Addiction treatment

Treatment, myths and misconceptions about addiction are discussed.

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Addiction is not well understood. There are a number of important questions that still need to be answered scientifically if we are to make any inroads in addressing this important public health problem:

- Why does addiction continue despite the serious negative and sometimes catastrophic consequences for the person with the disorder?
- Why is addiction sometimes so resistant to treatment?
- Why is relapse so common that some even consider it a defining feature of addiction?
- Why does addiction so frequently co-occur with other psychiatric disorders?

Efforts to answer these and other questions have typically tried to identify a singular mechanism responsible for addiction. Although most approaches are successful to varying degrees in accounting in part for a restricted set of phenomena related to addiction, they provide neither a comprehensive understanding of addiction nor have they resulted in treatments that are ubiquitously successful and produce lasting change. Perhaps the singular process approach has had such limited success because addiction is a complex, multi-component phenomenon.

Addiction treatment is often described as 'rehab'. Indeed, a current popular song by yet another UK miscreant lists the reasons why she 'don't want to go to rehab'. Implicit in the description of addiction treatment as rehab is the notion of failure. People with addictive disorders have failed themselves and society and therefore need to be rehabilitated. It is reminiscent of the Gulag, where people with ideological failure required political rehabilitation. Addiction treatment needs to be described for what it is, namely the treatment of a diagnosable entity, but therein lies the crunch. As we step gingerly into the 21st century, there remains no consensus as to what defines, constitutes or causes addictive behaviour.

In the absence of a universally accepted model of understanding of addiction, the area of treatment remains equally ill defined. This ranges from the faith-based treatment centres who, when asked to produce their treatment manual, will show you a Bible, to the more sombre disease model theorists who resort to a traditional biological model of understanding as the basis of intervention, to the mutual help 12-step programmes that sometimes proclaim a monopoly over the intervention process with a fundamentalist zeal. A broad body of experts sees addictions as arising from psychosocial variables in a person's environment, which would necessitate interventions at that level. So where does the truth lie, and what is the practitioner faced with a distraught addict and family in his consulting room to do?

The addiction treatment field today has two intrinsic shortcomings that make it very vulnerable to exploitation by anybody with an entrepreneurial edge and a smattering of knowledge about the problem. Firstly, the paucity of scientific knowledge about the condition means that charlatans and snake oil salesmen can have a field day; secondly, a patient population, very often with a degree of desperation, leaves people open to exploitation. We have seen the growth of a treatment industry in this country over the past 5 years that parallels the growth of a fast-food chain.

The Department of Social Development has attempted to correct this situation. In an attempt to introduce benchmark norms and standards, the Department took the Noupoort Treatment Centre, a faith-based facility, to court. Noupoort won, effectively establishing the principle that a facility with an infrastructure, a programme and accountability to a Board of Trustees could register as a treatment centre. While this inclusive approach is to be lauded, the Department seems relatively disinterested in the content of the programmes, and the registration of a facility is now virtually available on request.

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To a certain extent this has defeated the purpose of the exercise and has merely resulted in a register of facilities with no real scrutiny of norms and standards. The net effect is that facilities receiving departmental approval are now able to apply for a BHF registration, which allows them to access medical aid funding for services rendered. This in itself is not a problem but it does mean that those facilities that provide a more formidable professional service are remunerated at a similar rate to the more fragile facilities. The health insurance industry is delighted, as competition between various facilities irrespective of quality of care they provide, will help keep the price of treatment interventions down. However, it does leave the profitability and viability of the more orthodox treatment centres at risk, and they now often seek improved income streams by sourcing patients from abroad. This effectively subsidises local patients whose treatment intervention is remunerated by discounted medical aid rates.

South Africa is definitely a proud frontrunner, in that the 1998 amendments to the Medical Schemes Act mandated addiction treatment and most medical aids now fund treatment. The Council for Medical Schemes needs to be acknow-ledged for this progressive legislation, which effectively identifies addiction as a condition warranting treatment.

Overseas patients

The growth of the overseas addiction treatment referral industry has been an interesting phenomenon in South Africa over the past 5 years. While this phenomenon has not been confined to addiction treatment and now ranges from infertility procedures to cosmetic surgery, South Africa has become a target destination for addiction treatment for patients from overseas. Besides the obvious advantage of a favourable exchange rate that makes treatment much more affordable in this country, the steady stream of patients from abroad is equally a compliment to the quality of care provided by South African treatment centres.

An interesting addendum in recent times has been the emergence of overseas-based treatment referral agencies that have piggy-backed themselves onto the local treatment system. While the enterprise can been very profitable for all parties engaged in the business, the trans-national nature leaves many unanswered areas, including medicolegal accountability, undefined professional responsibility (especially when things go wrong) and, sadly, a concentration of the best South African treatment talent focused on foreign nationals.

Myths

Three myths persist around addiction treatment. The first is that addicts never get better irrespective of the intervention. All addicts are doomed to relapse sooner or later and treatment is rarely successful. While the prognosis for an addictive disorder is often very guarded, this myth raises the question of what constitutes a successfully treated addict. Is lifelong abstinence, one day at a time, the only measure of success, as many of the 12-step fellowships would have us believe, or is a post-treatment *pro rata* reduction in substance use in a less hazardous fashion also reflective of a successful treatment intervention? What role does quality of life play in assessing treatment outcomes, for abstinence does not necessarily imply contentment with life. Traditionally, abstinence has been a golden yardstick of success but in a condition characterised by relapse, is it fair to regard a return to active use as a sign of treatment failure? Often the quantum of treatment is determined by factors unrelated to the gravity of the condition.

The second myth about addiction treatment is that nothing ever works, in the sense that irrespective of the intervention, addicts get better when they choose to get better. Until that moment arrives, all attempts are in vain and doomed to failure. While it is true that the decision to address an addiction begins with a choice, treatment interventions at their most elementary aim to facilitate that choice by identifying and deconstructing the obstacles that prevent the choice. In truth, recovery from addiction is neither rocket science nor a miracle.

Successful addiction treatment has three objectives. Firstly, it will identify and remove the obstacles that prevent acceptance of the condition by removing the multiple rationalisations that surround the behaviour. Secondly, it will provide the addict with a working understanding of the condition such that abstinence becomes a meaningful exercise and, thirdly, it will help the patient find a sustainable commitment to the choice of sobriety and recovery. Very often, each treatment intervention simply moves the patient closer to making the decision and if that is achieved, the intervention may be regarded as successful. Most heroin addicts, for example, will require at least three treatment interventions. People come in to treatment with differing degrees of motivation. Most have been painted into a corner in one way or another and come in to treatment to sustain their addiction, not to address it.

By the same token, there are people who can achieve sobriety and an understanding of their own recovery without the inconvenience of a treatment programme. However, making sense of an addictive disorder on one's own without the benefit of a third-party intrusion in the form of treatment intervention is an arduous task. Addictive thinking always factors itself subconsciously into the conversation in a subtle way. Addiction treatment is a prolonged conversation with a person whereby mistaken beliefs are identified, cognitions are revisited and a narrative is rewritten. Although recovering from an addiction at times appears miraculous, it is not a miracle. The event does not require patients to do something extraordinary, but simply to choose, for their own safety, to refrain from substance use and other addictive behaviours one day at a time.

The third myth about addiction treatment that many facilities parade loudly is that their treatment modality is superior to that of another. While this has never been proven, the truth is that most psychosocial interventions have more or less the same outcomes. Therefore, the patient's needs and resources rather than the treatment centre's claims of excellence very often determine the selection of a treatment programme for a particular patient. Ironically, in a complex and thorough meta-analysis of the alcohol treatment outcome literature published in 1995, Miller *et al.* showed that the brief intervention, which is a category of intervention, could be cost effective and successful for people with problems of an earlier or less severe quality.

Where does this leave the practitioner faced with an addiction problem in his consulting room? Addiction treatment is about a conversation with the patient in an attempt to revise his cognitions and encourage a choice to engage in less self-destructive behaviours. In patients unable to resolve this conflict themselves, I would strongly recommend referral to a treatment facility where a more intense dialogue may help resolution of the variables. Like all malignant conditions, early intervention presages a more favourable prognosis.

In a nutshell

- Addictive behaviour raises many unanswered questions.
- There is little consensus about most issues related to the treatment of addictive disorders.
- Intervention and treatment services are vulnerable to exploitation.
- Attempts to introduce norms and standards have been made by the regulatory authority, with limited success.
- The growth of an overseas referral base has re-defined the local, private sector treatment industry.
- Addiction treatment is prejudiced by much detrimental mythology.