, is bound to have serious after-effects. Everyone knows about the hangover after drinking alcohol. Nevertheless, people who drink alcohol are prepared to go for the short-term thrill and suffer the longer-term after-effects – that is the trade off. Other drugs are no different; they all trade an immediate high for a downer some time later.

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4. Types of drugs

The different types of drugs will be handled with the aid of the following exercise.

Figure 3: The windows of four squares exercise

Exercise 4: The windows of four squares

Draw the following matrix on a blackboard or flipchart and ask participants to (a) brainstorm all the drugs they can think of, and (b) decide where they should be placed within the matrix

As participants are shouting out the names of various drugs, disagreement can occur as to where some drugs should go, e.g. "Should cigarettes be placed in the socially acceptable window?" or, "Are magic mushrooms illegal?"

This will move the social worker into looking at the breadth of the drugs that need to be considered:

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Socially acceptable	Over-the-counter
Alcohol, nicotine and caffeine which is included in tea, coffee, drinking chocolate and soft drinks	Solvents and gases, cough medicines, stomach preparations
Prescribed	**Illegal**
Barbiturates like tuinal, nembutal and seconal, tranquillisers like valium, ativan and librium, hypnosedatives like temazepam and painkillers like diconal	Heroin, amphetamines, LSD, ecstasy, cocaine, cannabis and magic mushrooms

Note. How far do you agree with this categorisation? For example, alcohol, while a legal drug, can also be illegal if consumed under age, and is bought over the counter.

5. Drugs and their effects

The social worker will start by showing a transparency, using an overhead projector, with the following statements about the four categories of drugs:

- Stimulants (such as amphetamine) quite literally speed up the body;
- Depressants (such as alcohol) slow the body down;

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- Hallucinogens/psychedelics (such as acid) alter the way people perceive the world around them; and
- Narcotics (such as heroin) induce a feeling of passive drowsiness.

These groups are chosen, because the drugs to be classified in each group all have the same overall effect on the central nervous system. Then, referring back to the participants' identified needs regarding drugs and their effects (see Session 3, Exercise 1 "What I need to know about drugs and their effects") and the participants verbalised need regarding certain other substances, information is provided on these drugs in terms of their (a) form, (b) mode of use, (c) effects, (d) withdrawal, and (e) dangers. (See Chapter 2, page 57.) It is also important to show participants what drugs look like. For this reason, the social worker will present examples of the different kinds of drugs, by means of transparencies, to the participants. (See Appendix 6, page 545.)

6. What affects the effect?

As well as knowing the names of drugs and what category they come under, it is important that participants are made aware of the following factors which affect the effect of any drug. The effect may be physical and/or psychological and, in some cases, may be affected by:

6.1 The method of use

- Inject – both intravenous (mainlining) and subcutaneous (under the skin) - e.g. amphetamine and /or heroin.
- Smoke, i.e. to smoke a cigarette or pipe (e.g. nicotine or cannabis)

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- Swallow, i.e. to take a substance orally (e.g. cannabis and prescribed drugs)
- Inhale – e.g. inhale solvents that are poured on to a piece of cloth or into a plastic bag
- Snort, i.e. sniffed up the nose (e.g. cocaine and amphetamine)
- Inhale, i.e. sniff from the bottle or a soaked cloth (e.g. of amyl nitrate, Poppers).

6.2 The purity of the drug

Street drugs such as heroin and amphetamines are normally "cut" or adulterated with other substances such as talcum powder or bleach, which lowers the purity of the drug, increases the profit to be made by drug dealers and increases health risks like abscesses and septicaemia.

Participants should recognise that drug users will not normally use a 100% pure drug, like heroin and that problems can arise, from either, the substances used to adulterate the drug, or in some cases, the sudden and rare appearance of a more pure drug for sale. Overdoses and possible death can occur from 100% pure heroin.

6.3 The mixture of drugs

It is normal for many drug users to mix the drugs they take without always being sure of the result. This polydrug use, as it is known, is particularly true of illegal drug use, is often chaotic, and usually based on what is available to be taken.

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6.4 Physical and psychological disposition

The effect of a drug can be affected by certain physical characteristics, for example, the weight, height and general health of a drug user. Increasingly, people with a suppressed immune system due to HIV infection are becoming less able to cope with the effects of drugs. Women are unable to use as much as men because of their lesser height and weight. The menstrual cycle also affects drug use and vice versa. A person's mood can affect the effect of a drug as can any predisposition towards mental illness.

6.5 Expectations and experience

Expectations of the effect of a drug may be based on the information already known about that drug, from friends, films or the written word. These expectations can influence initial use, both negatively and positively. This will be the first experience, which will then colour subsequent use of that drug, and so on.

6.6 Social setting and peer-group pressure

The feelings induced by using drugs in a warm, comfortable environment will necessarily be different from those resulting from drugs taken up an alley in the pouring rain. Peer-group pressure may dictate that everyone using the same drug, in the same place, at the same time should experience the same effects, e.g. groups of solvent users

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commonly report experiencing similar hallucinations, although this is known not to be true.

6.7 Tolerance/cross tolerance

The body can develop tolerance to a drug through repeated use, which leads to an increased amount of the drug being necessary to achieve the desired effect. This tolerance can also result in cross-tolerance with drugs, which have a similar effect on the central nervous system, e.g. alcohol.

6.8 Date of last use

If someone has not been taking their normal amount of any drug (due to, say, a period of imprisonment or other reason for abstinence) the body's level of tolerance is reduced. This can lead to overdose and possible death if what was their normal amount is suddenly used.

6.9 Knowledge of ritual

Part of the attraction of drug use often surrounds the rituals involved in the preparation of drugs and the method of use, e.g. preparing the cannabis, rolling the "joint" and passing it round offers to some a heightened social experience. Compare this to offering a packet of cigarettes around.

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7. The costs and benefits of drugs

At this stage, participants will be involved in more participatory exercises to bring together what they have already learned.

Exercise 5: Costs and benefits of drugs

In this exercise, participants will go into small groups of no more than nine people. Then subdivide each small group into three subgroups, and allocate each one of these three subgroups a specific drug, e.g. alcohol, heroin, cannabis or cocaine. Each participant is given a copy of the summary compiled by the researcher in Chapter 2 (page 59), and each subgroup is asked to read what is said in this about their allotted drug. When completed, ask each subgroup to explain to the rest of their small group the costs and benefits of this specific drug – 10 minutes for each drug, with adequate time left for discussion.

This exercise will encourage participants to assimilate knowledge through reading, and then allow them the opportunity to pass on their learning to others. Participants will gain more detailed knowledge about these drugs and are also given added confidence in their ability to teach others about drugs.

8. Will you or won't you take drugs?

At this stage, you may know exactly how you feel about drugs. You may have seen friends getting high and decided that next time you get the chance you're going to try drugs too. Alternatively, you may be someone who hates the idea of losing control, so much so, that you

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are determined never to take drugs – even if it makes you feel like an outsider at times. On the other hand, you may be in two minds: sitting on the fence and weighing up the good and bad points, and wondering which way to jump.

8.1 Be well informed

The best way to explore your feelings about drugs is to find out everything you can about them, and arm yourself with the facts. Talk to people you trust: your best friend, your parents or the adult you get on best with. Share your feelings with older brothers and sisters if you have any. Get advice from a teacher whose opinion you respect, or from a social worker attached to your school. Try talking to people who have tried drugs and are willing to give you an honest account of their experiences – that means the lows as well as the highs. Take your time weighing up all the information and remember it is okay to say "no" whatever your friends say or do. Remember you always have a choice.

8.2 What to think about

There are some important facts to consider when you are thinking about drugs:

- If caught with illegal drugs, you can go to prison.
- Taking drugs is a leap in the dark – you can have as many bad trips as good ones.
- Drugs mess with your mind and body – one bad trip can leave permanent damage.

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- You always have to come down, and the higher you go, the harder you fall.
- You can never be sure what is in a dose.
- You can become dependent or addicted to many drugs.
- If you are mentally unstable, drugs will make your condition worse; they can trigger mental illness.

8.3 Standing your ground

If you really don't want to do drugs:

- Make friends who do not take drugs. If your drug-taking friends try to make you feel like a freak because you will not join in, remember that there is plenty of other people who feel like you do.
- Avoid places where drugs are available.
- Focus on something positive that makes you feel good about yourself, such as your studies or your favourite sport.
- Look after your body – exercise boosts self-esteem and gives you a natural high.

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Session 5

Peer pressure

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Peer pressure

1. Introduction

At the very heart of every adolescent is the intense desire "to belong". Their social development is therefore characterised by an increasing interest in and involvement with the peer group. This increasing interaction with the peer group as well as with friends provide interpersonal contact beyond family relationships and plays an important role in psychosocial development. Not only does peer-group interaction contribute towards the satisfaction of the adolescent's emotional needs, but it also serves as an important source of information and opportunities for socialisation (Louw, Van Ede & Louw, 1998:449). The adolescents' peers are thus an important force to consider in skills training. For the purpose of this study, peer pressure has thus been identified as a risk factor for substance use/abuse.

The session's focus is on peer-group relationships with the aim to enhance participant's awareness and social skills within peer relations. Aspects that will be covered, include:

- Why it is important to include peer pressure in the programme,
- How peer pressure evolved,
- The importance of peer pressure for adolescents,
- How peer pressure can put you at risk for substance use/abuse, and
- How to cope with peer pressure.

The following Table provides the planned course for Session 5.

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Table 5: Peer pressure

Session 5	
09:00- 09:10 *(10 minutes)*	Introduction Exercise 1: Expectations
09:10 – 09:15 *(5 minutes)*	Why is it important to examine peer pressure?
09:15 –09:20 *(5 minutes)*	How peer pressure evolved
09:20 – 09:35 *(15 minutes)*	The importance of peer pressure for adolescents Exercise 2: Acceptance by peer group
09:35-09:50 *(15 minutes)*	How peer pressure can put you at risk for substance use/abuse Exercise 3: Peer pressure
09:50 – 10: 05 *(15 minutes)*	How to cope with peer pressure Exercise 4: Ways to say no to drugs
10: 05 – 10:10 *(5 minutes)*	Feedback

Start with the following exercise. It is a good "ice breaker" as it is non-threatening and enables everybody to participate and talk about the subject from the outset.

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Exercise 1: Expectations

Participants should brainstorm the following question for 5 –10 minutes. Write all the answers on a flipchart and ask the participants to keep a more detailed note of their own answer:

What do you expect to get out of this session on peer pressure? Imagine that you leave the session feeling good. What would you have learned and/or experienced to feel like that?

2. Why is it important to examine peer pressure?

There are several reasons why it is important to include peer pressure as part of the programme:

- Within the adolescent's personal environment, peers are regarded, next to family, as the most prominent interpersonal factor associated with adolescent risk and resiliency to substance use/abuse.
- It enables participants to examine personal relationships with their peers,
- It can begin to promote conventional behaviours and perceptions that substance use/abuse is unacceptable and unsupported by the dominant, non-drug-taking peer group
- It is a good way of making substance-using role models (e.g. close friends) less salient and substance-abstaining role models more salient.

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3. How peer pressure evolved

The roots of peer pressure evolved with birds. Birds learned that they were safer if they gathered in flocks. They could more easily warn others of danger if they stuck together. In a group, they were less likely to be singled out as prey. Birds learned how to stay together for safety. Because this worked so well, birds, over thousands of years, developed a feeling of wanting to be together. They developed social skills and began to make noises to keep together. Anyone who has heard a flock of geese fly over will testify to the active communication patterns of these birds. Communications became more complicated over the years. They developed a particular sound for relaxation, and a particular sound for danger. Birds developed the feeling of wanting to be together. These feelings are what we now call emotions.

High-order social activity continued to evolve in mammals. Baboons, for example, have very complicated social rituals. These animals groom each other to keep the troop together. The grooming serves to rid them of irritating insects and helps them to feel closer together. It is like a back scratch, and it says, if you scratch my back, I will scratch yours. These social rituals hold a group of animals together. If you go to the zoo, you will see animals rubbing and stroking each other. You will see mothers holding and licking their babies. The species thus becomes bonded together.

Acceptance is a very important feeling because an animal depends on acceptance by the group for survival. If the herd rejects them, they have a higher chance of being killed by predators. The animals are all safer if they are in a group

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As we move up the evolutionary scale, we finally get to human beings. Early people, as we know them, were social creatures. They gathered in groups or tribes for safety. The tribe could function better together. They could specialize and reap the benefits of another person's expertise. It was easier to hunt, fish and gather food if the tribe worked together. Some would do the hunting and some would make arrowheads. Each tribe member specialized in a particular function. It was very important for early people to be accepted by their tribe. If they were banished, they would have to fend for themselves. Being alone in the world would put an individual at great risk. Therefore, humans developed a desire, a wish, a need, to be liked, to be accepted. This was very important for survival.

4. The importance of peer pressure

Exercise 2: Acceptance by peer group

Give each participant a piece of flipchart paper to write down three reasons, why acceptance by their peer group is important to them. Then they divide into small groups of four or five. Each group elect a recorder who will take notes and feedback to the main group. The task is to negotiate the five most important reasons behind acceptance by their peers. Allow 5 minutes for this, and then each group gives feedback. Open discussion is encouraged to come to some consensus about this issue.

You are thus beginning to see why peer pressure is so important. Without the acceptance of the group, people feel more vulnerable to

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the world. Now you can see why we try so hard to get our friends to like us. We need our friends so we can feel safe.

It is very clear that being liked and being accepted by the group is important and good. It is important for all of us to learn the skills necessary to establish and maintain close interpersonal relationships. These skills keep the group together.

5. How peer pressure can put you at risk for substance use/ abuse

A few things about peer pressure can get you into trouble. Groups can get you to do things that you would not normally do. They might talk you into doing something that you do not want to do, things like stealing, drinking or even playing a practical joke on someone. If we always follow the group, we can be led into behaviour that we know is wrong.

Exercise 3: Peer pressure

Give each participant a piece of flipchart paper to list, at least five times; when they were talked into doing something they really did not want to do. After completion, participants hold their flipchart paper in front of them for others to read (or alternatively make a hole in the top of the paper and pull it over their heads) and walk around reading each other's lists.

Once participants have read each other's lists, they have to negotiate and choose two other people whose answers they identify with most, to form a small group. The task of the small group is to list three ways

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their friends try to get them to cooperate with them. These are written on a blackboard or flipchart. Each group then bring their completed flipchart to the larger group where all the charts are displayed on the wall. Discussion within the large group follows, after participants have had time to walk around and study each group's chart.

6. How to cope with peer pressure

It is important to stay in the group, but it is also important to make your own decisions. If you do not make all of your decisions, you will be held accountable for the decisions of others.

Here is a new concept for you: The only thing that you owe anyone else is to be different. You must be different from anyone who ever was or anyone who ever will be. You were created for your individuality. They only way you can reach your full potential in life are to make all of your own decisions. If you always follow a group, you cannot be yourself. It is important for you to have the skill to say "No". You need to be able to go against the group sometimes. If you are going to be an adult, you have to make all of you own decisions and live with the consequences. That is the only way you can take your own direction. You must think about every choice you make. You cannot let other people make your decisions for you.

When you decide to do something that is different from what the group wants, the group will apply pressure. The group will try to get you to conform. They may threaten you or make fun of you. They may get angry with you. However, remember: It is your responsibility to yourself, and to everyone else, that sometimes you will be different. Once you make a decision, and you believe in it, you must be able to stick to it. If

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you cannot do this, the group will always manipulate your choices. You need to develop the skill of going your own way, even in the face of group opposition.

You do not have to have a good reason for not doing what the group wants. It can just be your choice. You do not have to explain yourself or your opinions to anybody. You do not need an excuse. You can simply say, "Because I want to." That is reason enough.

You must keep the group informed about how you are feeling if they try to pressure you. This holds the group accountable for their behaviour. If the group is causing you to feel uncomfortable, you must express this feeling. This will keep their behaviour in line. "It makes me feel uncomfortable when you ask me to drink when you know I don't want to." Honest statements such as this will usually bring people under control. You must constantly keep people informed about how you are feeling and what you want from them. "I don't want any pot. I would prefer it if you would stop asking me." A simple "No," or "No, thank you," is enough in most circumstances. Say no, and stand your ground, you don't have to explain yourself further. If the group continues to coerce you even after you have said no, you may have to leave the situation. If they do not respect your wishes, you do not want to be with those people anyway. Just excuse yourself and go home. You have not lost anything – if the group does not care for how you feel, they are not the group for you.

People can always get you to feel a certain way if they try. They can get you to feel angry or guilty if they work at is, but even if they have some control over your feelings, they cannot control your actions. That is up to you. If they can get control over your actions by controlling your feelings, they have a slave; they can get you to do anything.

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Groups will often try to lay guilt on you if you do not cooperate with them, but they cannot make you do anything with this guilt. You are in control of your actions.

Exercise 4: Ways to say no to drugs

Brainstorm different ways to say no to drugs, in plenary. List all the answers on a flipchart or blackboard (e.g. "No, I can have fun without drugs" or "No, because I don't know what drugs might do to me.") Open discussion is encouraged.

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