CHAPTER - IV

DRUG ADDICTION: SOME TREATMENT MODELS

Planning the treatment

There are many treatment models, and some have been found to be more effective than others in specific setting as a model of treatment considered effective in one sociocultural setting does not necessarily give the same results in other places. Different models will indeed be necessary even for different areas in the same country. Plans must take account of the type of drug use, the target population of users and the relevant sociocultural factors. The ultimate goal of the programme is the social integration of each person into the life of the community.

Whom to Treat, and Assessment Prior to Treatment

A question that is commonly asked is – whom to treat? Not all drug users need treatment. Drug users should be carefully assessed to determine who needs treatment. Many young people and adults experiment with drugs and some use drugs irregularly. Many of these casual users are to be found in cities. It would be unrealistic to direct treatment programmes at all of these: Many will not want treatment, and it is doubtful if treatment has much to offer to them.
Traditional drug use in certain rural populations also needs a special approach. Traditional uses of various drugs are closely related to the environment and way of life in these areas. Traditional smoking and eating of opium in rural populations requires similar understanding. Programme for community development and the provision of primary health care and adequate nutrition is more needed rather than an undue medicalization of the problem. Police officers, judges and teachers often feel that for anyone taking drugs, even experiment in a treatment programme is better than punishment in prison.

When an individual is being assessed for treatment, it is important to determine which drugs and how much he is taking, how often he takes them and how long he has been taking them. Laboratory analysis of body fluids can help in the diagnosis, but can not indicate the degree of dependence. The determination of dependence and its severity remains a matter of clinical judgement based on history, observation and physical examination.

To understand the role of the family is also important. If treatment is to be given, it is then a matter of determining whether it should be ambulant, with detoxification at home, or in hospital or at de-addiction centre for an initial period or for a longer time.
Basic Treatment Approaches

There are four commonly used basic elements of treatment: (a) withdrawal and detoxification; (b) drug maintenance and substitution, and the use of blocking and sensitising agents; (c) self-regulating therapeutic communities; and (d) psychological and social counselling, vocational counselling, and follow-up. Each element may use a variety of intervention measures or methods, separately or in combination. The general measures of intervention that are briefly described in this chapter are mostly long-term measures, aimed at bringing about long term and fundamental changes.

Psychotherapy

The term psychotherapy, in its broadest sense is a treatment involving communication between patient and therapist aimed at modifying or alleviating the patient's 'illness' and any encounter between the patient and a health care worker thus offers an opportunity for psychotherapy. Awareness of the potential therapeutic value of this relationship and an appropriate structuring of the communication means that psychotherapy can become a component of an integrated approach to the treatment of
drug dependence rather than an alternative treatment strategy that is selected only occasionally.

Because many opiate-dependent individuals attend specialist treatment units regularly for long periods (months to years), either for opiate maintenance or for slow detoxification, long-term relationships can develop with clinical staff, which can be utilised to promote positive personality, growth and development. It has been suggested that the supportive relationship that develops between patient and therapist becomes a substitute for drug use, just as drug dependency may be a substitute for certain aspects for important interpersonal relationships. However, a skilled therapist is unlikely to become a mere substitute for a drug, but having formed a good supportive relationship with a patient, is able to use it to identify and alter intrapsychic processes using techniques of insight, persuasion, suggestion, reassurance and instruction. This will enable the patients to learn to see themselves and their problems more clearly and have the desire and the ability to cope with them. It should also be remembered that many drug-dependent individuals have significant psychiatric problems, especially in the areas of depression and anxiety. Drug use and abuse may result from attempts to medicate these problems and it is, therefore, not surprising that psychotherapy, which can often
help to alleviate depression and anxiety, may indirectly cause a reduction in drug use too. 1

Supportive Expressive Psychotherapy

This is an analytically orientated psychotherapy, as the name suggests, in which special attention is paid to the meanings that patients attach to their drug dependence and in which, using supportive techniques, the patient is helped to identify and work through problematic relationships.

Group Psychotherapy

The technique of group psychotherapy is treating patients in-groups rather than individually. The same group of individuals meets regularly, for example weekly or more often, with a trained leader who actively directs the focus of the group. The aim is to improve the ability of individual members to control their social behaviour - a skill in which many are deficient and to this end, the behavioural interactions between members of the group are subject to examination. Members of the group are confronted with observations on their own behaviour and become aware of their

effect on others and of the effect of others on themselves. They learn to listen to interpretations of their behaviour and to deal with the resultant anxiety, which may be difficult and painful at first so that, techniques of circumvention are employed. If group becomes a cohesive structure and its members identify positively with each other and with the group, then, in this supportive environment, individual growth is possible and the experience gained within the group can be transferred to life outside the group.

Group therapy superficially, is an attractive treatment option because it seems to be cost-effective method, compared with individual psychotherapy, of offering professional help to drug abusers. However, effective group therapy requires regular attendance by all members and drug abusers are often unreliable. They are not good at keeping regular appointments and when they try to do so, are often unsuccessful for legitimate social reason. Furthermore, effective group therapy requires a high level of disclosure and drug abusers, some of whom may have been involved in criminal activities, may not be sufficiently reassured about the confidentiality of the proceedings to be frank and honest. Finally, it is easy for group therapy with drug abusers to degenerate into a 'complaints session' about aspects of treatment policy and for the group to exert pressure for change in this policy. These factors,
together with poor attendance rates, make it very difficult to direct
the group into therapeutic interactions and a very skilful therapist
is essential. 2

Group therapy for drug abuse is not a substitute for individual
treatment but is an adjunct to it, aiming to foster individual
development and growth. Those most likely to benefit from group
therapy and most suitable for it usually have a long history of drug
abuse with only limited success at attaining significant periods of
abstinence and have interpersonal difficulties. In Delhi, many of
these patients are on long-term (usually for a year) treatment
process and receive maintenance prescriptions for opiates.

Family Therapy

The family as a whole may profoundly influence the behaviour of its
individual members because, as has long been recognised, use of
family therapy is particularly important in the treatment of drug
abuse. The family is a relatively stable system that tends to resist
change, and that drug abuse may have powerful adaptive

2. D.J. Armor, Addiction and Treatment, (New York, 1995) PP. 22-
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consequences that help to maintain the stability. For example, parents on the brink of divorce may remain united to cope with the recurrent crises of a drug-abusing child, and parents who cannot cope with the departure of their adolescent child from the family home, may overtly or covertly encourage the drug abuse that keeps the child dependent on them.

The first problem in Delhi is to persuade the families of drug abusers to participate in treatment. They feel, for example, that being invited for family therapy implies that they are in some way to blame for the patient’s drug problem. It is, therefore, essential to stress their potential helpfulness in the treatment process and it is useful if they know in advance the period of treatment to which they are committing themselves. They may, after all, have had several previous experiences of ‘failed’ treatments and be unwilling to engage in what seems like another gimmick.

Whatever the individual family ‘scenario’, the reactions of family members to the drug abuse of one of them often seem to reinforce the drug-taking behaviour, whether or not they played a predisposing causal role in its initiation. Members of the family, albeit unconsciously, may actually encourage or reinforce drug taking, and may seriously undermine any treatment programme,
especially at the stage when the patient is showing progress and
drug abuse is declining. The ‘family therapy’ term, the drug abuse
of the patient is really that of the family as a whole, and it is logical
to include the whole family in the treatment approach. Even when
the drug abuser is a young adult who has left home, and even when
that adult is married (with or without children), it is often the
family of origin that continue to have powerful influence on drug
taking are also the natural focus for family intervention.

The therapist will try to help the family to solve its problems and
the individual family members to relate to each other in more
positive and constructive ways. To do so, the therapist must ‘join’
the family group, initially by supporting the family and behaving
according to its rules – adopting the style and affect. A new family
system is thus formed, consisting of the old family plus the
therapist who must establish a positive relationship with each
member and establish a leadership within the family group. By
joining the group in this way, the therapist can experience, at first
hand, and participate in, the behavioural interactions that have
become the family’s response to a particular problem. Often these
habitual responses are maladaptive and series of interventions may
then be planned, using the therapist’s manipulative skills to
restructure the family’s patterns of interactions, in order to
implement change. Tasks may be assigned to individual family members to perform at home before the next session. This provides more ‘practice’ at better interpersonal relationships and increase the influence of the therapist whose presence is felt, even in the family home during everyday activities.

Of course, a typical and understandable expectation on the part of the family is that it is the identified patient who should change or be changed by treatment. However, the drug-abusing individual does not live and behave in isolation, but interacts with the family group; his / her drug abuse is maintained because the family participates in maladaptive responses and interactions, and treatment is, therefore, targeted at the whole family. Nevertheless, it should be remembered that the goal of therapy is not the more exploration of past events, but the alteration of the present situation. The symptoms of the identified patient should never be lost sight of, and the primary aim of treatment is to influence the rest of the family to help the patient with this problem.

A variation on family therapy is ‘multiple family therapy’ in which a number of drug addicts' families are treated conjointly. It is found that the families are able to support each other because of their shared experiences and that they learn to recognise and understand what is happening in their own family by observing similar
phenomena in other families. The support offered by the group is particularly helpful at the very difficult time when parents begin to detach themselves from the problems of their drug-abusing child. 3

**Drug Counselling**

Drug Counselling is primarily an advisory service. It deals with the realities of the patient's present situation, but the practical help of a professional counsellor backs up the advice that is given. Sessions occur regularly, by appointment, rather than on a casual, drop-in basis, and their frequency varies according to the particular needs of different patients. Counselling entails assessing the specific needs of individual patient and then providing, or directing the patient towards the services that meet these needs. The first step is to establish realistic goals, which may encompass not just drug-taking but also school, work, leisure-time activities, and relationships with family and friends. The available options are presented to the patient who is helped to decide the best course of action – and then helped to follow the chosen course. Progress in achieving the stated goals is monitored by seeing the patient

regularly, and problems can be appropriately dealt with as they arise, by a counsellor who becomes well known to the patient and trusted.

A whole range of problems is dealt with in counselling sessions. When appropriate, specific treatment-options can be discussed such as in-patient or out-patient detoxification, maintenance treatment, drug-free therapeutic communities, etc. and the necessary arrangements for their implementation can be initiated. However many areas of daily living may also be susceptible to advice. In particular, ways of avoiding encounters with other drug users and drugs should be explored so that essential changes in life-style are made.

If, for example, drug use always occurs in a particular situation with a particular group of friends, then the said environment has to be avoided at all costs; involvement in a different activity with non-drug users may be a sensible way of avoiding this problematical situation, but simple advice is unlikely to be effective. There must, in addition, be practical help aimed at engaging the drug users in new ways of passing leisure time. Similarly, it may be essential for some drug users to move house, away from their drug-taking environment, but again they must need positive help before this can be achieved. Thus drug counsellors often liase with other
agencies on the drug user's behalf and the value of this active, practical support cannot be overestimated.

Counselling, insofar as it offers the drug users supportive relationship with a trained counsellor, can of course be considered psychotherapeutic in its own right. Usually, however, no attempt is made to mediate intrapsychic processes or to engage in specific psychotherapeutic techniques. *Behavioural Techniques* a completely different approach to the management of drug abuse and dependence, is the systematic application of behavioural intervention techniques. This approach focuses on drug abuse as a 'disorder of behaviour', which it aims to eliminate. There is no attempt to identify its causes, which might or might not be amendable to treatment, nor to trace the history of the condition. Instead, drug abuse, as it exists when the patient presents, himself/herself is recognised as the pressing problem to be treated in its own right.

Drug abusers, however, often have other problems too, such as poverty, unemployment and homelessness, and it can be argued that it is pointless to try deal with the drug abuse without first, or simultaneously, dealing with the associated problems - an approach that implies that these problems are the cause of the drug abuse. On
the other hand, it can be argued that it is the drug abuse, which had led to other difficulties. If a behavioural approach is adopted there is no reason to be concerned about which is the 'cause' and which is the 'effect'. The principle is to find out which behaviours should and can be changed, to decide what change is wanted and to devise a way of effecting this behavioural change. In more technical terms, before behavioural therapy can be initiated, a behavioural analysis must be carried out so that current behaviours are understood, goals are identified and the way of achieving these goals is also defined. According to the individual behavioural analysis, the resultant programme may be narrow, focussing only on the problem of drug abuse, or broader, encompassing a range of related problems and dealing with various aspects of the individual’s behavioural repertoire. 4

The term 'behavioural intervention' includes many different techniques, some of which are as old as the hills, rewarding good behaviour, punishing bad one, and making medicine taste sweeter, are all ploys that are used routinely, often automatically, in many

4. Ibid, PP. 63-66
therapeutic situations. Their conscious and systematic application to all aspects of treatment, so that every therapeutic situation becomes a positive learning experience, is the basis of behavioural intervention.

Cognitive Behavioural Psychotherapy

This is an 'active, directive, time-limited treatment' that focuses on identifying and understanding the relationship between underlying 'automatic' thinking and attitudes to problematic feelings and behaviours. Patients can learn, with the help of a therapist, to correct negatively biased attitudes and beliefs about themselves and the world about them, learn to cope without drugs.

Contingency Management

Contingency management is a behavioural procedure based on the principle of encouraging previously agreed behaviour patterns by offering rewards (positive reinforcers) when they occur, and by punishing the individual if they do not, or if other undesirable behaviour patterns occur. In other words, specified rewards and privileges become contingent upon continuation of agreed behaviour. It is really the modern application of the well-known 'carrot and stick' approach, but with one important difference - the desired (target) behaviour is defined and explained first, together with the
contingent reward (or punishment) before the procedure is initiated, rather than the individual learning by trial and error as to what is expected of him or her and what is the price of failure / success going to be.

The key to successful contingency management is for the therapist to have control of appropriate positive reinforcers, where an opiate-dependent individual attends a clinic regularly and frequently for a prescription for methadone (or heroin), a variety of reinforcers can be utilised for contingency management. For example, methadone take-home privileges (rather than having to take the methadone under supervision at the clinic), frequency of clinic attendance, time of appointment, access to counselling and other 'helping' services, and advantageous holiday arrangements can all be made contingent upon certain behaviours. In practice, similar 'rewards' are often given for good behaviour, but in a non-contingent way. Thus, if patients ask for special arrangements to be made for opiate prescription while they are on holiday, their request is more likely to be granted if they have been 'doing well' i.e. attending regularly with no evidence of illicit drug abuse, etc. Planned contingency management, however, means that drug abusers learn much more directly and, therefore, more easily and more quickly, exactly what is expected of them.
One way of introducing contingency management into the treatment of drug dependence is to utilise a written contract between the medical staff and the patient. This defines the drugs (if any) to be prescribed, the dose reduction schedule, the duration of prescribing, the frequency of attendance at the clinic, other treatment approaches in which the patient will participate, the consequences of non-attendance and, in particular, the consequences of abusing illicit drugs etc. Usually, if patients fail to keep their side of the contract and particularly if they continue to abuse illicit drugs, the prescribed dose of drug is quickly reduced.

Although contingency management is theoretically simple, there are certain practical problems peculiar to its application to the treatment of drug abuse. For example, it is often quite difficult to find out quickly whether patients have been abusing illicit drugs because the results of urine tests may not be available for several days or even a week or more. The inevitable delay before contingent measures can be implemented unfortunately impairs their efficacy.

However, the use of positive reinforcement, as well as having a therapeutic effect on individual patients, may also have a wider effect on the social and therapeutic atmosphere of the whole clinic by reducing confrontation between staff and patients. Relationships
between staff and patients at such clinics are often difficult. Patients are often manipulative and threatening in their attempts to obtain their drug of abuse or larger quantities of it, and the staff, frustrated and disheartened by recidivism, develop coercive attitudes towards patients. It is too easy that the clinic appointment, far from being a therapeutic occasion, becomes little more than a time for bargaining about a prescription. 5

The deliberate adoption of contingency management procedures helps patients to achieve defined and realistic goals for which they can be rewarded, rather than being punished all the time for failure to make progress towards undefined targets. Equally, positive and non-punitive attitudes on the part of the staff are more likely to attract patients to treatment and to retain them in it. Many clinics already have rules, which effectively activate contingencies to control behaviour although if they are not applied systematically, maximum benefit is not achieved.

It should be apparent that where drug abusers are resident, either in hospital or in a therapeutic community, many potential

5. DD. Simpson, Effectiveness of Treatment for Drug Abuse (Toronto, 1991) PP. 5-7
reinforcers can be controlled and made contingent upon 'desired' behaviour. For example, access to recreational facilities, better food, visitors, etc. can all be made contingent on behaviour such as participating in certain therapeutic activities, grooming and personal care. A further refinement is to develop this into a 'point economy system' whereby points are given to patient's contingent on desired behaviour, and taken away contingent on maladaptive behaviour. These points can then be exchanged on the ward for a variety of goods and services. All of the transaction 'rates' are clearly defined at the start and are recorded in personal booklets. An advantage of this system is that while some components are applicable to all residents, others can be personalised for the specific treatment needs of individual patients.

It has been suggested that contingency management procedures are little more than 'training' and that their efficacy lapses when contingent rewards and punishments are discontinued. Undoubtedly, undesirable patterns of behaviour, including drug abuse, may recur when treatment stops but this should be seen as yet another instance of relapse due to the severity of drug dependence and not necessarily as a failure of treatment. Contingency management, carried out in a systematic and comprehensive way, provides a firm and consistent structure for the
drug abuser's life and it may be the first time, or the first time for a
long while, that he or she has experienced this. It provides the
patient with an opportunity to learn the boundaries of acceptable
behaviour, and even if relapse occurs, the learning experience will
not have been wasted. One way, improving the long-term efficacy of
contingency management is to involve the family because they may
have in their control many social and material reinforcers which can
be made contingent on 'desired' behaviour long after patient has
stopped attending hospitals and clinics.

Other Behavioural Approaches

Contingency management is a very direct approach to the treatment
of drug abuse. Other types of behavioural intervention may be
appropriate in certain cases. Many individuals resort to self-
medication with psychoactive drugs when they feel tense and
anxious, and the relief that they experience reinforces this
behaviour and may contribute to relapse. Teaching patients to be
aware of the situations that reduce these feelings and to recognise
their own emotional reactions is the first stage of teaching them how
to respond in a healthier way. Training in techniques of relaxation
may be of long-term value to these patients, reducing nervous
tension, providing a natural way of dealing with stress, insomnia
and life's challenges and inducing a feeling of general well-being.
Some individuals, with specific fears or phobias, may be helped by desensitisation and others may benefit from training in or acquisition of certain social skills.

The need for these very specific kinds of behavioural interventions becomes apparent in the course of the assessment procedure, which should establish if there are underlying or associated psychological problems that are amenable to intervention and treatment.

**Vocational Rehabilitation**

Vocational rehabilitation is a treatment modality aimed at helping patients to acquire job-related skills. These may be specific skills, related to specific jobs and / or interpersonal skills needed to obtain and retain employment. It should be noted in passing that there is actually no firm evidence to relate vocational rehabilitation and its ultimate goal of employment with treatment outcome, although there is a widely and strongly held belief in the therapeutic efficacy of work. This can, of course, become a self-fulfilling argument if being employed becomes a measure of treatment outcome. On behavioural grounds, it can be argued that because drug abuse is just one component of an individual's total behavioural repertoire, intervening to encourage and develop desirable behaviour (i.e. obtaining a job), may lead to reduction of the undesirable behaviour.
(i.e. drug abuse) by direct competition - a sort of 'Satan finds work for idle hands' theory.

Whatever the theory, it is undoubtedly true that unemployment rates may be very high among drug abusers and particularly among young drug abusers, and that they may be receptive of help in this area of their lives. Delinquent adolescent behaviour and drug taking may have interfered with their basic education. They may have extremely limited vocational skills and may be saddled with poor employment records. At times of high unemployment particularly, it may be impossible for them to get a job without specific intervention and help.

The first step is an assessment of the patient's motivation, expectations and goals and of existing skills and qualifications. A vocational plan can then be drawn up, with short and long-term goals including, as appropriate, remedial education, and specific academic and vocational skills, such as using newspapers, job centres, friends and relatives as sources of information. Knowing how to complete application forms is also important and, in particular, how to handle sensitive information about drug taking and criminal history and how to emphasise positive aspects of previous employment. In addition, the acquisition of interview skills
is vital; this may include learning relaxation techniques to reduce anxiety before the interview, good entrance and exit techniques, general behaviour during the interview with positive presentation of self, and how to cope with hostile interviewers. Role-playing and the use of video cameras may be useful preparation for these occasions. In particular, the problem of whether or not to tell the truth about drugs taking needs to be discussed. There is considerable prejudice against abusers and some employers may specifically try to find out about drug abuse through questioning and/or urine tests. Big companies with a high turnover of unskilled staff are most likely to be tolerant on this point.

The fear and anxiety of being rejected must also be dealt with, so that self-esteem, which may already be low, is not further impaired if the job application is unsuccessful. If successful, however, the ability to retain the job becomes very important and may rest equally on the individual’s ability to do the job competently and the possession of the interpersonal skills necessary for the work place. Vocational rehabilitation, therefore, encompasses a whole range of skills which contribute to the individual’s ability to go out and get a job and keep it. Many of the problems of drug abusers are no different from those of other long-term unemployed, and referral to
professional agencies may be valuable. However, schemes for vocational rehabilitation can also be incorporated into residential programmes for drug abusers and can be located in out-patient clinics. Access to vocational counselling, which may be eagerly sought, can be made contingent on desirable behaviour, such as desisting from the abuse of illicit drugs, and vocational goals may be included in the treatment contract for staff and patient programme.6

Therapeutic Communities

It has long been recognised that detoxification does not solve drug dependence, that the severity of drug-dependence often leads to relapse and that, it takes time for drug abusers to learn to live without drugs. For many people, the necessary change in their lifestyle is difficult or impossible if they remain in an environment where drugs are easily available, where they are among old friends who continue to take drugs where a moment's craving can be translated too easily into drug and relapse.

*Therapeutic Communities* have been developed as one response to

this situation. There are different types of communities with different underlying philosophies. All insist on their residents being drug-free, although often for only a short period (24 hours), before admission and some provide medical supervision of detoxification. Some have a 'democratic structure', others are unstructured, offering accommodation and time for those who want to explore the options that are open to them. Programmes last for varying lengths of time (3-15 months); they may offer group or individual psychotherapy, which may be compulsory. Some will accept residents who are on bail and conditions of bail, and some offer vocational training.

Church-based communities emphasise the importance of divine intervention in bringing about change, and Christian worship and Bible study form an important part of their therapeutic programmes. Community-based hostels integrate residents into the local community from the start, teaching them to live in the 'outside' world without resorting to drugs.

Concept Houses

The Concept house perhaps is the best-known type of therapeutic community because all inmates constitute a drug-free community and are residential so that they are within the
therapeutic environment for 24 hours every day. At first, residents are completely isolated from their former life and are not permitted to have visitors, letters or telephone calls. Daily life within the community is very structured with residents spending most of their time in organised group activities and with little opportunity for doing anything alone. This forces interaction with other residents and permits constant scrutiny of their behaviour by their peers, and appropriate outspoken criticism.

Concept houses have a rigid social hierarchy with an autocratic leadership. Newcomers have very low status – they have few privileges and may be assigned menial household tasks. Those who remain abstinent, participate fully in community life and show personal growth in terms of honesty and self-awareness, move up the hierarchy, assuming greater responsibilities and enjoying increased privileges so that senior residents become models for new residents.

There is also a defined system of rewards and punishments, ‘good’ behaviour being rewarded with greater privileges, while breaking any of the Community’s rules are followed by punishments such as severe verbal reprimands, job demotion and loss of privileges. A variety of group therapies may be employed, but the most important
is 'encounter' group therapy. This involves a small group of community members meeting three times a week or more. The composition of the group changes from session to session so that there is no opportunity for tacit or deliberate collusion between any members, and to emphasise the need for all residents to communicate with all other members of the community and not just with the few in a static group. The group leader may be formally appointed, may emerge from within the group or may be the most senior resident there. At an encounter group, there are aggressive verbal attacks upon individuals to confront them with their observed behaviour and attitudes within the community and sometimes complaints about an individual are submitted before the group meets. Total honesty is expected, both in the verbal attacks and the responses, and shouting and swearing, far from being discouraged, are seen as manifestations of basic and honest 'gut reactions' that cut through the usual more intellectual defences. Uninhibited responses such as these are only permitted within the encounter group meeting; at other times / places in the community such uncontrolled behaviour would be punished. An encounter group meeting may last for several hours', its violent, emotional assault can be very exhausting and supportive measures are often necessary
Selection of Patients

To change their self-image and to overcome their reliance on drugs by means of living in a therapeutic community may be a useful option for chronic drug abusers whose previous attempts at abstinence have failed. It is suitable for young people in whom there is room and time for personality growth and development, and many therapeutic communities have an upper age limit of 35 years. Those who lack social skills, including those who have problems of socialisation and problems of assertiveness, are particularly likely to benefit from community life.

The rigid, structured system of the concept houses is often helpful for the development of impulse control in young, risk-taking addicts, but it is unwise to expose anyone with a history of psychosis to the intense emotional experience of the encounter group.

Evaluation of the effectiveness of therapeutic communities is notoriously difficult but, generally, those drug abusers who 'stay the

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7. Ibid, PP. 81-83
course' and complete the programme subsequently do well. It is not surprising, however, that many who enter concept houses cannot endure the life-style and leave early; for this reason some houses now have a more flexible induction programme to encourage more residents to stay longer. Some of those who 'graduate' successfully from therapeutic communities and remain drug-abstinent subsequently find work in services for drug abusers if they still find it difficult to separate completely from the world of drugs and drug dependence. However, it should be remembered that residents of therapeutic communities usually have a long history of drug abuse and dependence and correspondingly poor prognosis. The success rate of the therapeutic communities, however small, is therefore especially creditable and valuable.

**Hostels / Half-Way House**

The risk of relapse is high if newly abstinent drug-dependent individuals return to their old haunts and life-styles, and hostel accommodation provides the opportunity for them to consolidate the success of withdrawal. Staying in a hostel reduces many of the pressures of daily life, and help as well as counselling is readily available if problems arise. However, there is little direct supervision so that the residents regain responsibility for conducting
themselves in a drug-free manner. Thus, hostels often act as a halfway house or stepping-stone between more supportive, residential treatment and ordinary life in the outside world. It is essential that rules about not bringing drugs or alcohol into the hostel be strictly enforced so that those who are still vulnerable to relapse and dependence are not exposed to increased risk prematurely.

Self Help Groups

Self-help groups are voluntary, small group structures formed by peers who come together for mutual assistance in handling a life-disrupting problem. Thus in chemical dependency, self-help groups have been organised by those having problems associated with chemicals, through mutual and, members, help of one another to maintain abstinence and also to bring about desired social / personal change. The concept of self-help, in the sense of mutual help within a community, is a traditional and valued approach to many problems. With the changing structure of society due to increased mobility and the loosening of family ties, this type of community support seems to occur less easily and more rarely, and more formal self help groups have emerged to fill the void.
Nowadays, a self-help group (SHG) is a group of individuals with similar problems who meet together voluntarily to help each other help themselves. In the field of substance dependence, the best known SHG is Alcoholics Anonymous (AA) which was followed in 1953 by Narcotics Anonymous (NA). Since then, a host of other groups have been formed in response to a variety of drug problems such as tranquilliser-dependence, opiate-dependence, solvent abuse and cigarette smoking. They aim to help the drug-dependent or drug-abusing individual become abstinent.

These groups often begin due to the energy and enthusiasm of one or two individuals in a particular locality, and sometimes, because of the absence (whether real or perceived), inadequacy or irrelevance of professional services for the particular problem. There is often an underlying philosophy that it is impossible for the individual to overcome the drug problem alone, but that this can be achieved with the help of the group. The common theme of all SHGs is that of mutual aid on the part individuals helping each other by offering friendship and sharing common experiences. They provide group support, social acceptance and social identity for individuals who may have become very isolated because of their drug problem. Furthermore, an established group possesses a wealth of experience and develops skills and expertise that may be of genuine practical
help to those trying to cope with a drug problem. Because those who have come off drugs usually continue to attend the group for a while, new members are able to meet and identify with abstinent individuals. This, in itself, may be a novel and very valuable experience for those who have been involved in a drug sub-culture for long time and they may, for the first time, become aware that recovery is an attainable goal. Because SHGs often develop where and because professional services fail to meet the needs of drug abuser, it is easy to understand why some have 'anti' professional attitudes. Equally, some professional health care workers feel very threatened by these groups which sometimes attract a lot of attention from the media. However, there need not be and should not be any conflict between the two 'systems'. Professional health care and SHGs should not compete but should complement each other, and professionals should recognise the value of SHGs in their areas and reinforce their activities. They should encourage patients with drug-abuse problems to attend them and should not hesitate to refer patients to them. However, it is essential that professionals should not become directly involved in SHGs; if they do, the groups are no longer 'self help' but just another professionally organised service with a consequent loss of their unique kind of support and
help. In addition to SHG for drug abusers, there is a complementary range of SHGs for their parents and families. These meet a need, which is largely ignored elsewhere, and help families cope with the strains of living with a drug abuser. Particularly in the early stages of a drug-taking career, parents may want to keep the knowledge of the drug problem within the family and, therefore, find it difficult to seek help. Unpredictable mental stress and unpredictable, sometimes aggressive behaviour may frighten them. They may be anxious about their own legal status if drugs are being taken in their home. Living with a drug abuser can thus be a very stressful experience and the support of others in the same predicament is usually a great relief. As the strength of the family unit as a whole is a very positive asset for the drug-abusing individual, any support given to the family may beneficially affect the outcome of the underlying drug-abuse problem.

**Narcotics Anonymous**

Narcotics Anonymous (NA) is an international fellowship or society for recovering addicts who meet regularly to help each other to stay off drugs. It is open to any one with any type of drug problem, and

the only requirement for membership is the desire to stop using drugs.

NA has a 'Twelve Step' programme for achieving abstinence. The 12 steps taken by every NA member include:

**Admitting that one is an addict and powerless over one's drug-taking.**

1. Acknowledging that only a 'Power', greater than oneself (God), can help, and turning one's life over to Him.

2. Making a fearless moral inventory, recognising defects of character and asking God to remove them.

3. Admitting previously committed wrongs and trying to make amends.

4. Carrying the spiritual message of NA to addicts and practising its principles in all aspects of daily life.

In addition, the 'Twelve Traditions' of NA safeguard the freedom of the group by outlining the principles that guide its organisation and administration: NA groups are autonomous and self-supporting and decline outside contributions. They are non-professional and do no become involved in any issue or enterprise that may divert them from their primary purpose. Above all, the rule of 'anonymity' is
considered paramount because it ensures that principles remain more important than individual personalities.

Members of NA attend meetings. There is often a discussion based on the twelve steps and great stress is placed on complete openness and honesty with other members of the group, the single, shared common problem creating strong bonds between individuals. The composition of the group changes, often from meeting to meeting and the constant flow of new members are valuable because the necessary reiteration of the basic tenets of NA is reinforcing for more longstanding members. New members are encouraged to look for a sponsor within the group, a particular person to turn to at times of great need, and the responsibility of being a sponsor can be rewarding and helpful for the person concerned.

An important component of the NA programme for staying off drugs is the adoption of limited objectives. It recognises that it is difficult (and sometimes impossible) for a drug-dependent person to envisage the rest of life without drugs, and so the addict is advised to promise himself or herself not to use drugs just for 1 day – something that many have done willingly or unwillingly in the past and have therefore known it to be possible. Having abstained for 1 day, the addict renews this short achievable contract on a daily basis. If a
day is too long, the promise of an even shorter time span without drugs (say 5-10 minutes at a time), can prevent the first resumption of drug use that signals relapse. This strategy focuses the addict's attention on the immediate problem of not taking drugs and undermines the practised excuses and rationalisation for drug taking offered by experienced addicts. In addition, attainable and attained objectives are immediately rewarding and, therefore, reinforce the desired behaviour.

The strong spiritual component of NA may be off-putting to some potential members, but the assertion that divine help is always available is necessary to counterbalance the admission, in the first of the Twelve Steps, that 'one is powerless over one's addiction'. Those who are willing to 'try' NA should be advised and encouraged to go to as many meetings as possible and even to attend the meetings of more than one group. Time spent at NA is time spent in a drug-free environment, away from all the secondary reinforcers of a drug-taking life-style, and is positively therapeutic in its own right. 9

Family Anonymous

Family's Anonymous (FA) is an organisation allied to Narcotics Anonymous (NA) and aims to help the relatives of drug-dependent individuals. FA meetings, like NA meetings, are based on openness and honesty and provide an opportunity for the families of drug abusers to meet others in the same situation as themselves and to share experiences which may never previously have been divulged. These meetings offer social acceptance and, for many families, a relief from social isolation, and the accumulated experience of the members means that they are able to offer constructive advice and help in dealing with particular situations and problems.

Attending FA meetings can help to heal the emotional damage inflicted on the families of drug-abusing individuals and in some relationships this may be crucial to the success of attempts at drug abstinence. For example, some family members may become accustomed to a particular role, which they may be reluctant to relinquish when the drug taker becomes abstinent, and they may unconsciously sabotage any hope of recovery. FA helps its members to be aware of the changes that occur within the family and to understand their own responses and, in this way, may make a very positive contribution, albeit indirectly, to the recovery of the drug-
dependent individual. Members of the family of drug addicts may attend FA meetings even if the drug abuser is not attending NA.

**Supportive Groups**

In addition to self help groups and groups that are conducted according to group analytical principles, there are a number of other groups, primarily supportive in nature, for drug abusers with particular needs. They differ from SHGs in being organised and run by a 'professional', but otherwise offer a similar, caring and non-critical environment. For example, there are an increasing number of drug-dependent individuals who are parents, and they and their children have special needs, which can be catered for – to a certain extent –, in an informal group setting. This facilitates mutual support between the members by providing them with a time and a place to meet. They can chat about general childcare matters and other topics, exchange and share baby clothes and equipment, and children can play with toys provided for the occasion. Clearly, this resembles the ordinary 'Mother and Toddler' playgroup meetings which are attended by many new parents and which provide them with much needed support. Drug-abusing parent need this support too – and perhaps more than those who do not abuse drugs – but may be reluctant to attend an ‘ordinary’ playgroup because of anxiety about their drug problem. Thus, a ‘family group’ may fill a
void in their lives and relieve their very serious problem of social isolation. This in turn may have a beneficial effect on other areas of their lives, including their drug taking.

A supportive group may also be helpful to those who have just come off drugs and who are still at risk of resuming drug use. Those who are near the end of a detoxification programme may also attend this group, and the example of those who have successfully become abstinent acts as an example and encouragement for them.

Groups such as these are frequently organised as part of the total programme of services of a drug-dependence treatment clinic. In addition, they are often organised by voluntary agencies as one component of a community-response to local drug-abuse problem.

The Minnesota Method

The Minnesota Method integrates many of the treatment approaches described in this chapter into a programme that is tailored according to individual needs. It involves a multidisciplinary team that includes doctors, nurses, social workers, counsellors, psychologists, etc. who can provide a wide range of professional services. Treatment may be as an out-patient or as an in-patient and begins with a thorough assessment and detoxification
if necessary. An individual treatment plan is then developed. In patient treatment, when deemed appropriate, lasts for 4-6 weeks. There are regular individual counselling sessions and group therapy twice daily. There is an education programme for patients with lectures giving advice about ways of achieving recovery, and organised exercise and relaxation sessions which improve general mental and physical health, as well as providing opportunities for social interaction. Families are also involved through family therapy or family counselling.

Perhaps, the unique feature of the Minnesota Method, if there is one, is the integration into the individual treatment programme of the NA philosophy. Patients participate in NA self help groups while in the primary stage of treatment, and continue to do so when shifted to after-care. Because, many patients find the idea of God and divine intervention in their recovery off-putting, the spiritual component of the philosophy is stressed rather than the religious component. The 'Higher Power' can be interpreted as the collective power of the whole group so that it is to the care of the group, rather than to God, that the patient surrenders his/her will and life. 10

10. Ibid, PP. 203-205
After a period of in-patient treatment, some patients may be discharged but continue to attend NA meetings. Others may require several months in a more structured environment such as a hostel where counselling and group therapy can continue, and where integration into the wider community can be achieved gradually while involvement with the local NA group is developing. Making attendance at NA a regular component of the treatment programme right from the beginning, perhaps increases the likelihood of long-term involvement, which in turn may be a significant factor in the reported success of the Minnesota method.

**Crisis intervention**

Crisis intervention provides a humane response at a time of great need. It is unlikely to have much rehabilitative value unless the staff succeeds in referring the drug abuser onwards to a long-term programme. In so doing, crises intervention proves its value as an acceptable entry point into treatment for many people who would otherwise not be helped. Nurses and social workers usually staff crisis intervention centres with a doctor on call for medical emergencies. They offer temporary shelter and social support to drug abusers at times of crisis, when it is hoped that they will be more receptive to help and more motivated to tackle their drug problem.
A crises intervention centre is a particularly useful facility for those who abuse barbiturates and other sedative hypnotic who arrive at hospital accident and emergency departments in a state of chronic intoxication. They cannot be discharged in this condition, but they are unwelcome patients on any conventional medical ward because their aggressive behaviour is often very disruptive. If they are referred and taken to a crisis intervention centre, their detoxification can be supervised by trained personnel, and when they are sufficiently recovered, the process of counselling can begin. Primary health care can also be offered to drug abusers who are unable to obtain it (or unwilling to seek it) elsewhere.

In-Patient Care

This is a residential treatment programme based on therapeutic community principle. This programme seeks to achieve a major behavioural and psychological re-orientation of the patient. The patient requiring in-patient treatment receives a full medical examination and is placed on a detoxification regimen if necessary. In order to assist the newly admitted patient to understand the programme, there is an introductory and orientation session explaining the structure of the programme and the patient's responsibilities and rights while in treatment.
A patient may be admitted for in-patient care for a variety of reasons:

1. For assessment of the state of dependence.
2. For stabilisation on opiates.
3. For stabilisation and subsequent detoxification of opiates, barbiturates, benzodiazepines or other sedative hypnotic.
4. For detoxification of alcohol complicating drug dependency.
5. For treatment of the secondary complications of drug abuse, e.g. abscesses, hepatitis, septicaemia, HIV infection etc.
6. For the general sorting out of the chaos that severe dependence on drugs can cause.
7. Assessment of mental state.

A multipurpose drug dependence in-patient unit is therefore likely to have, at any one time, patients with a wide range of problems and especially those who present a number of different and often difficult problems of management. It is fair to say that this is not an 'easy' group of patients. Although they come into hospital voluntarily (drug abuse and drug dependence do not constitute grounds for compulsory admission), they do not always comply with the prescribed treatment regime and may often go to extraordinary lengths to obtain extra drugs. This apparently wilful behaviour should be recognised as a manifestation of the severity of their dependence and, indeed, as a group, they are usually the most
severely dependent, many with a past history of failed attempts at detoxification. Some have still other conditions that make their drug-dependence more difficult to manage (e.g. pregnancy, psychosis, brain damage), and many have severe disorders of personality. However, the difficulties should not be exaggerated. Many patients are well motivated to comply with the treatment regime and successfully complete the detoxification schedule for which they were admitted.

Ideally, the in-patient unit provides a structured and therapeutic environment in which specific and general treatment interventions can be implemented. A variety of activities should be organised on a regular basis to form a well-balanced timetable of events in which the patients are expected to participate. These include various group sessions, some of which may be conducted on group analytical lines while others deal with the problems and difficulties associated with drug dependency.

The latter are primarily supportive, rather like self-help group, and may tackle issues such as the problem people have in relating to others, their attitudes, behaviour and responsibilities. Specialist speakers may be invited to talk about topics of special concern such as AIDS, rehabilitation units, etc. There may also be a range of
activities aimed at improving the patient's general health with sessions or classes in physiotherapy, relaxation, yoga, keep fit, routines, etc. Recreational activities may be organised including different sports, games and arts and crafts. It is hoped that patients in hospital, in this therapeutic environment, will start developing a way of life and a daily routine that is not centred on drugs and drug taking, and which they find more fulfilling. It would be naïve; however, to pretend that it is easy to bring about these changes in life-style and underlying attitudes.

The first essential requirement is obviously that the ward should be drug-free except for medically prescribed drugs. To this end, an inpatient unit for drug abusers is usually a locked ward; patients are only allowed to leave if escorted, and visitors are restricted to a few named and trustworthy individuals for each patient. If drugs are still smuggled in, it may be necessary for all gifts to patients to be inspected by the nursing staff, and for gifts of food to be restricted to unopened cans and packets. These measures seem, and indeed are, draconian. They have to be enforced because if just one person succeeds in introducing illicit drugs to the unit, the temptation to share them may prove too great for other patients whose treatment regime is therefore sabotaged. Before admission, patients may be
asked to sign a contract indicating that they understand the rules of the ward and agree to comply with them. 

Failure to keep the rules usually means that the patient will be discharged, but this apparently straightforward consequence may be difficult to implement in every case. Sometimes, there is no definite evidence that illicit drugs have been consumed - merely a strong suspicion on the part of the nursing staff. Confirmation of drug taking by a positive urine test may take so long that the result is irrelevant and discharge merely punitive, if in the interim period the patient has not taken illicit drugs and has participated fully in the treatment programme. In addition, there may be over-riding medical reasons for not immediately discharging an in-patient who has been abusing illicit drugs - if, for example, the patient is pregnant, or severely ill or in the middle of a barbiturate detoxification regime.

Aggressive behaviour is another problem that requires careful and sensitive management. It is not, of course, confined to drug-dependence treatment units, but is perhaps more likely to occur

there than on some other wards because of the high incidence of 'personality disorder' among drug-dependent in-patients, and sometimes because of intoxication with drugs. Undoubtedly, many patients find it difficult to tolerate the environment of a closed ward particularly if they cannot resort to drug taking, as they would undoubtedly like to. They may express their frustration by verbal and / or physical aggression. It is to be hoped that the professional skills and expertise of the staff minimise the risk of this, but patients should understand, before they are admitted, that violent or aggressive behaviour will not be tolerated. If it arises, the patients concerned may incur loss of privileges and visiting rights, or may be discharged immediately. On some occasions, however, even if there are good reasons to discharge a violent patient, there may be overwhelming medical reasons for not doing so.

WHAT IS AFTER-CARE?

After-care includes the package of services provided to the patients after successful discharge from the programme. After care activities can be viewed as the first line of defense against return to drug use. Management of chemical dependency is a complex issue, which has to be handled by professionals specialised in various disciplines. These specialists work together in the common task of treating and
rehabilitating the dependent. Addiction treatment goes through three distinctly defined phases.

**Detoxification**

Detoxification, a process supervised by medical professionals, aims at withdrawing the person safely from physiological drug dependence.

**Primary Treatment**

This includes a gamut of rehabilitation efforts through individual, group and family therapy, and can be a residential or an outpatient programme. Primary treatment aims at total abstinence from mood-altering drugs. It emphasises the need for a qualitative change in the life-style of the patient.

**After-care Services**

After-care includes any service offered to the patient after the goals of primary treatment have been largely met in order to help him to continue his sobriety. The package would be, follow-up counselling, self-help though Alcoholics anonymous (AA) and Narcotics Anonymous (NA), referral adjunctive services like vocational counselling, After-care centres of Halfway homes. After-care services reinforce the need to make positive life-style changes.
The Need for After-care Services

Recovery is not just the cessation of drug use; it also demands adjustment to a new way of life work. The chemically dependent has to rebuild each and every area of his/her life – family relationship, employment, finances, education etc. These activities can also impose new stresses and therefore require new coping skills.

Recovering patients need hope and determination in the phase of change. To make a truly new way of life, chemical dependants need much more than grit – they must have guidance to acquire new skills and make new contacts for total recovery.

Following are a few problems they must learn to handle.

There is the crucial issue of relapse. Relapse can be painful and can confuse the patient, his family and friends.

- Getting back to the same environment may pose a threat to sobriety.

- The negative emotions, which the patient experiences, lead to problems in recovery. Therefore, feelings of ‘Guilt’, ‘Shame’, ‘Hurt’, ‘Anger’ and ‘Grief’ have to be resolved.

- The recovering person may have to handle high-risk situations and therefore has to learn to say ‘NO’ to drugs.

- He must also learn to respond safely to stress.
- Patients have to relearn new ways of life and start rebuilding their values.
- Recovering persons have to learn to lead a fulfilling life without resorting to chemicals.

The patient should establish spiritual recovery by coming to believe in a 'Power' greater than himself/herself which can give strength and confidence to manage the variety of challenges one is likely to face.
- Also the family may find it difficult for sometime to accept the person back into its system.
- Hence, the family has to be helped to recover. 12

Goals of After-care Services

To manage the challenges, the after-care services have certain specific goals. Researchers have suggested four reasonable goals for after-care services.

1. After-care should increase family and other social support for successful living in the community without dependence on drugs and should seek to eliminate patterns of interaction with family and peers that contribute to relapses. In short, after-care should seek to develop or enhance social supports in the community.

2. After-care should seek to increase involvement in productive roles in the community, whether in work, school or at home.

3. After-care should facilitate the person's involvement in active recreational and leisure activities that do not involve the use of drugs.

4. After-care should assist the patient to recognise his negative emotions and deal with them appropriately.

**Process in After-care Services**

The process, by which change occurs in the recovering chemical dependent, begins with providing the patient with a drug-free environment, which will help in his recovery. At the first instance, the patient seeks to replace his dependency on drugs with dependency on the After-care Centre. This can later on be shifted to make the patient depend on himself. Ultimately, the after-care programme aims at returning the patient to the community as a competent, functional, more or less independence person.
**Policy to Deal with Relapses**

1. Patients are not allowed to use alcohol / drugs in the premises.

2. When patients return from an outing, they will be searched for possession of alcohol / drugs each time they enter the premises.

3. If a patient has used chemicals in the premises or returned after an outing under the influence of chemicals, he will not be allowed to stay inside.

4. Patients who are under the influence of chemicals will be sent immediately for detoxification. (It is useful to have a liaison with a local detoxification facility / unit.)

5. If a patient has had one relapse during his stay in the centre, he is given a warning and subsequently his out -passes will be curtailed for 15 days. If the patient continues to use / possess drugs / alcohol, he will be discharged from the centre.

6. Any other patient who is found to be involved / helping in malpractice or being aware, does not disclose it, will also have to face similar consequences.

7. During the patient’s stay, the staff retains the right to check the patient’s self or belonging periodically.
CONCLUSIONS

It is extremely important to remember one vital fact: a drug addict or an alcoholic is never cured. Stopping drugs is only the first step towards recovery. One will need the maintenance help of continued NA or AA meetings to stay off drugs. It is rather like having diabetes. Diabetes is an illness from which people can recover quite simply – by taking insulin. But if they stop taking their insulin, they relapse back into the active phase of the illness, Insulin helps them recover from diabetes, but it is not a once-for-all cure. In the same way, Narcotics Anonymous will help addicts to recover from their addiction, but it is not a once-for-all cure. If they are attending NA or AA, they may find that it is all they need to do. Many addicts have recovered from chemical dependence in this way without needing any further help. However, it is possible that they may need professional help at the time when they are stopping drugs. This is because once the drug-dependence has been experienced in ones life, the potential propensity to go back to the same state continues to lurk in the psycho-physiological system and has to be watched constantly and regularly.