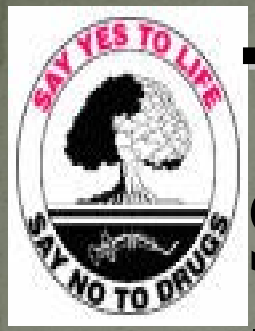
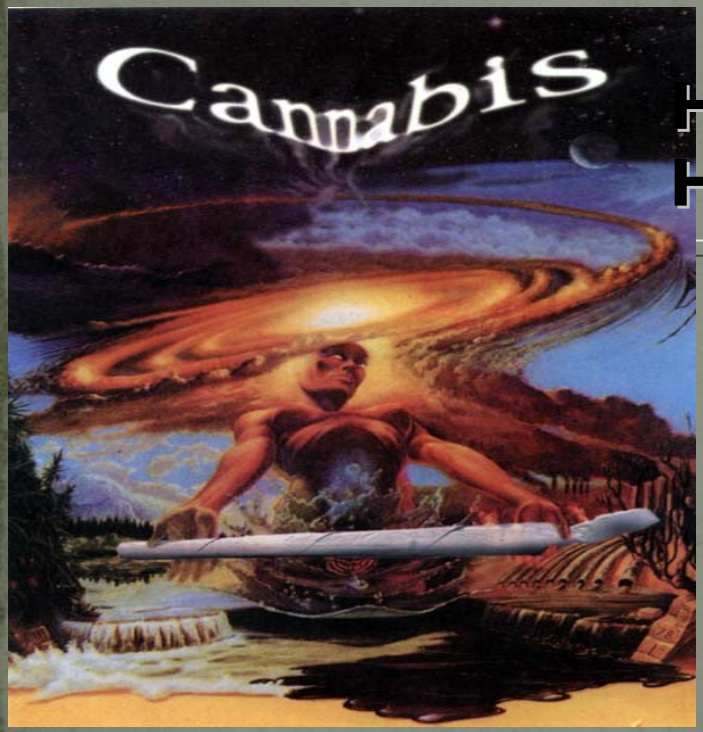


TREATMENT FOR SUBSTANCE ABUSE In the 21st century



HOPE CONFERENCE BOMBAY2008
HRC CONFERENCE – MIAMI 2008

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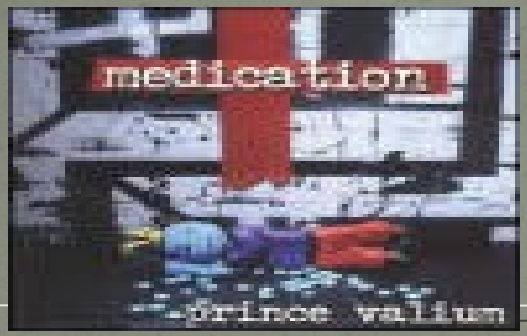
INTRODUCTION

- It has become increasingly difficult to assist an individual to maintain long term recovery from substance abuse.
- Irrespective of which treatment centre the individual has been to, none guarantees a successful recovery.
- This is frustrating to individuals, their families and also service providers.
- The reason for this trend is not absolutely clear.
- Many treatment centres are rigid in use of their programs and depend on aftercare to improve recovery rates
- Service providers are increasingly acknowledging that there is no one ‘best treatment’ option as there are too many variations and complexities in reaching the goal of freedom from dependence and social

QUESTION ARISES:



ARE TREATMENT PROGRAMMES USED IN RESIDENTIAL CENTRES EFFECTIVE?

AIMS & OBJECTIVES

- To identify strengths and weakness of the different models/programs used in Residential Treatment Centres in South Africa.
- With a view to recommend changes in order to complement and combine the strengths of the different models for Phd purpose.
- In order to accommodate such complexities and sustain recovery.

RESEARCH METHODOLOGY

“Science is an enterprise dedicated to ‘finding out’… though there will be a great many ways of doing it”.

This statement not only reflects the open mindedness of the researches but is also poignant for service providers to embrace best practices of all treatment modalities, whilst shedding that which is unhelpful.

INTRODUCTION

- This study used a qualitative research design to obtain rich descriptions of traditional treatment models for substance abuse.
- This design allowed respondents to acknowledge successes and gaps and alter ideologies “in the light of emerging insights”.
- Specifically, an exploratory design was used as the research interest was relatively new in shedding insights on moving beyond the disease model in South Africa.

THE SAMPLE

- 3 CENTRES: a) Minnesota/ Disease Model –Durban
- b) Therapeutic Model (TC) – Cape Town
- c) Narconon Model – Johannesburg

- 2 DATA SOURCES: a) Professional Staff (Service Providers)
- b) Patients undergoing treatment
- Thus methods triangulation was achieved in that each sample illuminated the data supplied by the other.

- Stratified random sampling - adequate representation
- Purposive sampling – researches knowledge – centres will co-operate
- Staff Sample – 5 and Patient – 2 groups 4 in each

RESEARCH INSTRUMENTS

- Structured interview was used with staff with the interviewer guiding respondents through a series of open ended questions, whilst carrying out a conversation to explore actual experiences.
- Focus group was used with patients because it gave space to patients to together create meaning regarding treatment and share experiences about needs, problems and frustrations.
- Qualitative data analysis was used by grouping responses into meaning units and analysed accordingly.

LIMITATIONS

- The sample size being small, limited generalization – this did not invalidate the research, as this was a qualitative, exploratory study.
- In researching the TC model , only 1 staff member was available for the interview.
- Unavailability of staff and poor co-operation may have comprimised results pertaining to this model.
- The results reflected the perception of staff who may not have had expert training in the model they practised, further limiting the scope of the study.

RESULTS AND DISCUSSION

Results are conflated according to the themes/questions used in both research instruments and presented together to offer a comprehensive picture of treatment.

Where appropriate, actual words are cited to get a glimpse of the participants' world view

1. SAMPLE PROFILE

- Minnesota Model – STAFF – 2 graduates of Psychology and Social Work and a paraprofessional who is a life skills facilitator. The patient sample comprised of 2 groups of 4 members each.

- Therapeutic Community Models – had only 1 staff member available for the interview, a paraprofessional The patient sample comprised 2 groups with 3 members each.

- Narconon Model – had several staff members (ex patients) who were trained by the centre. The patient group consisted of 2 groups with 4 members each.

2. MODEL DESCRIPTION

- Questions pertaining to this theme were asked of the **staff sample only**, to gauge the philosophy underpinning treatment.

- Consistent with the literature, the Disease/Minnesota Model staff viewed addiction as a chronic, hereditary, medical disease, located in the midbrain, that may be triggered by traumatic events in childhood and aimed to achieve lifelong recovery from the disease20,21,22.

- In contrast, the T.C. Model staff saw addiction as a psycho-social problem with behavioural dysfunction. Thus, behaviour modification is offered along with peer pressure to accomplish goals. The client is kept for a long period ranging from 1 to 2 years and later sent to a halfway house until resistance to overcoming addiction is absent or minimal. The person rather than the drug is regarded as the problem23.

- The Narconon Model staff consider addiction a hurdle that has to be overcome and tailors a comprehensive education-treatment program over 41/2 months for curing addiction. It is essential that the stay be completed.

- Staff clearly articulated the philosophy underpinning their centres. The descriptions were in synchrony with theory pertaining to their programs.

3. STRENGTHS

- **Both staff and patients** were questioned about what promoted change and recovery in the programs.

- The Disease/Minnesota Model staff and patients emphasized the following factors: "*overcoming denial; honesty; intrinsic and extrinsic motivation; strong support system; spiritual guidance and accountability".* Patients also valued a holistic approach where physical fitness was incorporated into the program whilst being accorded trust and respect as people rather than as patients/problems. This comment is suggestive of the need to de-emphasize the biological and move to a more bio-psycho-social focus with disease being appreciated multi-dimensionally.

- In the T.C. Model, both staff and patients identified the following: "*client's belief in himself/herself; voluntary treatment; balanced diet; exercise; spirituality; role modelling; emotional and psychological intervention"*. Patients valued in particular the importance given to family and preparing them vocationally to "*survive life outside the centre"*. In accord with the emphasis of modifying behaviour, it is noteworthy that various intrinsic and extrinsic aspects to behaviour change are incorporated into the program. Again, the perception was that a holistic focus promoted recovery rather than the use of a singular intervention viz. behaviour modification.

- The Narconon Model staff and patients attributed success to "*addressing underlying issues leading to drug usage; ability to confront and communicate; having determination, honesty and sincerity; and family support".* In addition, patients valued the "*sauna as cleansing and the preparation to confront, control and communicate effectively for sober living in society".* A holistic program with the "alternate" component of sauna was clearly appreciated.

4. WEAKNESSES / DISADVANTAGE

- **Both staff and patients** were questioned about what inhibited recovery in their programs.
- The Disease/Minnesota Model staff and patients emphasized the following factors as retarding recovery: "*seeing addiction as a disease and being helpless; confrontation rather than support of family; expecting a quick fix; association with high-risk situations; not wanting to let go of the past; and blaming everybody else".*
- Patients explained that they did not appreciate being "*forced/coerced into following aspects of the program they did not believe in".* Power relations seem to exist between patient and professional and need addressing so that through teamwork, sobriety may become a joint endeavour. This may mean change or adjustment to the philosophy of disease with accompanying powerlessness before both groups can work together. That the disease concept was considered unhelpful is significant in suggesting a paradigm shift to incorporate alternate philosophies and strategies.

- Staff using the T.C. Model identified "*being in denial; not implementing life skills and not being responsible/disciplined"* as preventing recovery. Patients could not identify anything as retarding progress, this perhaps being attributable to control and sanctions by authorities who may take away privileges and rewards (in accord with the behaviour modification principles) should patients complain about the centre.
- Staff using the Narconon Model emphasized the following factors as preventing recovery: "*socializing with other addicts; being in denial; the program having a poor outside image; returning to the same environment and visitors not being controlled during treatment"*. The patient group was unable to identify weaknesses in the program maybe because they did not see any room for improvement or because they too feared reprisal and censure. The "voicelessness" of the patient group is a concern, because they appear to remain disempowered and unable to "confront, manage conflict or communicate", these being cited earlier as factors facilitating recovery.
- Staff and patients at all centres suggested that there was room for improvement in the existing offering at

5. AFTERCARE

- Only the **staff group** was questioned on the role of after care in sustaining recovery at each centre. The patient sample was asked for general recommendations to improve success so as not to lead patients in any way.

- In the Disease Model, aftercare focused on improving communication between the client and family; empowerment using life skills; reviewing and resolving existing problems; and inviting patients to visit and *"refresh"* when necessary.

- In the T. C. Model, aftercare takes the form of attending AA/NA meetings, which is crucial to sustaining recovery. Generally the traditional T.C. Model has a one year program making aftercare somewhat redundant. Due to the centre being interviewed having a three month program only, aftercare in the form of AA/NA meetings was essential.

- In the Narconon Model, patients who are completely detoxified by the purification process and complete all life improvement courses do not require aftercare. However, those that are finding it difficult to cope on the outside are allowed to come and assist so that they can "*refresh*" on their recovery.

- Staff recognized that even though aftercare may not always be a component of the residential program, that it was sometimes necessary to "refresh". They appear to accurately perceive that their programs do not assure high success and that patients relapse and return for services, formally or

6. LINGUISTICS

- The theme of linguistics was explored with **both sample groups** to understand the effect of language use (words/phrases) in conveying messages of hope and/or empowerment for recovery. These were:
- ***"Disease; Incurable; Once an addict-always an addict; Lifelong recovery; and Powerlessness"***
- The terms overlap in meaning and connotation and are thus combined in the analysis to yield understanding of the purpose for probing their use viz. as they contribute to recovery.

- In the Disease Model, a patient is never regarded as fully cured as the “defect” is considered to reside in midbrain dysfunction making recovery a lifelong endeavour.
- Patients’ helplessness was evident in them saying: *“it’s a lifelong road…we know we are recovering addicts”* and fearing relapse that is considered part of recovery.
- The staff similarly cautioned about high risk situations that invite relapse, stating clearly that the patient had to remember that he was a “*potential addict*” and that *“without submission to God/ Higher Power, the patient cannot garner strength to stay clean*”.
- The powerlessness pervading these sentiments is abundantly clear and may be disempowering to addicts, preventing them from believing in their recovery.

- In the T.C. Model, the staff member explained that powerlessness is invited by the term “*potential addict*” and that hope could instead be generated by not “*encouraging relapse*”.
- These statements are somewhat contradictory as there is inherent suggestion of powerlessness in admitting to the possibility of relapse, yet patients are not referred to as addicts.
- Perhaps this is precisely the dilemma of the patient who needs to believe in his/her power while knowing that there is always a need for vigilance to prevent relapse.
- According to the patients/clients, labels of being an “*addict*” were degrading and made them feel as “*lesser than normal*”; but they agreed that “*recovery is a lifelong process*” and that *“it gets harder to achieve sobriety with each relapse”.*
- The latter statements again reflect the afore-

- With the Narconon Model, staff clearly articulated that addiction is "*not considered a disease since there is no physical basis or physical impediment".* Neither is it "*incurable*". With determination, the student can stop using substances.
- Staff expressed concern that such terminology was disempowering to patients. Further, the life skills program allowed patients to take charge of their own destinies and sobriety.

- The patient sample in the TC Model was more guarded stating that that they had to be ever vigilant of relapse implying that "*lifelong recovery*" was a "*reality"* although they were adamant that the addiction was "*curable".*
- Again these statements are contradictory, suggesting the need to acknowledge the hold of the substance over the user whilst also being cautious not to imply a fatalistic attitude that relapse is inevitable.
- Replacing the term "addict" with "patient" and "student" are attempts to change the mind set and regain a sense of control in the patient.

7. HOLISTIC TREATMENT

- Only the **staff sample** was asked about a holistic approach to treatment.

- The Disease Model staff discussed a holistic approach to include attention to a *"healthy diet and physical fitness, professional counselling, life skills, group work and family work and the services of a psychologist".* They explained that it does not make sense to choose recovery while other related lifestyle choices are unhealthy. The need to move beyond the physical and biological is clearly evident in these explanations.

- With the T.C. Model, the staff member explained that a holistic approach attends simultaneously to "*mind, body and soul"*
- whilst staff at the Narconon centre clarified that holistic treatment means attending to patients "*physically and mentally*" but did not clarify what attention to the "*soul*" or the "*mental*" focus would involve.
- Perhaps, the latter is difficult to specify as it involves working with the esoteric dimension that professionals find difficult to embrace in their professional armament25.

- Holistic treatment involves attention to the “soul”, and may be the spiritual dimension used in several centres and self help programs.
- Staff were asked to unpack how spiritual dimensions to treatment were addressed.
- With the Disease Model, spirituality was addressed at AA/NA meetings where the philosophy of inviting and submitting to a Higher Power was accepted as facilitating recovery. The “*dark, evil qualities of addiction cannot subsist with spirituality*” explained staff. Spirituality was regarded as facilitating “*inner healing, which occurs before external healing*”.

- The response by the T.C. Model staff member was non committal in this regard.
- In comparison, staff from the Narconon Model articulated clearly that spirituality was not given "*specific prominence*" unless it was sought by the student, in which case it seemed to have provided for a "*sense of purpose or direction in life*".

- Holistic treatment may also include alternate therapies.
- Alternate adjuncts to treatment were identified as massages for pain and the sauna for detoxification.
- The Disease Model staff also boasted camping, physical activity and television as

8. RECOMMENDATIONS

- Both **staff and patient** groups were questioned about suggestions to improve treatment at their centres.
- All of them requested additional, specialist staff who underwent regular in-service training as the complexities of addiction were respected as needing specialist and updated attention.
- This may not be a big task given the rather low recovery rates and costs to a nation reeling from effects of addiction

- Recommendations to the Disease Model included more "*sauna and vitamin therapy, exercises and other activities".*
- Patients requested "*creative activities"* suggesting that change was stimulating and necessary to help one adhere to the rigours of treatment.
- The T.C. and Narconon Model staff and patients identified the need for "*more physical activities; promoting interpersonal skills and improving diets"*; this was explained by the patient groups who asked for more interaction with other recovering addicts to understand addiction and empower themselves with skills during their stay at the centre.
- They even suggested that a *"diploma"* be given upon completion of the program

CONCLUSIONS & RECOMMENDATIONS

CONCLUSIONS

- That addiction is a complex, multi-layered problem was evident from the wide range of philosophies and treatment options provided by each centre.
- Indeed, programs sometimes deviated enormously from the traditional format e.g. the T.C. program studied offered a 6 week program compared to the traditional 1-2 years.
- Of note, is that besides deviation from the traditional, all centres discussed the importance of holistic treatment that incorporated alternate strategies.
- Sauna, vitamin and nutritional therapy and massage were regarded as useful for addressing health problems as well as enhancing detoxification.

- Results also pointed to a need to change terminology that was considered disempowering e.g. “addict”, being “guarded” for the rest of one’s life and “lifelong recovery”, that suggested helplessness.
- Conflicting messages about such terminology was evident in aiming to empower patients whilst alerting them to the potential for regressing and relapsing.

RECOMMENDATIONS

- Understanding substance use and the self through in depth, intensive therapies via individual counselling by specialists, structured involvement of family and significant others, intensive educative programs, discussion groups and practical applications.
- Empowering the user by discontinuing the label “addict”. Alternatives to the label could be the terms ‘student’, ‘peer’ or ‘friend’ as used in the Narconon program. Empowerment may also include the use of affirmations that are positive, short statements to be repeated

- Including alternate and creative strategies such as vitamin therapy, healthy diet, sauna, physical activity and massage into the program: The substance abuser benefits greatly if regular and rigorous exercise is incorporated as the body's natural detoxification mechanisms are thereby enhanced, endorphins released to fight depression, and absorption of valuable nutrients improved through inclusion of such strategies.
- Including a spiritual focus as part of holistic care that encompasses the faith of the user to give direction and emotional strength during and after treatment. This may address the need for work with the "soul", an empowerment strategy that may address ethical and moral dilemmas faced by users.
- Interdisciplinary teamwork based on the ecological paradigm: The presence of a **team** of professionals to comprehensively address the multiple layers of addiction.
- Future studies to include quantitative research with larger samples to improve generalization; and research to study success rates of current and proposed models/strategies.

CONCLUSION

- *The weakness of existing programs was thus clearly found to lie in a uni-dimensional philosophy and program that was repetitive and unchanging.*
- *Staff and students identified the need for more holistic, comprehensive and creative approaches.*
- *These had to compliment traditional strategies, rather than replace them, in accord with the multi-faceted and multi-layered complexities of substance abuse.*
- *In keeping with this finding, was the call for in depth interventions to make the transition from being an addict, to one who is empowered and free from dependence.*
- *Users must not be viewed as victims of their circumstances but be encouraged to reclaim an inner locus of control.*

MINDS Alive

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