Treatment for substance abuse in the 21st century: A South African perspective

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Abstract

Background: 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 service providers. The reason for this trend is not absolutely clear. Many treatment centres are rigid in the use of their programmes and depend on aftercare to improve recovery rates.[1] 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 reintegration.[2] Hence the focus of this article is on research that has been undertaken to identify the strengths and weaknesses of the different models/programmes used in different residential treatment centres in South Africa with a view to recommending changes to accommodate such complexities and sustain recovery.

Methods: Qualitative methodology was used to assess the strengths and weaknesses of programmes at three key residential rehabilitation centres in South Africa. The sample comprised both patients and service providers at each centre and the research instrument was focus group discussions with the former and individual, semi-structured interviews with the latter. Non-probability criterion sampling was employed to secure the participation of the required categories[3] of treatment centres, and probability sampling was used thereafter, based on availability of respondents (both patients and staff) and easy access to them.

Results: Despite tradition dictating a fairly rigid programme, most of the centres' staff and patients requested attention to the full biopsychosocial self of the patient, instead of being unidimensional such as paying more attention to one aspect at the expense of another such as to the physical as in the case of the disease model. A key finding was the need for a paradigm shift away from the disease model, with its accompanying helplessness, to that of a holistic approach that emphasises empowerment, embraces alternative strategies such as massage, sauna for detoxification, dietary improvements and physical activity, and uses language that is consistent with power and control. The centres also employed a multidisciplinary team, consistent with a focus on the "mind, body and spirit", albeit requesting additional staff to comprehensively and effectively address all aspects of the holistic approach. Thus, they accorded importance to the spiritual dimension of the patient, although this did not always translate to action or programme content.

Conclusion: The weakness of existing programmes was clearly found to lie in a unidimensional philosophy and a programme that was repetitive and unchanging. Staff and students identified the need for more holistic, comprehensive and creative approaches. These had to complement traditional strategies, rather than replace them, in accordance 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 and substance dependent to a person 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.

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Introduction and context

There has been significant public support for the disease concept relating to alcoholism[4] in order to assure consumers that only a few will fall victim to the disease, while the rest will control it or recover, given appropriate doses of an antidote. The psychosocial and emotional features of both alcohol and drug use and specifically the power and control of the individual (empowerment) have received less support.[1] Otto laments that this trend exists in treatment as well, since the disease approach to treatment appears to work well in the short term, but is ineffective in maintaining recovery over time.[5] This article does not claim to ascertain whether or not substance abuse is a disease, but will present a bit of both sides of the ongoing debate with a view to fill gaps in the programmes that perpetuate ineffective and unsustainable recovery.[6,7]

Aims and objectives

The overall aim of the study was to analyse the effectiveness of current traditional treatment models being used in residential drug and alcohol rehabilitation centres in South Africa. The following objectives were critical to this process: (a) critiquing traditional rehabilitation models; (b) identifying their strengths and weaknesses; and (c) securing recommendations regarding review of and change from service users and providers.

Review of treatment options

The ultimate goal of all substance abuse treatment is to enable the dependent person to achieve lasting abstinence. Commonly used treatment programmes are multi-fold as follows: outpatient drug-free treatment programmes: these do not include medication, but a variety of strategies such as individual or group counselling; therapeutic communities (TCs) are structured, with patients staying at a residence for six to 12 months: patients in TCs include those with long histories of drug dependence, crime and impaired social functioning; short-term residential programmes, referred to as chemical dependency units, involve a three- to six-week inpatient treatment phase followed by extended outpatient therapy or participation in 12-step self-help groups; detoxification residential programmes involve a stay that may be short term (a few days to a few weeks) or longer term (a few months to approximately one year): they provide a structured environment, often based on the 12-step approach, and include education and different types of therapy (group, individual, and sometimes family or couples therapy); methadone maintenance programmes for heroin addicts are usually successful in treating clients with opiate dependence.

There are also a number of self-help programmes, as a form of aftercare, to help the individual deal with addiction. These are Narcotics Anonymous (NA), a self-help organisation for drug abusers and is an offshoot of Alcoholics Anonymous, using a group meeting format, group intervention and the 12-Step Programme;[8] Secular Organisations for Sobriety (SOS), a network of independently run meetings using "alternative" recovery methods;[9] Self-Management And Recovery Training (SMART), a programme that employs self-empowerment and self-directed change;[10] Women for Sobriety (WFS), an organisation focusing specifically on the needs of women who abuse substances;[11] and NARCONON, which uses exercise, sweating in a sauna and nutritional supplements and courses to achieve sobriety and personal stability.[12]

Theoretical framework

A systems perspective provides the theoretical backdrop for appreciating the various treatment modalities that could serve the user - Inadequacy in any one treatment strategy will affect the treatment product as a whole. Approaching treatment from this perspective will facilitate the commitment to a multi-layered, multi-dimensional approach, which suggests that various modalities may work in synchrony rather than in competition to best serve dependents.[1,13]

Research methodology

"Science is an enterprise dedicated to 'finding out'… though there will be a great many ways of doing it."[14] This statement not only reflects the open-mindedness of the researchers, but is also poignant for service providers to embrace the best practices of all treatment modalities, whilst shedding that which is unhelpful.

This study used a qualitative research design to obtain rich descriptions of traditional models for the treatment of substance abuse. This design allowed the respondents to acknowledge successes and gaps and to alter ideologies "in the light of emerging insights".[15] Specifically, an exploratory design was used since the research interest is relatively new in that it aims to shed insights on moving beyond the disease model in South Africa.[16]

The sample

Two data sources and samples were used – the professional staff (service providers) and individuals undergoing treatment at the same residential treatment centre. Methods triangulation therefore was achieved in that each sample illuminated the data supplied by the other.[3]

Stratified random sampling was employed to secure adequate representation of the various traditional categories of residential treatment commonly offered in South Africa,[14] viz. the Minnesota or Disease Model, the Therapeutic Community Model and the NARCONON Model. Purposive sampling was then employed, as the final sample was based on the researchers' knowledge of the treatment centres specifically with a view to ensuring cooperation.[3,17] The staff sample was relatively small (one to five respondents from each centre) and the patient sample consisted of two groups of about four respondents per centre at the following three centres:

1. Minnesota/Disease Model in Durban, South Africa
2. Therapeutic Community Model in Cape Town, South Africa
3. Narconon Model in Johannesburg, South Africa.

Research instruments

1. Structured interviews were used with the staff/service providers, with the interviewer guiding the respondents through a series of open-ended questions whilst carrying out a conversation to explore actual experiences.[14,18]
2. Focus groups were used with patients because they provide space for the patients to create meaning regarding treatment together and share experiences about needs, problems and frustrations. Qualitative data analysis was used by grouping the responses into meaning units and analysing them accordingly.[14,18]

Ethics – informed consent

Permission was granted by the University of KwaZulu-Natal to undertake the study. Informed consent was secured from all the participants. Respondent privacy, anonymity and confidentiality were respected. The researchers are professionals who are skilled in working with substance abuse and who offered on-site assistance or referral where required.[19]

Limitations

The sample size limited generalisations, as it was small. This did not invalidate the research, however, as it was a qualitative, exploratory study. In the research on the TC model, only one staff member was available for the interview. The unavailability of staff and poor cooperation may have compromised the results pertaining to this model. The results reflected the perceptions of the staff, who may not have had expert training in the model they practised, further limiting the scope of the study.

Results and discussion

The results are conflated according to the themes/questions used in both research instruments and presented together to offer a comprehensive picture of the treatment. Where appropriate, actual words are cited to provide a glimpse of the participants' world views.

1. Sample profile
The professional staff at the treatment centre for the Disease/Minnesota Model comprised two graduates in both Psychology and Social Work and a paraprofessional who was the life skills facilitator. The staff complement clearly is meagre, given the complexity of treatment required to address substance use. The patient sample in this centre comprised two groups of four members each.

The treatment centre for the Therapeutic Community Model (TC) had only one staff member available for the interview, namely a paraprofessional (despite appointments being made with more of the staff members). The patient sample comprised two groups with three patients in each group. This rather small sample and lack of staff interest suggests that there may be a serious staff shortage, that crises dictate the running of the centre or, as the researchers believe to be the case, that there is reluctance to examine and evaluate the programme at the centre. Being "stuck" in a mode that stifles evaluation is dangerous to the addict, who needs every possible form of help.[5]

The treatment centre for the NARCONON Model had several staff members (ex patients) who were trained by and qualified in the centre. The patient group consisted of two groups with four patients per group.

2. Model description and aims of centre
Questions pertaining to this theme were asked of the *staff sample only* to gauge the philosophy underpinning the treatment.

Consistent with the literature, the staff representative of the Disease/Minnesota Model viewed addiction as a chronic, hereditary, medical disease, located in the midbrain, that may be triggered by traumatic events in childhood, and they aimed to achieve lifelong recovery from the disease.[20,21,22]

In contrast, the staff representing the TC Model saw addiction as a psychosocial problem with behavioural dysfunction. Thus, behaviour modification is offered, motivated by peer pressure, to accomplish goals. The client is kept for a long period, ranging from one to two years, and later sent to a halfway house until resistance to overcoming the addiction is absent or minimal. The person, rather than the drug, is regarded as the problem.[23]

The staff representative of the NARCONON Model considers addiction a hurdle that has to be overcome and tailors a comprehensive education-treatment programme over four and a half months to cure the addiction. It is essential that the stay be completed.

The staff clearly articulated the philosophy underpinning their centres. The descriptions were in synchrony with theory pertaining to their programmes.[12]

3. Strengths, success rate, factors facilitating recovery
Both staff and patients were questioned about what promoted change and recovery in the programmes.

The staff and patients representative of the Disease/Minnesota Model emphasised the following factors: "*overcoming denial; honesty; intrinsic and extrinsic motivation; strong support system; spiritual guidance and accountability*". The patients also valued the holistic approach, where physical fitness was incorporated into the programme and they were accorded trust and respect as people rather than as patients/problems. This latter comment is suggestive of the need to de-emphasise the biological and move to a more biopsychosocial focus, with disease being appreciated multi-dimensionally.

With regard to the TC Model, both the staff and patients identified the following: "*client's belief in himself/herself; voluntary treatment; balanced diet; exercise; spirituality; role modelling; emotional and psychological intervention*". The patients particularly valued the importance given to family and the fact that they were being prepared vocationally to "*survive life outside the centre*". In accordance with the emphasis on modifying behaviour, it is noteworthy that various intrinsic and extrinsic aspects of behaviour change are incorporated into the programme. Again, the perception was that recovery was facilitated by a holistic focus rather than the use of a singular intervention, viz behaviour modification.

The staff and patients practising the NARCONON Model 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 programme with the "alternative" component of sauna was clearly appreciated.

4. Failure, disadvantages and factors preventing recovery
Both staff and patients were questioned about what inhibited recovery in their programmes.

The staff and patients applying the Disease/Minnesota Model emphasised 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*". The patients explained that they did not appreciate being "*forced/coerced into following aspects of the programme they did not believe in*". Power relations, evidenced in being thus managed and controlled, seemed to exist between the patient and the professional and need to be addressed so that sobriety may become a joint endeavour through teamwork. This may mean a change in or adjustment to the philosophy of disease, with an element of 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 that attend to self control, teamwork and seeing the use and abuse as more than disease necessitating a multi-modal apprach.

Staff using the TC Model identified "*being in denial; not implementing life skills and not being responsible/disciplined*" as preventing recovery. Patients could not identify anything as retarding their progress, although this could be attributable to the control and sanctions of the authorities, who take away privileges and rewards (in accord with the behaviour modification principles) should the patients complain about the centre.

Staff using the NARCONON Model emphasised the following factors as preventing recovery: "*socialising with other addicts; being in denial; the programme 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 programme, possibly 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.

The staff and patients at all the centres suggested that there was room for improvement in the existing offering at their centres.

5. Aftercare
Only the *staff group* was questioned on the role of aftercare in sustaining recovery at each centre. The patient sample was asked for general recommendations to improve success so that their answers would not be led in any way.

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

In the TC Model, aftercare takes the form of attending AA/NA meetings, which is crucial to sustaining recovery. Generally, the traditional TC Model follows a one-year programme, making aftercare somewhat redundant. Since the centre where the interviews took place has a three-month programme 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*" their recovery.
The staff recognise that even though aftercare may not always be a component of the residential programme, it is sometimes necessary to "refresh". They appear to accurately perceive that their programmes do not assure high success and that patients relapse and return for services, whether formally or informally.

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 words and phrases were: "*disease; incurable; once an addict always an addict; lifelong recovery; and powerlessness*".

These terms overlap in meaning and connotation and are thus combined in the analysis to yield an understanding of the purpose for probing their use vis-à-vis how they contribute to recovery.

According to 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. The patients' helplessness became evident in expressions such as "*it's a lifelong road … we know we are recovering addicts*", and in their fear of relapse, which 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, the patient cannot garner strength to stay clean*". The powerlessness pervading these sentiments is abundantly clear and could be disempowering the addicts, preventing them from believing in their recovery.

In the centre employing the TC 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 an inherent suggestion of powerlessness in admitting to the possibility of relapse, yet the 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, being labelled an "*addict*" was degrading and made them feel "*lesser than normal*", although 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 aforementioned concerns.

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

The patient sample in the TC Model was more guarded, stating 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 mindset 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 staff using the Disease Model discussed a holistic approach as including 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 TC Model, the staff member explained that a holistic approach attends simultaneously to "*mind, body and soul*", while staff at the NARCONON centre stated that holistic treatment meant attending to patients "*physically and mentally*", although they did not clarify what attention to the "*soul*" or the "*mental*" focus would involve. The latter possibly is difficult to specify, as it involves working with the esoteric dimension that professionals find difficult to embrace in their professional armament.[25]

Holistic treatment involves attention to the "soul", and may be the spiritual dimension used in several centres and self-help programmes. The staff were asked to unpack how the spiritual dimensions of 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 the staff. Spirituality was regarded as facilitating "*inner healing, which occurs before external healing*".

The response by the TC Model staff member was non-committal in this regard. In comparison, staff using 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*". Kasiram[24] similarly cautions against the need to ensure that the spiritual focus is more about the client system than about the service provider, as it may easily overtake treatment and spiral downwards into "converting" clients to the provider's religious persuasion.

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

8. Recommendations

Both the *staff and patient* groups were questioned on 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 viewed as needing specialist and updated attention. This may not be too much to ask, given the rather low recovery rates and costs in a nation reeling from the effects of addiction.[25]

Recommendations in relation to the Disease Model included more "*sauna and vitamin therapy, exercises and other activities*". The patients requested "*creative activities*", suggesting that change was stimulating and necessary to help one adhere to the rigours of treatment. The TC 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 programme because of the extent of education necessary for understanding addiction.

Conclusions and recommendations

That addiction is a complex, multi-layered problem was evident from the wide range of philosophies and treatment options provided by each centre. Indeed, programmes sometimes deviated enormously from the traditional format, e.g. the TC programme offered a six-week programme, compared to the traditional one to two years. Of note is that, besides deviation from the traditional, staff and patients at all the 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.

The 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", which suggest helplessness. Conflicting messages were evident in the terminology, which was aimed at empowering patients whilst alerting them to the potential for regressing and relapsing.

Recommendations for treatment in the 21st century include understanding substance use and the self through in-depth, intensive therapies via individual counselling by specialists, structured involvement of the family and significant others, intensive educative programmes, discussion groups and practical applications. One possibility may be empowering the user by discontinuing the label "addict". Alternatives to the label could be "student", "peer" or "friend", as used in the NARCONON programme. Empowerment may also include the use of affirmations that are positive, such as short statements that can be repeated when necessary. It may also mean including alternate and creative strategies, such as vitamin therapy, a healthy diet, sauna, physical activity and massage, in the programme. The substance abuser benefits greatly if regular and rigorous exercise is incorporated, as the body's natural detoxification mechanisms are thereby enhanced, endorphins are released to fight depression, and the absorption of valuable nutrients is improved.

Including a spiritual focus in holistic care that encompasses the faith of the user so as to give direction and emotional strength during and after the treatment may also be considered an empowerment strategy. This may address the need for work with the "soul" to address ethical and moral dilemmas faced by the users.

An important recommendation is for interdisciplinary teamwork based on the ecological paradigm. The presence of a *team* of professionals will comprehensively address the multiple layers of addiction.

Finally, future studies need to include quantitative research with larger samples to improve generalisation. Research should also focus on the success rates of current and proposed models/strategies.

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