THE TREATMENT OF DRUG ABUSE IN CAPE TOWN

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ABSTRACT

Three questions concerning drug use and its treatment in Cape Town are posed in an attempt to guide planning of the treatment system. Firstly, is drug use in Cape Town of a problematic nature and magnitude? An affirmative conclusion is reached here by analysis of relevant local studies but is rendered tentative by inadequacies of the data. Secondly, are the relevant professional medical-psychological treatment facilities able to meet the treatment needs of all drug abusers in Cape Town? Analysis of the treatment system by means of a questionnaire produced a negative conclusion which was necessarily tentative. Thirdly, what directions should future expansion or modification take in order that cost-effectiveness be maximised? Three areas were investigated by review of the literature - should psychotherapy be included in drug abuse treatment? Can drug abusers be effectively treated alongside other psychiatric patients? Can drug abusers be effectively treated as outpatients? Affirmative conclusions were reached in each case. Suggestions are made for accurate "matching" of patients to in- or outpatient treatment situations.

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CHAPTER ONE

INTRODUCTION AND CLARIFICATION OF TERMS

1.1 Rationale and aims

Concern over illicit drug use in Cape Town resulted in the formation of the Drug Action Committee in 1983. This body unites professional and lay members from various walks of life in a common conviction that drug use in Cape Town constitutes a problem and in a concern that this be effectively dealt with in both preventative and treatment modes (Rabinowitz 1983). This committee is thus based on a number of assumptions - firstly, that drug use in Cape Town is problematic (and that it therefore demands a treatment response); secondly, that existing services fail to treat drug use adequately.

These assumptions give rise to the following questions which form the basis of this thesis:

(a) Does drug use indeed constitute a problem in Cape Town?

(b) Are existing treatment facilities indeed adequate in dealing with the problem?

If, in the process of discussion, the assumptions of the Drug Action Committee are validated, a further question, (c), arises - what plans should be made for improving the effectiveness of the treatment system?

This thesis aims to provide some answers to the above questions in order that any action proposed or taken by a body such as the Drug Action Committee be informed by an accurate assessment of local needs and by relevant clinical and empirical research.

1.2 Outline of discussion

Discussion is based on the three questions posed above and proceeds as follows. Question (a) raises the issue of whether drug use constitutes a problem in Cape Town. This demands an elucidation of the social and individual factors which cause drug use to be labelled drug abuse as well as an investigation into the extent and nature of drug use in Cape Town. These points are discussed in Chapter One and Two of this thesis. Chapter Three proceeds with an analysis of Cape Town's drug abuse treatment system, following question (b) above. The relative adequacy of this system is assessed in relation to the extent and nature of drug abuse in the city.

Chapters Two and Three, then, in analysing drug use in Cape Town and the related adequacy of the treatment system, form Section One of this thesis. If the existence of problematic drug use is not established and if the treatment system proves adequate further chapters providing suggestions for expansion and improvement of the treatment system will be unnecessary. However, in the event that drug use is established as problematic in some respects at least and that the treatment system, as is expected, is found to possess weaknesses as well as strengths, Section Two will proceed with an analysis of three issues

important in any planned expansion of the system. These issues, which arise out of Section One's discussion, are as follows - should psychotherapy be included in drug abuse treatment (Chapter Four); should drug abusers be treated in separate, specialised centres (Chapter Five); should inpatient or outpatient centres be favoured in plans for expansion (Chapter Six)? The aim in this section is to provide guidelines for future expansion in order that a cost-effective drug treatment system relevant to the needs in Cape Town might be established.

Section Three provides guidelines for maximization of cost-effectiveness in the existing treatment system. This is achieved, specifically, by suggesting strategies for accurate matching of individual patients to the most appropriate treatment situation (that is, inpatient or outpatient treatment).

The present introductory chapter now proceeds to clarify some of the procedures and terms used throughout this thesis.

1.3 Scope of the literature reviewed

Throughout discussion of the above issues literature regarding three groups of patients is used - general psychiatric patients, alcoholics and users of other drugs. Conclusions reached in studies of general psychiatric and alcoholic patients cannot merely be accepted as automatically applicable to other drug users. However, such studies are useful in this discussion in that they provide a widely-researched background against which to evaluate the relatively recent and scanty drug abuse

literature. Thus literature pertaining to general psychiatric and alcoholic patients often lends support to tentative conclusions reached regarding treatment of drug use and allows one to weigh the evidence for and against a particular position.

The issue of the degree of similarity or difference between general psychiatric patients, alcoholics and other-drug users as regards treatment is more fully discussed in Chapter Five. It is sufficient merely to mention here that McLellan et al (1980), in one of the key articles used in this thesis, states that the traditional alcoholic-drug user dichotomy is oversimplified, is not systematically related to treatment outcome and does not correspond with actual patterns of abuse.

Furthermore, many of the conclusions reached in this review regarding outpatient psychotherapeutic treatment of drug users concur with those reached in studies of alcoholics and other psychiatric patient populations.

It is suggested, then, that studies of general psychiatric and alcoholic patients can be usefully quoted in this thesis. The reader's attention will always be drawn to the particular patient group studied, however.

It is not possible within the scope of this thesis to present a comprehensive review of the relevant literature. Instead, the most important, relevant and methodologically sophisticated studies will be selected for discussion.

1.4 Clarification of basic terms and concepts

This section aims to clarify some of the terms and concepts which are central to continued discussion in the area of drug use and its treatment. Less fundamental terms will be clarified at appropriate points in later chapters.

1.4.1 Drugs, drug use and drug abuse

A drug is sometimes described in terms too broad to be helpful. For example, the World Health Organisation (WHO) Expert Committee of 1969 defined a drug as "any substance that, when taken into the living organism may modify one or more of its functions". Such definitions specify neither the nature of the substance (food substances are not excluded) nor of the functions modified. This study focusses on drugs taken for their psychoactive or "mind-altering" properties and for the purposes of this study, Dawes' (1979) definition will be used:

> "A drug...is seen as a pharmacological agent, which through oral, nasal or intravenous ingestion, contributes towards the alteration of the state of affect, observed behaviour and perceptual experience of the individual. The three aspects of functioning noted above may occur singly or in various combinations (p.10)".

The definition given above includes no value judgement - drugs are not defined as being intrinsically dangerous and their use is not automatically abuse. The most obvious example of this nonpathological substance use is the use of drugs as

prescribed and supervised by a competent medical practitioner. This medical use of drugs is generally accepted as beneficial (Dawes 1979). Furthermore, certain types of non-medical drug use may also be regarded as non-pathological when used in a specific manner and amount in a given society. Thus the Third Edition of the Diagnostic and Statistical Manual of Diseases (American Psychiatric Association 1980) notes that:

> "In our (Western) society, use of certain substances to modify mood or behaviour under certain circumstances is generally regarded as normal and appropriate. Such use includes recreational drinking of alcohol...and the use of caffeine as a stimulant in the form of coffee. On the other hand, there are wide subcultural variations. In some groups even the recreational use of alcohol is frowned upon while in other groups the use of various illegal substances for recreational purposes is widely accepted" (p.163, brackets mine).

Drug use, then, is not synonymous with drug abuse - it is clear that a definition of drug abuse must carefully specify the circumstances under which this label may be applied. Such specification is of central importance to continued discussion here since in its absence any analysis of the existence and need for treatment of drug abuse in Cape Town lacks a clearly defined conceptual foundation. The following discussion seeks to provide an understanding of what is meant by the term drug abuse in this thesis.

Some theorists have stressed the role of society in determining the adaptive or maladaptive status of drug use. Dawes (1979), dealing with the issue of how society comes to define certain situations as problematic, notes that:

> "The notion of a social problem has its base in a system of morality which comes to define certain phenomena as being functional or dysfunctional in terms of prevailing values. Social problems are potentially disruptive to a particular social order" (p.4).

Dawes (1979) suggests a number of reasons for western society's labelling of certain drug use as maladaptive (p.14). These include cultural resistance to the altered state of consciousness induced by drug use because of their association with the irrational, the unpredictable and the abnormal (after Mogar 1965, Weil 1975). Dawes notes that these correlates have, in western society, traditionally been devalued and treated with suspicion. Different cultures, however, place different values on these functions and some recognise an adaptive function in the irrationality induced by drug use (Dawes 1979).

According to this argument then, societies which repudiate certain types of drug use and label it problematic do so because the perceived effects of that drug use run counter to the prevailing moral order. If a large group of people become unpredictable, irrational and thus less open to social

influence (Leifer 1972, in Dawes 1979) society is threatened and responds by applying a problem label and by entrusting certain bodies or disciplines with responsibility for researching and ameliorating the problem.

Some psychiatrically-oriented theorists have, in contrast to the above, stressed the importance of individually-based factors in the attribution of drug abuse status. This is illustrated by the criteria laid down in the Third Edition of the Diagnostic and Statistical Manual of Diseases (American Psychiatric Association 1980) for a diagnosis of drug abuse or dependence. These criteria are reproduced below as they provide the basis for the use of these terms in this thesis.

Substance Abuse

Three criteria distinguish nonpathological substance use from Substance Abuse.

A pattern of pathological use: Depending upon the substance, this may be manifested by: intoxication throughout the day, inability to cut down or stop use, repeated efforts to control use through periods of temporary abstinence or restriction of use to certain times of the day, continuation of substance use despite a serious physical disorder that the individual knows is exacerbated by use of the substance, need for daily use of the substance for adequate functioning, and episodes of a complication of the substance intoxication (e.g. alcoholic blackouts, opioid overdose).

Impairment in social or occupational functioning caused by the pattern of pathological use: Social relations can be disturbed by the individual's failure to meet important obligations to friends and family, by display of erratic and impulsive behavior, and by inappropriate expression of aggressive feelings. The individual may have legal difficulties because of complications of the intoxicated state (e.g. car accidents) or because of criminal behavior to obtain money to purchase the substance. (However, legal difficulties due to possession, purchase, or sale of illegal substances are highly dependent on local customs and laws, and change over time. For this reason, such legal difficulty on a single occasion would not be considered in the evaluation of impairment in social functioning for diagnostic purposes).

Occupational functioning can deteriorate if the individual misses work or school, or is unable to function effectively because of being intoxicated. When impairment is severe, the individual's life can become totally dominated by use of the substance, with marked deterioration in physical and psychological functioning. Incapacitation is more frequently associated with chronic Opioid and Alcohol Dependence than with dependence on other substances.

Frequently individuals who develop Substance Use Disorders also have pre-existing Personality Disorders and Affective Disorders with concomitant impairment in social and occupational functioning. It is, therefore, necessary to determine that the social or occupational impairment associated with the diagnosis of Substance Abuse or Dependence is actually due to the use of the

substance. The best clue is a change in functioning that accompanies the onset of a pathological pattern of substance use, or the development of physiological dependence.

Duration: Abuse as used in this manual requires that the disturbance last at least one month. Signs of this disturbance need not be present continuously throughout the month, but should be sufficiently frequent for a pattern of pathological use causing interference with social or occupational functioning to be apparent. For example, several episodes of binge drinking causing family arguments during a one-month period would be sufficient even though between binges the individual's functioning was apparently not impaired.

Isolated instances of pathological use of a substance can be adequately diagnosed by noting the specific Organic Brain Syndromes that were associated with this use. For example, a history of one or more instances of maladaptive use of alcohol over a three-week period may be noted as prior episodes of Alcohol Intoxication.

Substance Dependence

Substance Dependence generally is a more severe form of Substance Use Disorder than Substance Abuse and requires physiological dependence, evidenced by either tolerance or withdrawal. Almost invariably there is also a pattern of pathological use that causes impairment in social or occupational functioning, although in rare cases the manifestations of the disorder are limited to physiological dependence. An example

would be an individual's inadvertently becoming physiologically dependent on an analgesic opioid given to him by a physician for the relief of physical pain.

The diagnosis of all of the Substance Dependence categories requires only evidence of tolerance or withdrawal, except for Alcohol and Cannabis Dependence, which in addition require evidence of social or occupational impairment from use of the substance or a pattern of pathological substance use.

Tolerance: Tolerance means that markedly increased amounts of the substance are required to achieve the desired effect or there is a markedly diminished effect with regular use of the same dose. When the substance used is illegal and mixed with various dilutents or with other substances, tolerance may be difficult to determine. In the case of alcohol, it should be noted that there are wide individual variations in the capacity to drink large quantities of alcohol without intoxication. Since some persons have the capacity to drink large amounts despite limited drinking experience, the distinguishing feature of tolerance is that the individual reports that the amount of alcohol he or she can drink before showing signs of intoxication has increased markedly over time.

Withdrawal: In withdrawal, a substance-specific syndrome follows cessation of or reduction in intake of a substance that was previously regularly used by the individual to induce a physiological state of intoxication. See Withdrawal as an Organic Brain Syndrome, p.122.

Many heavy coffee drinkers are physiologically dependent on caffeine and exhibit both tolerance and withdrawal. However, since such use generally does not cause distress or social or occupational impairment, and since few if any of these individuals have difficulty switching to decaffeinated coffee or coffee substitutes, the condition does not appear to be of clinical significance. Therefore, caffeine dependence is not included in this classification of mental disorders. In contrast, caffeine intoxication is often clinically significant, and therefore is included. (p.160).

This psychiatrically oriented diagnostic system implies that the presence of drug abuse and/or dependence can be objectively determined by investigation of factors specific to the individual even in the absence of social disapproval of that drug use. For the purposes of this thesis the attribution of problem status to drug use in an individual or in a group relies on an analysis of both social and individual psychiatric factors. Thus problematic drug use is judged to exist where the DSM III criteria for abuse and/or dependence exist in the context of a social group which repudiates that type or extent of drug use.

This definition demands clarification on at least three points. Firstly, how does one determine whether a particular group does in fact repudiate a certain type of drug use? The group manifests this repudiation by establishing bodies in religious, legal, medical - psychological and other fields to forbid, punish and treat drug use. It is important to note here that the community itself must establish or at least support such agencies. A group

whose drug use is forcibly curbed by authorities representing other politically powerful groups does not necessarily repudiate that drug use.

Secondly, clarification of what is meant here by a "social group" is necessary. Chapter Two of this thesis attempts to determine the presence or absence of a drug abuse problem in each of the four major population groups in Cape Town - namely, Black, White, Coloured (including Malay) and Asian groups. These population groups are then further subdivided into three socio-economic classes (working, middle and upper class). A social group here is therefore defined by population and socio-economic variables alone. This broad definition of the social groups in Cape Town may be problematic in that it conceals the variation in drug-use attitudes amongst various sub-cultural groups and accepts the legal categories as true divisions. However, it is not possible within the scope of this thesis to analyse the attitudes of each sub-group, hence the use of broad categorization.

Thirdly, the definition notes that the social group may disapprove of the type or extent of drug use practiced by an individual. Thus cannabis use for example, may be accepted in certain groups in so far as it conforms to societal norms (Du Toit 1980, Grinspoon 1971). However, the user who oversteps these bounds and becomes drug centred in his life-style usually incurs disapproval (Dawes 1979). It would seem that these socially-determined excessive use patterns may correspond to the DSM III criteria for

problem status. Thus social and psychiatric criteria of abuse converge at this point. For this reason, the DSM III criteria are felt to have wider applicability for present purposes and are used as the primary criteria by which drug abuse is recognised.

The terms drug abuse and dependence are used in this study rather than substance abuse and dependence since the former tends, in general usage at least, to imply substances other than alcohol thus being more applicable to this study. The general term drug abuse is used in this study in preference to dependence since many patients may not fall into the more severe category of dependence. Drug abuse as used here corresponds to the DSM III term "substance use disorder" but is more convenient for use.

1.4.2 Psychotherapy

This term, as used here, denotes formalized contact between a mental health professional and a patient where the aim of such contact is the alleviation of the patient's subjective distress by application of psychological (mainly verbal) techniques. The three broad types of psychotherapy described by Wolberg (1977) are included here.

a. Supportive therapy where the primary goal is to return the patient to a state of equilibrium and where the focus is removal of symptoms and strengthening of defences and control. This category includes guidance and advice, reassurance and environmental manipulation; medication and relaxation training are often used as adjuncts in supportive therapy.

b. Re-educative therapy where the therapist attempts to modify maladaptive attitudes and inappropriate goals by increasing the patient's awareness of maladaptive reactions and then modifying behaviour to allow for more flexibility and creativity. This category includes all types of behaviour therapy.

c. Reconstructive therapy where the therapeutic aim is the patient's achievement of insight into unconscious conflict in order that extensive changes might occur in character structure. Psychodynamic therapies are included here.

Psychotherapy, as used here, thus includes all forms of individual, group, family and marital therapy. Counselling which deals primarily with social, financial and legal problems is excluded.

1.4.3 Mental health professional

The terms psychotherapist, therapist, clinician and mental health professional are used interchangeably to denote a professionally trained person engaged in the administration of psychotherapy. Such an individual may be a clinical psychologist, psychiatric social worker, psychiatrist or psychiatric nursing sister.

1.4.4 Patient

The term patient is used in this thesis to refer to the drug abuser, alcoholic or psychiatrically disturbed person who presents for treatment. The use of patient, as opposed to client, does unfortunately connote a "sick" person in need of help - a connotation

which may often be unjustified since, as has been discussed, not all drug users are drug abusers. Nevertheless the term is used here for the sake of convenience and convention - it is the term generally used in the literature reviewed since issues of treatment of drug abuse are usually dealt with in a medical-psychological context.

1.4.5 Outpatient-inpatient treatment

Outpatient treatment for the purposes of this thesis, refers to an arrangement in which the patient regularly attends the treatment centre for relatively short periods of time (about one half to two hours) while residing in the community and maintaining relationships there. It is distinguished from inpatient treatment, where the patients reside at the treatment centre, and from day patient treatment, where the patient attends the treatment centre all day for a period of time while returning to the community at night. The frequency with which the patient attends the centre is dependent on the degree of need for intensive contact and may vary from daily contact in initial stages of therapy to six-monthly contact in the follow-up stage. Weekly or two-weekly contact in the main treatment phase is considered the norm for the purposes of this thesis.

Summary

This introductory chapter has sketched the rationale and outline of this study and has attempted to clarify some of the terms to be used. Definitions have been provided to standardize the meaning of terms used throughout this thesis. The DSM III has been established as providing a basis for definition and diagnosis of problematic drug use but the importance of the social context of such abuse has been emphasized.

SECTION ONE

DRUG USE AND ADEQUACY OF THE TREATMENT SYSTEM IN CAPE TOWN

Chapter Two: Drug use - international and local trends and figures.

Chapter Three: Drug abuse treatment facilities in Cape Town - how adequate are they?

CHAPTER TWO

DRUG USE - INTERNATIONAL AND LOCAL TRENDS AND FIGURES

2.1 International trends in drug use

- 2.1.1 Increased prevalence
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- 2.1.3 Use in non-traditional sub-groups of society
- 2.1.4 Decreasing age at first drug use
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- 2.2.1 Drug use amongst Black Capetonians
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2.3 Summary and comment

CHAPTER TWO

DRUG USE - INTERNATIONAL AND LOCAL TRENDS AND FIGURES

President Reagan, in launching the USA's National Strategy for Prevention of Drug Abuse and Drug Trafficking (1984), called drug abuse "one of the gravest problems facing us" and warned that if we fail to act, we are "running the risk of losing a great part of a whole generation" (p.3). These emotive words indicate that problem status is ascribed by a powerful group to drug use in the USA. Furthermore, many religious, legal and medical-psychological bodies throughout the Western world have become involved in "stemming the tide of drug abuse". It is important, in the face of this widespread acceptance of drug use as problematic, that the reasons for this be evaluated before any discussion of or recommendations for drug abuse treatment be initiated.

A society in transition has been said to be vulnerable to changes or intensification in its established patterns of drug use (Beckett 1974). These changes, according to Chapter One's discussion, arouse societal disapproval and concern (President Reagan's sentiments, for example). The following trends in drug use over the past 30 - 40 years have been described and are proposed here as the changes that may have contributed to this concern. They relate mainly to Western, industrialized societies (USA and the United Kingdom for example) as relevant literature is more readily available here. These trends are dealt with briefly since the aim is merely to set the scene for discussion of drug use in Cape Town.

2.1 International trends in drug use

2.1.1 Increased prevalence of drug use

Kramer and Cameron (1975) state that in the past 30 to 40 years there has been a perceived and actual increase in the number of people engaged in the non-medical use of psychoactive drugs. These authors attribute this, at least in part, to modern transport and communication systems which facilitate rapid and extensive contact between countries and people. World figures regarding the prevalence of drug usage are of limited usefulness here as the significance can be interpreted only in the context of local attitudes to drug use, predominant drugs of abuse and total population figures. Suffice it to say that studies have reported an increase in drug use in many countries. For example, in Britain the number of new heroin addicts doubled every 16 months between 1959 and 1966 (Bewley et al 1968; see also Bewley 1966, Fish 1974). Australia, once felt to be remarkably free of drug abuse problems, is also having to contend with a major drug problem (Rosenberg 1969).

An increased prevalence of drug abuse has also been apparent in the United States of America (see the National Commission on Marihuana and Drug Abuse 1973). Drug use in the USA spread rapidly in the 1960's and 1970's but the National Strategy for Prevention of Drug Abuse and Drug Trafficking (1984) states that the 1980's have seen a levelling of this increase. However, figures are still perceived to be high - 20 million Americans use marihuana at least once a month, over four million are cocaine users and over one half million are heroin users (National Strategy 1984).

2.1.2 Use in non-traditional geographic areas

Drug use increasingly occurs in societies outside traditional geographic areas of use. Thus cannabis, traditionally used in the Indo-Pakistan sub-continent, Africa, etc. is now also used in the Western Hemisphere and Europe (Kramer and Cameron 1975). Powerful first world countries (for example, the United Kingdom and the USA) now recognise drug use within their borders and engage in energetic research, treatment and eradication programmes which are facilitated by the economic wealth and technological sophistication available. The repudiation of drug use in these capitalist, wealthy nations may be the result of their perception of such use as violating the Protestant ethic of industriousness and resulting in decreased productivity, thus threatening the continued existence of a capitalist society (see Chapter One's discussion). Poorer countries, in contrast, may be less concerned about productivity since they may tolerate drug use as a panacea which facilitates acceptance of adverse conditions. In addition, such countries may not have the economic or technological resources to investigate the extent or effects of drug use within its borders.

2.1.3 Use in non-traditional sub-groups of society

Drugs are also now used by all strata of society where use was previously associated, correctly or incorrectly, with working class groups (Walker 1982). Thus a sector of middle and upper class groups now also engages in drug use. This is important in understanding the relatively recent upsurge of voluble outrage regarding drug use - influential and wealthy people are now

distressed by drug use observed in their own social class. This may result in expensive and audible counter-action which is not available to poorer working-class groups. In addition, middle and upper-classes may be more likely to be distressed when their youth turn to drug use since this may be perceived as an abandonment of the capitalist ideals so intrinsic to the survival of these classes (World Health Organisation 1973). It may be that working class groups accept drug use more easily - it may represent an alternative method of coping with adversity.

2.1.4 Decreasing age at first drug use

Illicit drugs (those drugs not commonly used and not acceptable in a particular community) are being used by people of an ever-decreasing age - that is by adolescents and pre-adolescents (Ahers 1972, World Health Organisation 1973, O'Connor 1979).

It seems that, while some types of drug use are acceptable in many societies, drug use must conform to certain norms which may vary from society to society. Norms for drug use in Western societies seem to specify that even users of acceptable drugs (alcohol and tobacco) must be adult. This is manifested in the banning of minors from public drinking houses. Similarly, rural and urban African populations indicate that, while adult male cannabis use is considered normal, use by adolescents is cause for concern (Du Toit 1980).

Once again it is apparent that established patterns of drug use are undergoing change.

2.1.5 Development of sub-cultural drug use

Stephens and Levine (1971) and Kramer and Cameron (1975), amongst others, note that a further trend, following on society's disapproval of drug use is that users drop out of society and enter sub-cultures where drug use is the norm. The continued existence of the society is thus possibly further threatened as an increasing number of its members, particularly its youth, repudiate established ways of life.

In addition, society often associates drug use and the adoption of the alternative lifestyle with an increase in crime (Stephens and Levine 1971) - societal alarm is therefore increased.

2.1.6 Change in drugs used

Section 2.1.1 noted that improved communication and transport networks have increased the availability of drugs in areas to which they are not indigenous. A further trend is the introduction of new laboratory-manufactured drugs (for example, LSD, heroin), following advances in science and medicine (Kramer and Cameron 1975). Non-medical use of these drugs may be generally viewed by society as problematic since the drugs are unfamiliar and produce markedly deleterious side-effects on the individual and, it is feared, on society as a whole.

Polydrug abuse (that is, use of more than one drug by an individual either simultaneously or at different times) forms another important trend in drug use today (World Health Organisation 1973). A WHO study group (1973) noted that the sequential or simultaneous use of large numbers of different types of dependence-producing drugs by regular users is a relatively new phenomenon.

It would seem, then, that problem status has been ascribed to drug use for various reasons all of which involve violations of societal norms for drug use and/or increased harm to the user.

After World War Two drug use spread rapidly from the USA to Britain and then to South Africa (Ben-Arie 1984). Many of the above trends in drug use are now apparent in South Africa and may be largely responsible for the growing concern over drug use in Cape Town. The following section evaluates drug use in this city and mentions the trends which characterise it.

2.2 Cause for concern in Cape Town?

In Cape Town professional and lay people have become increasingly concerned regarding what they consider to be a major drug abuse problem. Dr D Rabinowitz, Senior Psychiatrist at Groote Schuur Hospital, Cape Town and Chairman of the Drug Action Committee, states that:

> "We appear to be facing an epidemic of drug abuse in our community and perhaps even nation-wide".
> (Sept. 1984).

It is important to ask at the outset of this review whether such concern is warranted - does Cape Town have a drug abuse problem which needs to be addressed? If so, is it being adequately contained and treated by existing medical-psychological facilities? The relevance of the major aims of this review (to establish guidelines for the future development of drug abuse treatment facilities and for the accurate placing of each patient within the treatment network) can only be established when these questions have been answered.

This section, then, examines the available literature on drug use in Cape Town in the light of the definition of problematic drug use discussed in Chapter One. Drug use will be considered problematic when the group as a whole disapproves of the nature of drug use practiced and when a growing percentage of that group's members are, according to DSM III criteria, abusing drugs. It is expected that some of the modern trends in drug use patterns will be in evidence in any group which is said to have a drug abuse problem since these trends have been associated with increased concern over drug use (see earlier discussion).

In general, only studies of Cape Town itself will be reviewed but studies of other South African areas will be used where the former are not available. Since segregation of ethnic groups is a central characteristic of South African society, most studies used distinguish between Black, White, Coloured and Asian groups. I wish to state clearly that these terms are not used in this study in support of the status quo but only because research and services have been designed around racial segregation in the past. In addition, certain differences in drug use patterns are apparent and warrant comment. The limits of these classifications follow those set by the Population Act of 1950 (see Swartz 1985 for further discussion).

The reader will note that many of the studies of drug abuse in South Africa focus on cannabis [(i)] abuse, and neglect to provide

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Footnote: (i) The term cannabis in this study, as in the DSM III (1980, p.156), refers to all substances with psychoactive properties from the cannabis plant as well as chemically similar synthetic substances. In South Africa the most commonly used form is cannabis sativa, commonly called dagga.

information regarding use of other drugs. This is due to the widespread use of cannabis and the relatively small percentage of other drug use (see later discussion). These studies of cannabis use are relevant to this discussion of the prevalence of drug use in general as cannabis is over-whelmingly the major drug of abuse in South Africa.

Eath of the major ethnic groups in South Africa is discussed below with regard to trends in the extent, type and pattern of its drug use and community attitudes to this.

2.2.1 Drug use amongst Black groups

Studies of the use of drugs (other than alcohol) by Black South Africans are scarce. The following information relies largely on Du Toit's extensive work on cannabis use in Africa (1980).

The following brief description of rural Black drug use is included to provide a background for discussion of urban drug use since some Blacks residing in Cape Town are of rural origin (Du Toit 1980).

Du Toit (1980) investigated rural Black drug use by interviewing a sample of cannabis-using Xhosa- and Zulu-speaking Blacks deriving from rural areas of Natal. Application of this study to the Cape area is unfortunately limited by being Natal-based; however, the sample did include Xhosa-speaking people thus increasing its applicability to Capetonian Blacks, most of whom are Xhosa-speaking. The use of the interviewing method constitutes a further limitation of this study, as Du Toit admits, since it requires honest admission of illegal cannabis use to an unfamiliar person. Despite these limitations, however, the study is useful here since it

provides one of the few documented accounts of drug use amongst Black South Africans. A brief summary of some of Du Toit's findings follows.

Cannabis has a long history of use in this population group and Du Toit notes that

> "As far as we can ascertain there was little moral sentiment attached to its use as men smoked the herb as a relaxant at the end of the day" (p.28).

Cannabis is very commonly used in this population particularly among males. No prevalence figures are given, however, since only cannabis smokers were interviewed. The relatively recent illegality of the drug has apparently influenced the traditional acceptance of the drug use only slightly (Du Toit 1980).

This longstanding tradition of cannabis use and the community's acceptance of such use as "normal" resembles in some respects the widespread acceptance of alcohol use in other societies. Cannabis users in this society are not automatically deviant and I suggest that this may help to prevent the development of a drug problem at societal and individual levels since the effects of social disapproval, which may encourage adoption of a subcultural life-style (see section 2.1.5), do not operate. Of course, as with alcohol use in other societies, this does not mean that individuals may not become problem drug users in terms of the DSM III's definition of this. The following cultural practices regarding cannabis use also help to contain drug use within certain acceptable limits.

Tradition dictates that cannabis be smoked only by adult men and that the cannabis content of a "zol" be always mixed with an equal quantity of tobacco to avoid madness, foot ulcers and expense (Du Toit 1980, p.14). Use of drugs other than cannabis and alcohol is almost non-existent. These norms do not of course preclude the development of problem use in individuals or in this society in the future. Modern inroads on traditional patterns of use have possibly already led to a decrease in the traditional age of first use - Du Toit's sample (1980, p.99) shows that the mean age of first use is still within traditional limits (18,7 years) but that a sizeable percentage now begin in early teen and pre-teen years (16,3% and 3,3% respectively).

The prevalence of drug use and abuse amongst Capetonian Blacks cannot be accurately assessed at present. Statistics obtained from the South African Police (Kotze 1985) indicate that 139 Black Capetonians were arrested on cannabis - and mandrax-related charges in 1984. This figure is set against 146 White, 751 Coloured and 5 Asian arrests. Such a figure, however, is of little value in assessing the prevalence of drug use and abuse in this population group - many users (and abusers) never come to police attention and police attitudes and arrest practices may differ in different population groups.

Du Toit (1980) provides perhaps the most relevant, though imprecise, prevalence information when he states that cannabis is probably as widely used by and as available to urban as to rural Blacks (p.163). This author also indicates only slight differences in other aspects of rural and urban cannabis usage amongst Blacks (p.163 - 211). Some of these are noted as follows.

The percentage of female users is increased and the mean age of first use by males is decreased slightly to 17,6 years. The youngest age of first use was 7 years and 3,2% of the urban sample started smoking before the age of thirteen. Once again, cannabis is not usually smoked in its pure form but is mixed with an equal amount of tobacco and the majority of users (89,2%) smoke three times a day every day. 99,2% of Du Toit's sample had never used drugs other than cannabis and alcohol - thus urban blacks do not seem to be party to the poly-drug phenomenon which is emerging worldwide (Du Toit 1980, p.195).

Urban Black drug use, then, has in some respects changed relative to traditional rural patterns. This group might produce some drug users who would meet the clinical criteria for a diagnosis of substance abuse since drug use may be intensified in response to alienation from traditional value systems and the pressures of urban black life. Thus Du Toit (1980 p.187 - 190) discussed the fact that urban black cannabis users feel that regular cannabis use facilitates intimacy with drug using peers and gives energy, strength, courage and concentration which enables one to cope with adversity without overt aggression.

Du Toit (1980) notes that the urban black community is somewhat less accepting of cannabis use than its rural counterpart. Some family members of smokers have "basically negative feelings, a smaller number are neutral, and a very small number feel positive about the smoker" (p.191). The difference in attitude is perhaps due in part to the increased risk of discovery by police in a city

and raises the possibility that the community itself regards drug use as problematic. However, a clinical study (Ben-Arie 1984) describing attenders at an outpatient department in Cape Town notes that urban Blacks do not generally present at such a clinic for drug abuse treatment (see section 2.2.4 for further discussion of this study). Similarly, later discussion (section 2.2.4) of the Drug Counselling Centre indicates that very few Blacks attend. This finding could be interpreted in various ways - perhaps Capetonian Blacks do not regard drug use as sufficiently problematic to warrant treatment; perhaps they do not regard an outpatient hospital clinic as the appropriate centre for treatment. This area could be usefully researched in the future; for present purposes we can only suggest on the basis of the limited information available, that urban Black cannabis use may be slightly increased relative to rural use, that such use is to some degree disapproved of by some elements in the community but that it does not generally result in the user seeking treatment at a hospital outpatient department. No firm conclusions as to the presence or absence of a 'drug problem' can be reached on this inadequate basis and further research here is important if drug use in Cape Town is to be accurately assessed and dealt with.

2.2.2 Drug use amongst White Capetonians

White groups in Cape Town fall into two main categories - English and Afrikaans speakers. These groups differ in their attitudes to and use of drugs with "liberal" (that is, more tolerant) attitudes and drug use being more prevalent amongst the English speaking group (Groenewald 1973, Levin 1972, Van der Burgh 1977a).

The prevalence of drug use amongst young White South African males, including Capetonians, was investigated by Van der Burgh in 1975 using a sample representative of various education levels and geographical areas but which was somewhat under-representative of English-speakers. The study found that 20% of the sample had used cannabis and/or other drugs at least once. The majority of these respondents were experimental (had used drugs once) or occasional (used drugs "now and then") rather than regular users (used drugs at least once a week).

This study also found that the large majority of respondents condemned the use of drugs - 82% and 91% agreed that cannabis and other drug use, respectively, had detrimental effects on an individual. These attitudes, in turn, were largely consistent with the respondent's drug behaviour (i.e. whether drugs were used or not). Van der Burgh's studies on the attitudes of White South Africans (1977a) to drug legislation support this finding - the majority held traditional attitudes to drug abuse and felt it should be punished.

Van der Burgh concluded that the extent of illicit drug use by White South African youth in 1975 was not of the magnitude portrayed by the media. Rather, the majority held traditional attitudes to drug abuse and acted in accordance with these. These findings may be somewhat biased by the over-representation of Afrikaans-speaking respondents who have been shown to hold more conservative (less tolerant) views on drug abuse as previously discussed. The conclusions reached are also rather surprising given the figure of 20% having used drugs at least once, since this figure is fairly high for a population group where cannabis use is not traditional.

What is important, however, is the finding that the majority did not become regular users. South Africa cannot be said to have a "drug problem" if most users use drugs on an experimental basis only. According to the DSM III criteria pathological use, impairment in functioning and one month's duration of use are necessary before a diagnosis of substance abuse can be made.

Studies conducted in more specifically defined populations provide interesting, although less generalisable prevalence figures. A study by Ben-Arie and Gild in 1970 (quoted in Ben-Arie 1984) found that 21% of a representative sample of University of Cape Town students (24% of the male respondents, and 12% of the females) had experimented with drugs. Only 24% of these were regular cannabis users and an even smaller percentage, almost exclusively male, were heavy users. Drugs other than cannabis barely featured. These results support Van der Burgh's (1975, 1983) and Du Toit's (1978) prevalence figures.

A more recent study (Van der Burgh 1983) of 2 650 young White men found that 18,1% had used cannabis at least once (10,3% had used it in the past 6 months). This may suggest that prevalence of drug use in this group has dropped slightly relative to the 1975 figures. However, statistical significance of the 2% decrease and equivalence of the sample would have to be established before this suggestion could be accepted. Further research on prevalence trends is essential if accurate planning of future services is to be achieved. At present, on the basis of very inadequate data, it is possible only to roughly estimate prevalence in the following manner (after Ramer and Flohr 1974 and Nurco 1971). According to the most recent data available (Van der Burgh's 1983 survey), about 18% of young White South African males have used drugs. The Population Census

(1980) indicates that 40 612 White males between the ages of 15 and 24 live in the greater Cape Town area (statistical region 01 in the Census). Application of Van der Burgh's 18% to this population shows that about 8 122 young White males in Cape Town may have used drugs.

Several problems arise with this computation, however. Firstly, the direct application of Van der Burgh's figure to Cape Town may be invalid as this figure was achieved by means of a nation-wide survey. Secondly, the population figures used here may be outdated as they derive from the 1980 census. Gross data from the 1985 census is available (Population Census 1985) but has not yet been processed to provide age and sex details. Comparison of the 1980 and 1985 census data indicates that the White population of the area under study has increased from 252 684 in 1980 to 323 788 in 1985. It would seem, therefore, that the figure calculated earlier is more likely to under- rather than over-estimate the number of drug users in Cape Town. Furthermore, the figure does not include female users or users of other age groups.

Thirdly, the figure does not indicate the number of drug abusers, or those drug users who are likely to need treatment. SANCA has suggested that 6 - 8% of alcohol and drug users become abusers (War on Drug Abuse 1983). Van der Burgh (1983) notes that about 10% of drug users had used drugs in the month prior to the survey, thus being more likely to be regular drug users. If a median figure of 8% is accepted, about 650 young White males may be in need of treatment for drug abuse. Once again, this figure is proposed with

extreme caution. For the reasons discussed above, it is likely to seriously underestimate the true figure.

It is difficult to assess the presence or extent of any drug abuse problem merely from a number. The implications of these and other figures for the drug abuse treatment network in Cape Town will be discussed in Chapter Three. At present it is noted that a considerable number of drug abusers exist in the White population. The following trends are also evident.

No socio-economic group seems to be free of drug-abuse. Staff at the Drug Counselling Centre note that all groups are represented in their patient load (see Appendix I). In addition, the average age of first drug use is apparently decreasing. The average age of first use in White male South Africans has generally been set at high school level at about 15 years (Louw 1973, Levin 1972, Van der Burgh 1975, Van der Burgh and Heaven 1979). Van der Burgh (in Ben-Arie 1984) states that, as in previous studies, cannabis use was shown to have commenced at secondary school but the initial contact with drugs was now often made at primary school with the greatest proportional increase occurring between Standards 7 and 8.

> "...A significant proportion of users start cannabis in their early teens...the use peaks in the 18 - 22 year age group, then decreases to a relatively low level by the early twenties" (p.14).

This suggests that the stage of first drug use is in fact decreasing from secondary to primary school level, as is the trend in other Western countries.

Section 2.1.5 noted the international trend towards a "drug subculture". It would seem that little work has been done in South Africa in this area to date and it is suggested as a fruitful area for future research.

The last trend noted in Western countries is that towards the use of new and unfamiliar drugs. The situation in South Africa, and presumably Cape Town, is somewhat different.

Studies indicate clearly that cannabis is the primary drug of abuse amongst South African Whites as well as Blacks. Levin (1972) showed that 98,3% of his sample of White drug abusing national servicemen used cannabis; 30% used only cannabis and 68,3% used cannabis with other drugs. Van der Burgh (1975) showed that, of 4 600 White males, 20,1% had used cannabis and/or other drugs at least once; only 0,3% had used other drugs without cannabis. Van der Burgh and Heaven (1979) showed that in all but 1 of the 44 White drug abusers interviewed cannabis had been the first drug used.

Regarding frequency and quantity of cannabis used, Levin (1972) notes that 38,2% of the national servicemen mentioned above used cannabis daily and that more than three quarters of the group used more than 115 grams of raw cannabis daily. This indicates fairly heavy cannabis use (Levin 1972).

Other drugs of abuse are given by Levin (1972) in descending order of use prevalence:

Amphetamines	33%
LSD	30,6%
Cough Mixtures	22,1%
Alcohol	21,4%
Opium	21,4%
Inhaled substances	20,3%
Barbiturates	15,9%
Mandrax (Methaqualone)	7,8%
Heroin	3,8%

These figures are not necessarily up to date. Ben-Arie (1984) notes that the group of non-cannabis using drug abusers has increased disproportionately from Levin's 2% to its present 12%. Thus the trend towards "poly-drug abuse" is important in the South African "drug scene" although at present the percentage of such users is relatively small.

2.2.3 Drug use amongst Asian and Coloured groups

The combined discussion of these two groups does not necessarily imply similarities between them. They are discussed together for reasons of convenience and because very little relevant data is available for the Asian group.

The inadequate data that is available suggests that young adults and adults of both groups use drugs and that prevalence figures possibly parallel those of White groups. Du Toit's study (1978) of 1 150 high school students in Durban found that 19% of Indian students, 14% of White students and 12% of Coloured students had used cannabis. However, the statistics supplied by the South African Police (Kotze 1985) indicate that drug use may be less prevalent amongst Asians (section 2.2.1).

The South African National Council in Alcoholism's study (1985) was launched in response to an ever-increasing demand for counselling and community work service in the field of drugs other than alcohol. SANCA initiated a limited survey of cannabis use amongst 807 Std. 8 Coloured boys in Athlone, Cape Town in October 1983. The sample was drawn at random from Std. 8 boys of 14 schools in the area and a structured questionnaire was used to gather information. The findings were as follows:

a) Of the total sample, 14,5% had used cannabis - i.e. 1 in every 7 pupils had used cannabis at least once. This figure corresponds to those suggested by Du Toit (1978).

b) One-third of those who had used cannabis had also used mandrax (methaqualone) at least once.

c) Cannabis use occurred amongst respondents of all the schools concerned, the highest and lowest percentage being 29,5% and 2,9% respectively.

d) Of those pupils who had never used cannabis (nor, we cautiously presume, any other drug since cannabis is almost always used first - see later discussion) 28% indicated that they had been asked to join in the use.

Despite imperfections admitted by the researchers (e.g. limitations of the structured questionnaire technique) the study does provide indications as to the extent of cannabis use in Athlone schools. The study does not indicate the presence/absence of "regular users"

in this adolescent sample - that is, it does not provide details which would facilitate a decision as to the presence or absence of drug abusers, as opposed to drug users, in this population.

The extent of drug use and abuse amongst Asian people cannot be estimated here due to lack of data. However, drug use amongst Coloured Capetonians can be estimated by following the procedure used to estimate use in White Capetonians (see Section 2.2.2).

SANCA's prevalence figure (14,5% of Coloured boys in Std. 8) provides the most recent data. This figure is, rather arbitrarily, increased to 18% to allow for increased number of drug abusers in older adolescence. It is then applied to the number of Coloured males between the ages of 15 and 24 (92 000). According to this computation about 16 722 Coloured Capetonian males may have used drugs.

If the 8% figure used in section 2.2.2 is again accepted as the possible percentage of users who become abusers, calculation shows that about 2 338 Coloured males in Cape Town may require treatment for drug abuse.

It is important to note, however, that the deficiencies which were stressed in section 2.2.2 also apply here - conclusions have been generated from a small and selective study and population figures derive from the 1980 Census. The data therefore probably underestimates the true extent of drug use and drug abuse.

Trends in drug use in Coloured and Asian communities have not been fully investigated. Botha and Le Roux (1981) performed a descriptive analysis of cannabis use amongst Coloured people of the Cape Flats area. The reader is referred to this study for a valuable description

of the content, availability and methods of use of cannabis in this population. It is not possible to fully discuss all the findings of this study. Suffice is to say that many cannabis abusers were available for interview and that deleterious effects of heavy cannabis use on psychological and social functioning were indicated.

The conclusion reached from the above studies is that cannabis use occurs amongst the Coloured population of the Cape Flats and that it may be used heavily enough to produce severe psychological and social disruption. This conclusion should be viewed in the light of Van der Burgh's finding (1977b) that the majority of Coloured and Indian South Africans hold traditional (negative) attitudes to drug use and feel it should be punished.

2.2.4 Evidence from surveys conducted in treatment centres

The following discussion of the history and development of drug abuse treatment in Cape Town adds to the limited information discussed above. Much of the data is obtained from Professor Ben-Arie's report (1984).

A drug-assessment clinic was opened in the early 1970's at the psychiatric outpatients department, Groote Schuur Hospital, in response to increasing professional concern. However, at that stage existing psychiatric facilities could cope and the clinic was closed after 8 months.

Figures regarding drug abuse have apparently escalated since the early 1970's such that in the early 1980's treatment facilities in Cape Town could no longer cope (Ben-Arie 1984). For this reason the

Department of Psychiatry, University of Cape Town conducted a survey of all patients presenting with drug abuse to units at Groote Schuur and Valkenberg Hospitals between January and June 1983 (Ben-Arie 1984). The findings are summarised in Table 1 and discussed below.

Table 1

Results of survey of drug abusers presenting to GSH Outpatients department (January to June 1983)

Population Group	No. who presented at OPD	Peak age of presentation	DRUGS OF ABUSE			Other drugs of abuse (used with or without cannabis)	% Intravenous users	TREATMENT CONSIDERATIONS		
			% using cannabis only	% cannabis and methaqualone	Polydrug abuse with cannabis			Number motivated for treatment	Age range of those motivated for treatment	Management of those not suitable for treatment
Whites	75	Young Adult Life	21%	14%	Just one half of those presenting	12% used one drug only	At least 7%	49/75 (61% of males, 39% of females)	Vast majority under 30 years	Rehabilitation centre
Coloureds	97	Young Adult Life	41%	51%	No information	4% on methaqualone alone. 4% other polydrug use without cannabis	No information	66/97 (88% of males. 12% of females	Vast majority under 30 years	Rehabilitation centre
Xhosa	1	NO INFORMATION								
Indians	NO INFORMATION									

Table 1 indicates that the majority of patients presenting were from White or Coloured groups; only one Xhosa-speaking (Black) person presented. Most patients presented in young adult life. Analysis of the drugs abused by these patients indicates that a large number use cannabis with or without methaqualone and other drugs. Thus one half of White patients used cannabis with other drugs (methaqualone, benzine, stimulants, cough mixtures, barbiturates, opiates, benzodiazepines, etc.), 12% were selectively dependent on one drug other than cannabis and 7% were intravenous users. Ben-Arie (1984) points out that "...there is a small number who become dependent on one drug only (e.g. Wellconal) some injecting it intravenously. It is this latter group who may eventually constitute a formidable problem by influencing others, and by developing the complications of intravenous drug use and a drug-oriented lifestyle with its attendant psychological and physical morbidity" (p.16).

This supports findings reported earlier in this chapter - cannabis is the major drug of abuse but methaqualone and other drugs may be used with cannabis or alone. As a result of this survey and of the growing conviction that available facilities were inadequate, the Drug Action Committee (DAC) was established (as discussed in Chapter One). This committee established the Drug Counselling Centre, an outpatient crisis-oriented centre which aimed to fulfil some of the treatment needs associated with what was considered a major drug abuse problem (Rabinowitz October 1984). This centre, which is further described in Chapter Three and in Appendix I, has produced the following statistics (Table II) regarding the number of patients seen at the centre between February and August 1985.

Table II.

Patients seen at the DCC 7.2.85 - 8.8.85

	Coloured		White		Black	
	Female	Male	Female	Male	Female	Male
	6	88	18	67	1	2
Sub-totals:	94		85		3	
Total:			182			

Staff at the centre note that all socio-economic groups are represented in those presenting for help (see Appendix I). Unfortunately statistical data regarding this breakdown is not available.

These statistics provided by Groote Schuur Hospital Outpatients Department and the Drug Counselling Centre raise an important point - Coloured and White Capetonians are shown to be the groups most likely to attend a medical-psychological drug abuse treatment clinic. This may indicate that these groups, unlike the Black group, consider drug use problematic and are more likely to consider medical-psychological treatment appropriate. As discussed earlier, however, one cannot conclude that Blacks do not have a drug abuse problem simply because they do not attend a drug abuse clinic.

The large numbers of drug users seen by the Drug Counselling Centre (DCC) since its recent inception seems to imply that Capetonians, particularly Whites and Coloureds, are abusing drugs and that society considers treatment necessary. Thus the presence of a drug abuse problem suggested earlier in this chapter, is supported.

Summary and comment

This chapter reviewed world-wide trends in drug abuse and then reviewed South African studies to discover whether these trends are sufficiently in evidence here to warrant concern. The racially segregated nature of South African society necessitated a format which discussed each major ethnic group separately.

It was not possible to state categorically on the evidence available that overall prevalence of drug use had increased although the clinical study undertaken at Groote Schuur Hospital (Ben-Arie 1984) indicated increased demand for treatment in Coloured and White groups at least. The available data did, however, indicate that no racial group in Cape Town is exempt from drug use. This use was described as non-traditional and therefore as cause for concern in White and Coloured groups at least. Black groups, both rural and urban, tend to be far more accepting of drug (particularly cannabis) use. No conclusion could be reached regarding drug use in the Asian group due to inadequate information. It would seem, according to South African Police statistics (Kotze 1985), that such use may be low.

Further trends in drug use in all four major groups were discussed. It seems that changes occurring in all four groups include use in middle- and upper-class groups and decreasing age of first use. With regard to changes in types of drugs used, it appears that cannabis is the major drug of abuse throughout South Africa and Cape Town but that polydrug abuse is becoming apparent, particularly in White groups. The argument may be raised here that this predominant use of cannabis rather than other drugs (for example, opiates) decries the ascription of problem status to drug use in Cape Town. This argument has some validity. However, the DSM III accepts that cannabis use can become problematic. Other works (for example, Rottanburg et al 1982) have also suggested that cannabis use can have deleterious effects.

It is suggested that these changes in established patterns and types of drug use amongst the various communities contribute to concern and a demand for action regarding what is now labelled as drug abuse. This is manifested, partly, in the establishment of the DAC and the DCC largely by middle-class professional White and Coloured Capetonians (see Appendix I).

The establishment and support of the DCC and the DAC, together with the above data, seems to suggest that some sections of Capetonian society, at least, perceive drug use in the city as being of problematic proportions. The clinical study undertaken in Cape Town to determine the adequacy of drug abuse treatment resources in the city (Ben-Arie 1984) suggested that these are inadequate in dealing with the problem described in this chapter. This issue is examined in the following chapter.

CHAPTER THREE

DRUG ABUSE TREATMENT FACILITIES IN CAPE TOWN - HOW ADEQUATE ARE THEY?

3.1 Composition of the drug abuse treatment system

3.2 Level of adequacy of this system

3.2.1 Adequacy regarding number of drug abusers needing and presenting for treatment

3.2.2 Adequacy regarding demographic variables

3.2.2.1 Race

3.2.2.2 Socio-economic status

3.2.2.3 Age

3.2.3 Adequacy regarding types and levels of severity of drug use

3.3 Summary and comment

CHAPTER THREE

DRUG ABUSE TREATMENT FACILITIES IN CAPE TOWN - HOW ADEQUATE ARE THEY?

This chapter seeks to determine the adequacy of Cape Town's treatment facilities in relation to the preceding discussion of the extent and nature of drug abuse in the city. Theoretically speaking, this enquiry may produce one of three possible results - existing facilities may be found to be adequate, inadequate or adequate in some respects but inadequate in others. The latter is the expected result and, if correct, will form the basis for any suggestions to be made in later chapters of this thesis for improved effectiveness of Cape Town's drug abuse treatment network.

An "adequate" treatment system, for the purposes of this thesis, implies that the system consists of centres, which, taken together, can provide appropriate treatment for all drug abusers who present for treatment. This means that the system must be appropriate to deal with the numbers and with the types of drug abusers that present. An adequate drug abuse treatment system in Cape Town, therefore, must be able to deal with a fairly large number of drug abusers (see Chapter Two) of all race groups and of different levels of severity (measured against DSM III standards).

Further questions also arise in the definition of an adequate treatment network. These will be raised here and dealt with at various points in this thesis: should such a system provide psychological as well as medical treatment (Chapter 4); should it treat drug abusers separately from other psychiatric patients (Chapter 5); should both inpatient and outpatient treatment be included (Chapter 6)?

Accurate assessment of the strengths and weaknesses of the entire treatment system depends, firstly, on knowledge of each facility involved in the treatment of drug abuse. To this end Table III lists these centres with details of referral procedures, patient and treatment characteristics and of any alleged inadequacies of the centre in the comprehensive treatment of drug abusers. These are "inadequacies" only in terms of this study - it is not implied that these centres are inadequate in themselves. For example, Ward D12 may, in terms of this study, be inadequate as a comprehensive treatment centre for drug abusers but no statement is made or implied regarding its effectiveness per se.

The chapter then continues with a closer examination of the alleged inadequacies of the treatment system to determine the validity and relative importance of these.

3.1 Composition of the drug abuse treatment system

The information in Table III was obtained from the Lifeline Directory of Cape Town Services and Resources (1984), from personal professional familiarity with many of the centres and from discussion with those in charge of centres.

Table III

Drug abuse treatment facilities in Cape Town

Name of Centre	Race and age groups accepted	Nature of referral to centre	In-or out patient treatment	Function/types of treatment offered	Type of patient seen at centre	Any inadequacies raised re comprehensive treatment of drug abuse here
A. GENERAL HOSPITALS						
1. Groote Schuur Hospital Psychiatric Casualty (K4)	All	By self, family, mental health professionals (MHP) or GP	Outpatient generally; may do in-patient detoxification (duration ± 1 week)	*Assessment and referral *Crisis management *Detoxification (inpatient and outpatient	Any	*No facilities for long term treatment *Pressure of time since serves as a general psychiatric "emergency" room for much of Cape Town. Not a specialised drug abuse treatment centre. (see section 3.2).
2. GSH Psychiatric Outpatient Department (OPD)	All	As for K4	Outpatient	*Assessment and referral *Outpatient medical and psychological treatment including individual, family and group therapy. *Follow-up of patients treated in the wards.	Any Must be sufficiently motivated to remain in outpatient treatment	*Pressure of time as this is a busy general psychiatric OPD - appointments may be too widely spaced to maintain drug abuser in therapy. *Not a specialised drug abuse treatment centre
3. GSH Adolescent Clinic (at Psychiatric Day Hospital	Adolescents of all races	Usually MHP's, schools, etc.	Outpatient	*Assessment and referral *Individual and family therapy *Follow-up of adolescent patients treated in the wards	Any As for GSH Psych. OPD above	*Pressure of time (Adolescent Clinic only held afternoons per week). *Not a specialised drug abuse treatment centre
4. GSH Psychiatric Day Hospital (PDH)	White adolescents and young adults (16-40 yrs)	Usually by MHP's, GP's, Psych. OPD	Day patient status (i.e. live at home after hours)	*Milieu therapy with individual, family and group therapy (6 wks - 3 months duration) *Medical treatment (e.g. anxiolytics)	Young adults experiencing difficulty adapting to life	*Not a specialised drug treatment centre. *A minority of drug abusers in a predominantly "neurotic milieu" can be problematic *Treats relatively few patients at any time

Table III cont.

Name of Centre	Race and age groups accepted	Nature of referral to centre	In- or out patient treatment	Function/types of treatment offered	Type of patient seen at centre	Any inadequacies raised re comprehensive treatment of drug abuse here
5. GSH Psychiatric Ward (D12)	White adults and older adolescents	Usually by MHP's, GP's, Psych. OPD	Inpatient	*As for PDH above	Anxiety, eating and depressive disorders. Some personality disorders but latter not well suited here; similarly drug abusers not felt to be appropriate here	*As in A4 above
6. Tygerberg (TH) Psychiatric Casualty	AS	FOR	A.1	ABOVE		
7. TH Psychiatric OPD	AS	FOR	A.2	ABOVE		
8. TH Psychiatric Wards	AS	FOR	A.5	ABOVE		
8. PSYCHIATRIC HOSPITALS						
1. Avalon (Administered by GSH)	Coloured and Black patients of all ages	Usually by MHP's, GP's	Inpatient	*Corresponds to A5 above *As for A5 above	*"Psychiatric cases" as for A5	*As for A5
					*Alcoholics in specialised alcoholic treatment section of centre	*A minority of drug abusers in an alcoholic treatment centre can be problematic
2. Stikland	Whites over 16 years	Usually by MHP's, GP's	Outpatient Inpatient			
3. Valkenberg Hospital (VH)	Adults over 16 yrs of all races with in-patient adolescent unit (Sonstraal) for non-Whites)	By self, family, MHP's, GP's	Outpatient	*Counselling of individuals or families *Follow-up work *Medical treatment (e.g. of accompanying anxiety); no detoxification	All	*As for A2 above

Table III cont.

Name of Centre	Race and age groups accepted	Nature of referral to centre	In- or out patient treatment	Function/types of treatment offered	Type of patient seen at centre	Any inadequacies raised re comprehensive treatment of drug abuse here
			Inpatient	*Range of treatment from custodial care to "milieu" therapy with individual, family or group therapy *Medical treatment (not detoxification).		*As for A4 above *Pressure of time and low staff-patient ratio
4. William Slater Hospital (WSH)	White adults	By self, MHP's, GP's	Inpatient	*2 weeks milieu therapy with individual, family or group therapy *Education re alcohol	*Alcoholics fairly motivated for treatment *Not vagrants *Some drug abusers	*A minority of drug abusers in a predominantly alcoholic group can be problematic *Only a small number of drug abusers accepted for treatment
			Outpatient	*Long-term weekly outpatient group *Individual therapy *Follow-up by community sisters	*As in B4 above	*As in B4 above
C. STATE WELFARE DEPARTMENTS						
1. Dept. of Co-operation and Development Welfare Office	Black people of all ages	Self or other	Outpatient	*Welfare services re housing, employment etc.	*Any with employment and housing problems	*No treatment offered *No resources for dealing with drug abuse problems
2. Dept. Internal Affairs (Coloured) - 2 regional offices	Coloured people of all ages	Self or other	Outpatient	*Welfare services (See Lifeline Directory, 1984, p.128, for definition) including grants, rehabilitation, etc., Counselling	*Any with "Social problems" (e.g. need welfare grant) *Vagrants and alcoholics for rehabilitation	*No treatment offered, only referral to rehabilitation centres

Table III cont.

Name of Centre	Race and age groups accepted	Nature of referral to centre	In- or out patient treatment	Function/types of treatment offered	Type of patient seen at centre	Any inadequacies raised re comprehensive treatment of drug abuse here
2. Administrative Head Office cont.				*Welfare services as above *Welfare services	*Any with "social problems"	*No long-term treatment of drug abuse offered
3. Welfare Administration Office	Indian people of all ages	Self or other	Outpatient	*Welfare services	*Any with social problems	*No long-term treatment of drug abuse
4. Dept. Health & Welfare Head Office & 1 Branch Office	White people of all ages	Self or other	Outpatient	*Welfare services *Alcohol safety school	*Any with social problems	*As for B2 and 3 above
D. REHABILITATION CENTRES						
1. De Nova	Coloured males and females; 21-60 yrs	By MHP's or courts	Inpatient		*Alcoholics of long standing *Cannabis users of long standing *Vagrants	*Not a specialised drug abuse centre *Only for abusers of long standing
E. PRIVATE SECTOR						
1. Psychologists, psychiatrists, GP's and social workers in private practice	All	Self of other	Outpatient usually, may use short-term in-patient treatment at private clinic	*Assessment & referral. *Individual, family therapy, occasionally group therapy *Medical treatment	*Usually "middle-class" patients with personal funds or on a medical aid *As for A2	*Practitioner usually not specialised in drug abuse treatment, therefore usually doesn't have adequate facilities e.g. group therapy with other drug abusers, follow-up facilities, etc.
2. Private clinics (Listed in telephone directory)	All	MHP's, GP's	Short-term inpatient treatment	*Removal from stressful environment *Individual psychotherapy by private clinician *Medical treatment as prescribed by practitioner	*Usually "middle-class" patients with private funds or on a medical aid scheme	*No specific treatment for drug abuse except that given and prescribed by the patient's therapist, e.g. no group therapy. *Relatively few patients treated in this way. *Expensive

Table III cont.

Name of Centre	Race and age groups accepted	Nature of referral to centre	In- or out patient treatment	Function/types of treatment offered	Type of patient seen at centre	Any inadequacies raised re comprehensive treatment of drug abuse here
F. PUBLICLY FUNDED PROFESSIONAL ORGANISATIONS						
1. SANCA (5 branches)	All	By self and others	Outpatient	*Assessment and referral *Co-ordinating organisation providing information community services back-up services to family and employers	*Alcoholics *Some drug abusers	*No treatment offered *Focus on alcoholics
2. Drug Counselling Centre (DCC)	All	Self and others	Outpatient	*Preventative education re drug abuse *Assessment and referral *Crisis management *Psychological treatment of suitable patients *Research	*Any	*Limited resources - only 3 full-time professional staff members. *No inpatient facilities
3. Cape Mental Health Society	All	By self, family, professionals, etc.	Outpatient	*Assessment and referral *Social work services	*Any	*Not specialised drug centre (see section 3.2) *Treatment offered is limited
4. SA Red Cross Society - Parents' Support Group	All	Self and others	Parents attend weekly meetings	*Informal support group to parents of drug abusing children	*All	*Not a drug abuse treatment centre
G. SELF-HELP ORGANISATIONS						
1. Nar-Anon	All	Self and others	Relatives attend weekly meetings	*Support group for relatives of drug abusers *Works closely with Narcotics Anonymous	*All	*Focusses on support of family members - not a drug abuse treatment centre

Table III cont.

Name of Centre	Race and age groups accepted	Nature of referral to centre	In- or out patient treatment	Function/types of treatment offered	Type of patient seen at centre	Any inadequacies raised re comprehensive treatment of drug abuse here
2. Narcotics Anonymous	All	Self and other	Drug abusers attend weekly meetings	*Rehabilitation of drug abuser by providing group support (as in Alcoholics Anonymous	*All - must be sufficiently motivated to maintain attendance, however.	*Provides a support group only
H. RELIGIOUS ORGANISATIONS						
1. Coffee Bar	All but mostly White teenagers and young adults	Self or referred	Drug abusers "in the street" are invited to the Coffee Bar. No residential facilities	*Spiritual counselling with a view to rehabilitation	*"Drifters" *Drug abusers	

3.2 Level of adequacy of this system

This chapter seeks to examine the adequacy of the treatment system outlined in Table III above with a view to suggesting efficiency-promoting changes in the functioning of the system (Chapters Four, Five and Six) and in units within the system (Chapter Seven). Cape Town's drug abuse treatment system will be evaluated in terms of these requirements for adequacy discussed earlier. In addition, issues raised by mental health professionals in Cape Town in support of the contention that the treatment network is inadequate will be discussed. These issues are taken from memoranda of the Drug Action Committee (Rabinowitz 1983 and 1984).

This source is supplemented by statements made by mental health professionals in Cape Town in response to a short questionnaire (see Appendix II). This questionnaire, compiled for the purposes of this thesis, was sent to a senior mental health professional (psychologist, psychiatrist, sister-in-charge or social worker) at each of the general hospital wards, psychiatric hospitals, rehabilitation centres and publicly-funded organisations listed in Table III. These categories were considered to be the most relevant to a survey of medical-psychological treatment of drug abuse. Thus State Welfare Departments, self-help and religious organisations were omitted because they do not offer professional medical-psychological treatment. This omission does not imply that these centres are unimportant contributions to Cape Town's drug abuse treatment system, however, merely that they fall outside the scope of this thesis which considers only professional medical-psychological modes of treatment.

The questionnaire was sent to senior mental health professionals at certain centres with a request that they respond to the following questions regarding the particular centre's treatment of drug abusers -

i) What diagnostic groups does your centre assess and/or treat?

ii) How many patients presented at your centre between 1 January and 31 December 1984?

iii) How many of these had a diagnosis of substance (not alcohol) abuse as one of the diagnoses?

(iv) Do you feel that substance abusers (not alcoholics) are suited to treatment at your centre? Please give reasons.

Where accurate statistics were not available, an approximate figure was provided by the mental health professional concerned. This was felt to be adequate for the purposes of this thesis and accuracy, though not assured, is hopefully increased by the fact that only professionals senior in and familiar with the day-to-day running of the centre were asked to respond.

Unfortunately certain centres were unable to provide this information and therefore could not be included in this discussion. This applies only to Tygerberg and Stikland Hospitals, both of which are located out of the central Cape Town area in the Northern suburbs. However, they are potentially important centres in the treatment system of the

greater Cape Town area. Table III indicates that these hospitals correspond respectively to general (GSH) and psychiatric (VH) hospitals in central Cape Town. It is therefore suggested that lack of data from these centres probably does not invalidate any conclusions drawn in this survey.

3.2.1 Adequacy regarding capacity

Ben-Arie (1984) states that, since the early 1980's, treatment facilities have been unable to cope with the increased prevalence of drug abuse in Cape Town. The following discussion examines the validity of this statement.

Table III lists 26 centres/organisations which deal with drug abuse problems. Of these, 17 are professional medical-psychological units, a number which, taken at face value, might appear sufficient. On closer analysis, however, it becomes clear that only 14 of these centres (detailed in Table IV) actually treat drug abusers and that many of these 14 treat a small number of abusers amongst a majority of patients with other psychiatric disorders. Table IV shows the number of drug abusers treated in central Cape Town's major professional medical-psychological units in 1984 as a percentage of the total number of patients of all diagnostic groups treated by these centres over the same period. Only 2,12% of all patients treated were drug abusers. This data is derived from questions (i), (ii) and (iii) of the questionnaire (Appendix I) and, as previously mentioned, figures are unfortunately not available for all the relevant centres listed in Table III.

Table IV Percentage of drug abusers in total patient population of major centres in Cape Town

Name of Centre	Total no. of patients seen in 1984	Accurate (A) or Estimated (E) figure	No/ % drug abusers		Are drug abusers suited to your centre?	Why/Why not?
GSH Psychiatric Casualty (K4)	6 537	E	261	± 4%	Some are	Suited to dealing with medical detoxification of drug abuse and occasional crisis counselling.
GSH Psychiatric OPD		E	Almost none		No	a and b
GSH Adolescent Clinic	783	E	78	± 10%	Some are	If drug abuse is symptomatic of other disturbances - i.e. when it is not a symptom of conduct disorder or chronic abuse pattern
GSH PDH	47	A	7	15%	No	b
GSH Psychiatric Ward (D 12)	61	A	5	8%	No	b and c
Avalon	9 995	A	89	0,89%	No	a, b and c
VH OPD (Observatory) and Satellite clinics	18 383	E	184	± 1%	No	a and b
VH OPD (Pinelands) and Satellite clinics	45 149	E	451	± 1%	No	a and b
VH Neuroclinic (Observatory)	Figures not available	E		± 1%	No	a and b
VH Neuroclinic (Pinelands)	Figures not available	E		± 10%	No	a, b and c
WSH Inpatient	214	A	35	16%	No	a, b and c
WSH Outpatient	4 997	E	350	5-10%		
De Nova	405	A	58	14%	No	a, b and c
SANCA	962	A	152	16%	No	a and b
DCC	No. of patients seen Feb-Aug '85 182	A	182	All	Some are	All can be assessed but not all suited to treatment here - need inpatient treatment for some

Table IV also indicates responses to question (iv) on the questionnaire "Do you feel that substance abusers (not alcoholics) are suited to treatment at your centre? Please give reasons". The following key is used to indicate the most common reasons given:

a) Drug abusers need to be treated in a specialised drug abuse centre which we cannot provide.

b) Drug abusers need to be treated in a specialised treatment programme which we cannot provide.

c) Drug abusers need a controlled treatment environment which we cannot provide.

d) Drug abusers are generally younger than alcoholics and therefore do not fit in well with the latter - a separate treatment centre is therefore necessary.

Table IV indicates that 11 of the 14 medical-psychological centres purporting to treat drug abusers are considered by senior mental health professionals to be unsuited to this task. It is for this reason, presumably, that these centres accept only a relatively small number of drug abusers for treatment while accepting larger numbers of alcoholics and other psychiatric patients. The reasons given for this unsuitability are discussed later in this chapter.

Analysis of Table IV shows that 1 671 drug abusers were treated by these centres in 1984. This figure excludes those few treated at the two VH Neuroclinics (for which adequate data could not be obtained) and at the DCC (which opened in 1985). Chapter Two noted that there

this system can probably meet the demand for assessment only - 4 680 persons could be seen at the DCC each year provided they were seen only once. Some modification or expansion of the system is suggested in order that treatment be freely available. Later chapters examine the possible forms that such expansion could take.

Evaluation of the adequacy of the system also relies on factors over and above its patient capacity. Some of these are discussed as follows.

3.2.2 Adequacy regarding demographic variables

Demographic characteristics vary widely amongst drug abusers. Chapter Two showed that no racial or socio-economic group is exempt from drug use and therefore that persons from any of these groups could present for treatment in the network. Other demographic characteristics (for example age and sex) also vary over the drug abusing population as discussed in Chapter Two. The present section discusses these demographic variables in relation to the treatment network's capacity to treat all types of patients likely to present in the treatment network.

3.2.2.1 Race

Previous discussion noted that few Black persons present at medical-psychological drug abuse treatment centres and that the majority of patients are from Coloured or White groups. This was borne out by discussion of the GSH Psychiatric Outpatients survey (Ben-Arie 1984) and of the DCC's statistics (section 2.2.4). No information is available regarding the rate of presentation of Asian groups and therefore no conclusions can be drawn at present.

This suggests that an effective medical-psychological treatment system in Cape Town needs to provide facilities for a large number of Coloured and White persons and for a smaller number of Black persons. At the most obvious level this means that the system must be able to accept all races for assessment and treatment. The DCC and K4 are able to do this, Further issues are, however, involved in determining whether the present treatment system is adequate for treatment of Black drug abusers. Chapter Two noted two possible reasons for their low rate of presentation at professional medical-psychological treatment centres - (a) they do not regard drug use as problematic and (b) they do not regard such a centre or mode of treatment as the appropriate method of obtaining a cure for drug use problems. Further research is necessary here before any conclusions can be drawn as to the adequacy or inadequacy of the existing treatment system. At present the system may be viewed as adequate to treat the few Blacks who present or as inadequate in that it does not address the problem in a manner likely to attract Black drug abusers.

The DCC, which provides most of the psychological assessment and treatment in the system, is staffed exclusively by White middle-class professionals. Jones (1978) discusses the issues which complicate psychological treatment when therapist and patients are of different races and concludes that such therapist-patient matches limit the effectiveness of the treatment. This suggests that the DCC does not treat Black, Coloured and Indian patients as effectively as it can treat White patients. The following discussion of socio-economic status in relation to treatment issues is closely linked to this.

3.2.2.2 Socio-economic status

Chapter Two indicated that persons of all socio-economic groups use drugs. Reliable information regarding the relationship between socio-economic class and rate of presentation at a medical-psychological treatment centre was unfortunately not available. However, literature was presented in Chapter Two which suggested that middle- and upper-class persons may present more readily than working-class persons and that the latter group may tend to be more tolerant of drug use.

As discussed above regarding different racial groups, all socio-economic groups can be assessed and treated at the DCC and at K4. However, research has also indicated that psychotherapy is most effective where therapist and patient are of similar socio-economic status (Jones 1974). It is therefore suggested that the DCC at least, being staffed by middle-class White professionals, is at its most effective in the treatment of White, and to a lesser extent Coloured and Black, middle-class drug users.

3.2.2.3 Age

Both the DCC and Ward K4 accept patients of all ages for treatment. However, age specialization occurs naturally since most patients presenting at the DCC are adolescents or young adults (Appendix I). This may increase its effectiveness with younger patients by providing a homogeneous group (see Chapter Five's discussion of the advantages and disadvantages of this). It may also have the advantage that psychotherapists at the DCC, although not specifically trained to work with adolescents, become highly skilled here due to constant exposure to this age group.

Older drug users, however, may be disadvantaged in this system due to difficulty in merging with a predominantly younger group of patients. Chapter Five addresses this question of homogeneity or heterogenity in group therapy.

Demographic factors, then, do not specifically exclude drug users from treatment in the network but certain demographic categories may be considered to be more effectively dealt with than others. Middle-class White, and to a lesser extent Coloured and Black, adolescents and young adults seem to be considered most suited to the psychological treatment offered at the DCC and are therefore more likely to be accepted for treatment.

3.2.3 Adequacy regarding types and levels of severity of drug use

The definition of an adequate drug abuse treatment network given early in this chapter noted that such a network, in addition to being able to deal with a large number of drug abusers of all demographic backgrounds, must also provide appropriate treatment of all relevant types and levels of severity of the disorder. In Cape Town this implies appropriate treatment of cannabis and mandrax abusers as well as of a smaller but increasing number of other polydrug abusers (see Chapter Two). Similarly, drug use occurs at different levels of severity - some adolescents experiment only while others become heavy users (Chapter Two).

Can Cape Town's treatment network (consisting mainly of the DCC and Ward K4) provide appropriate treatment for all types and levels of severity of drug use? The response of the professional at the DCC to the questionnaire is taken as a starting point in this

discussion. This professional stated that the DCC could only treat certain kinds of drug abusers. Exploration of this with two staff members revealed that in-patient treatment and a carefully constructed program is held to be necessary for successful psychotherapeutic treatment of some drug users. Outpatient care seems to be considered unsuitable for chronic subcultural drug users and the DCC tends to accept for treatment only experimental or occasional users (Appendix I). This belief suggests then that an outpatient treatment system cannot treat all types of abusers. The value of this treatment situation is examined in Chapter Six. It is not possible here to examine the psychotherapeutic methods and orientations presently used in treatment nor to evaluate their relative effectiveness in treating different types of drug abusers. This area warrants further research, however, if effectiveness of treatment is to be maximised.

3.3 Summary and comment

This chapter briefly reviewed all centres involved in the assessment and treatment of drug abuse in Cape Town (Table III). On examination of these it became clear that only two professional medical-psychological centres (the DCC and Ward K4) actually view themselves as being available for the treatment of drug abusers per se although other centres (for example, Psychiatric Day Hospital) do treat a few selected abusers. This two-centre system was then examined with a view to determining its adequacy and appropriateness in dealing with drug abuse in Cape Town.

Evaluation was based on highly inadequate data due to lack of studies of drug abuse in Cape Town. It was suggested, however, that the system cannot adequately treat all drug abusers. Firstly, the system may be unable to deal with large numbers of drug abusers. In addition, abusers from various demographic backgrounds are possibly treated with differing degrees of effectiveness - certain racial, socio-economic and age groups are probably more effectively treated. It was suggested that experimental and occasional users are more often treated in the psychotherapeutic arm of the system than heavier users.

Expansion and modification of the system is therefore suggested. Many areas could be examined here if space permitted. However, three issues relevant to any planned expansion are singled out for evaluation in Section II of this thesis. Firstly, should psychotherapy, a costly and time-consuming treatment, be included in treatment (Chapter Four)? Should drug abusers be treated in separate specialized units (Chapter Five)? Should a treatment system include both inpatient and outpatient centres (Chapter Six)? These issues are examined in order that any future expansion or modification might provide the most cost-effective service possible. This means that the course of action most likely to produce the greatest amount of desired outcome will be the most attractive option (after Des Jarlais et al 1981). This is particularly important given the fact that government funding is by no means assured - the DCC is a publicly funded organisation and any expansion may be, of necessity, similarly funded.

SECTION TWO

ISSUES INVOLVED IN EXPANSION OF THE SYSTEM

Chapter Four: Should psychotherapy be included in drug abuse treatment?

Chapter Five: Should drug abusers be treated separately?

Chapter Six: Can outpatient psychological treatment of drug abuse be effective?

CHAPTER FOUR

SHOULD PSYCHOTHERAPY BE INCLUDED IN DRUG ABUSE TREATMENT?

4.1 Overview of methods and orientations commonly used in drug abuse treatment

- 4.1.1 Medical
- 4.1.2 Psychological

4.2 Should psychotherapy be included in a drug abuse treatment system?

- 4.2.1 Effectiveness of psychotherapy in general - has this been established?
- 4.2.2 Is psychotherapy effective with drug abusers?
  - 4.2.2.1 Doubts regarding effectiveness
  - 4.2.2.2 Support for effectiveness

4.3 Evaluation of and suggestions for the Cape Town treatment system

4.4 Summary and comment

CHAPTER FOUR

SHOULD PSYCHOTHERAPY BE INCLUDED IN DRUG ABUSE TREATMENT?

Cape Town's present drug abuse treatment system, as discussed in Chapter Two, consists mainly of a psychologically-oriented centre (the DCC) and of a hospital-based emergency centre (Ward K4) which undertakes medically-supervised detoxification of drug abusers. The present chapter examines the appropriateness of the psychological component of this system and aims to determine whether this has sufficient empirical support to warrant its inclusion in any future expansion of the system. This question is of particular relevance given the expense involved in providing psychotherapy (Des Jarlais et al 1981) - the issue thus revolves around cost-effectiveness.

The latter part of the chapter returns to the Cape Town drug abuse treatment system in evaluation; suggestions for increased effectiveness are made.

The following section (4.1) introduces the chapter by briefly noting types of medical and psychological treatments commonly used in drug abuse treatment.

4.1 Overview of methods and orientations commonly used in drug abuse treatment

The purpose of this section is merely to mention the major forms of medical and psychological treatment used in order that the terms may be used with greater clarity. Detailed description and evaluation is not possible here.

4.1.1 Medical

a) Detoxification. This term, as used here, implies medically supervised withdrawal of the drug of abuse. The nature of intervention depends on the particular drug involved. This may mean only care and observation while the drug-induced state gradually abates as, for example, in the case of cannabis where a withdrawal syndrome has not been conclusively demonstrated (DSM III, APA 1980). Active intervention may be necessary in other cases - for example, decreasing doses of methadone may be administered to opiate dependents to suppress the withdrawal syndrome (Kaplan and Sadock 1981). Amphetamine and barbiturate withdrawal should be carefully managed as severe symptoms may appear (ibid).

Drug-induced psychotic states may also require pharmacotherapy during detoxification.

Detoxification can be accomplished on an in- or outpatient basis depending on the nature and severity of the abuse, overall physical health of the patient, and the availability of community health services (ibid).

b) Methadone maintenance (or methadone hydrochloride maintenance). This drug treatment has been widely used, since its introduction in the early 1960's, in the medical treatment of narcotic (particularly heroin) abuse. Methadone, an addictive drug resembling morphine in its properties and pharmacology (Kaplan and Sadock 1981), acts in the treatment programme as a legal substitute for illegal heroin. The rationale for the use of this treatment is stated as follows:

> "Although complete abstinence from narcotics is an optional goal, many addicts cannot remain abstinent permanently. For these addicts, a controlled addiction to methadone is preferable to an uncontrolled addiction to heroin. Methadone maintenance is held to be the only realistic mass-treatment modality for the hundreds of thousands of heroin addicts" (ibid, p.509).

The proposed advantages of this treatment include removal of the need to engage in illegal and criminal practices to procure heroin. The abuser does not have to be preoccupied throughout the day with plans to procure his "fix" but can become engaged in more constructive activity. Methadone maintenance, according to Kaplan and Sadock, is not expensive in comparison with other therapeutic efforts. Disadvantages include the fact that the patient remains addicted to a narcotic and may have to remain on methadone permanently. Methadone may also be diverted to the black market, especially in poorly controlled programmes. The reader is referred to the following works for further discussion of the benefits, shortcomings and administration of methadone maintenance treatments: Dole and Nyswander 1965, Dole et al 1982, Martin et al 1973, Sells 1977.

Narcotic antagonists (for example, naltrexone) are also used in the medical management of narcotic abuse. The agents block the action of the opiates (Fink and Freeman 1970) and, unlike methadone, do not have narcotic effects and are not dependence-producing (Kaplan and Sadock 1981).

c) Treatment of co-existing psychiatric (and physical) disorders

Rounsaville et al (1982) showed that, of a sample of 533 opiate dependents in a multi-modal treatment program, most were given a diagnosis of at least one psychiatric disorder in addition to opiate abuse and dependence. The most common diagnoses included major depressive disorders and anxiety disorders. This suggests that treatment for the drug abuser may often include pharmacotherapy for other psychiatric disorders.

Drug use may also affect physical aspects of functioning and medical intervention may be necessary to remedy this.

4.1.2 Psychological

Psychotherapy was defined in Chapter One as formalized contact between a mental health professional and a patient where the aim of such contact is the alleviation of the patient's subjective distress by application of psychological techniques. Within this broadly defined area psychotherapies may be distinguished from each other at different levels of specification.

Firstly, psychotherapy may occur in an outpatient or an inpatient setting. In this thesis this is termed the treatment situation. Secondly, at a more specific level, psychotherapy may be directed at individuals, groups or families; for present purposes these are termed treatment methods. Thirdly, within the method chosen different orientations may be used - for example, psychodynamic, behavioural or cognitive.

All the above treatment situations, methods and orientations have been used in the treatment of drug abuse and it is not possible here

to evaluate the relative effectiveness of each one. Instead, evaluative analysis is applied to diverse studies which use any combination of the above psychotherapies. The treatment situation, method and orientation is specified where possible.

This attempt to evaluate effectiveness of a general psychotherapy may be problematic in that it may obscure differential effectiveness of different psychotherapies. This problem is alleviated somewhat by the similarity that exists in the psychotherapeutic conditions offered in different studies - most describe the use of individual, group and family therapy with psychodynamic, behavioural or cognitive orientations.

It should be noted that the term therapeutic milieu denotes residential treatment which attempts to deal with the psychological causes of addiction by modifying the abuser's personality style (Kaplan and Sadock 1981). Individual, group and family therapy are usually included.

The term drug counselling is used in some studies. This is not a psychotherapeutic intervention in the present context but is used as a minimum treatment control condition against which to measure the effects of psychotherapy. It focusses on identifying specific needs and delivering concrete services (Woody et al 1983).

4.2 Should psychotherapy be included in a drug abuse treatment system?

The decision to include or to exclude psychotherapeutic management in the treatment of drug abuse devolves on the question of its effectiveness both in the general psychiatric population and, more specifically, in the drug abusing sector of this population.

The effects of psychotherapy have been the subject of numerous "outcome studies" which, by various empirical and clinical research methods, seek to establish the extent to which the therapeutic endeavour results in gain for the patient (Goldstein et al 1984). Where this gain is demonstrably present the therapy is described as being effective. The difficulty here, however, arises in the definition of "gain to the patient". Imprecise definition of this concept has reduced the contribution of many outcome studies (Sells et al 1978b) and could nullify any conclusions reached in this chapter, hence the importance of clarification here.

Goldstein et al (1984) define gain for the patient in terms of "improvement of the underlying disorder, relief of symptoms, and/or restoration of normally adaptive behaviour and other mechanisms permitting coping with the psychological rigours of life" (p.480). This raises two points of particular relevance to the definition of effective psychotherapy or successful outcome. Firstly, what degree of improvement in the disorder (in this case drug abuse) is required before the label "effective" is applied? Secondly, should criteria other than levels of drug usage be included in the definition of success in therapy? That is, should the outcome of psychotherapy be evaluated in terms of multi- rather than unidimentional criteria, and, if so, what are the relevant criteria? To quote Goldstein et al (1984) here:

> "Should someone who, through the impact of a programme, has regained employment, resumed a marriage, and reported increased self-esteem while maintaining a low level of substance use be regarded as improved as someone who uses a similar amount of alcohol and/or drugs not accompanied by psychosocial improvement?" (p.482).

Much has been written regarding the necessity for close attention to these details in outcome research (for example, Sells et al 1978b). For present purposes it is sufficient merely to state that the term effective psychotherapy, as used here, implies a decrease, however slight, in drug use and/or an increase in adaptive functioning in other relevant spheres (social and occupational functioning). This definition is closely related to the DSM III's diagnostic criteria for substance abuse. Two of the three criteria for diagnosis of substance abuse (a pathological pattern of use and impairment in social and occupational functioning) are used, in modified form, in this definition of improvement.

This definition implies that any positive change in the patient's drug use or associated levels of functioning is the result of the therapeutic contact. This assumption is not justified in the absence of rigorous controls since change may be due to factors extraneous to the therapeutic situation. The reader is referred to Luborsky et al's review (1971) for further discussion of methodological ground rules in outcome research.

According to Goldstein et al (1984), outcome evaluation studies in the area of drug abuse have suffered from design problems including the lack of control groups, prospective designs, adequate outcome measures and sufficient follow-up. To ensure that studies which lack methodological rigour are not given undue importance in this discussion, major studies are marked briefly according to Goldstein et al's standards by means of a table provided at the beginning of discussion of each study. This table also includes details of treatment conditions, therapist and patient variables which are considered essential in determining the generalizability of the studies discussed.

Has psychotherapy been shown to be effective, in terms of the above definition, in the treatment of drug abuse? In other words, is its inclusion in drug abuse treatment programmes supported by well-researched evidence as to its effectiveness? Discussion of this question begins with a brief review of psychotherapy outcome research in the general psychiatric patient population; this provides the background and rationale for evaluation of psychotherapy with the drug abusing sector of this population.

4.2.1 Effectiveness of psychological treatment in general - has this been established?

The issue of the relative effectiveness or ineffectiveness of psychological treatment has been debated back and forth over the years since Eysenck (1952) posed the spontaneous remission hypothesis.

This states that there is a general tendency for persons to recover from a non-psychotic emotional disturbance with the passage of time and without the intervention of a professional psychotherapist (Subotnik 1972, p.33).

Eysenck (1952) stated that two-thirds of neurotics improve within 2 years with or without psychotherapy and concluded that the success rate of eclectic psychotherapy could not better the spontaneous remission rate. Psychoanalytic therapy, he said, could even lead to worsening of symptoms. Cartwright (1955) corroborated this "deterioration effect" by highlighting the significant variation in outcome among patients treated in dynamically oriented individual and group therapy - some improved significantly while some deteriorated. "Deterioration", according to Cartwright, could involve the appearance of new symptoms and/or other factors including the development of dependence on therapy and the development of unrealistic expectations leading to overly ambitious actions.

Thus Eysenck and others have challenged the effectiveness of psychotherapy on the basis of the "spontaneous remission hypothesis" and the "deterioration effect". Many telling counter arguments have been raised, however, and invalidating methodological flaws have been exposed (see Bergin and Strupp 1969; Bergin 1971; Garfield and Bergin 1971; Malan 1973). Furthermore, and on a more positive note, many reviews of outcome studies have maintained that insight-oriented, client-centred and behaviour therapies can be effective (Meltzoff 1969, Luborsky et al 1975, Garfield and Bergin 1971).

The basic rationale for further investigation of psychotherapeutic effectiveness has thus been established. The following section, continuing with this, narrows the focus to discuss the effectiveness of psychotherapy in the treatment of drug abuse.

4.2.2 Is psychotherapy effective with drug abusers?

4.2.2.1 Doubts regarding effectiveness

Drug abusing patients have long been considered unsuited to many forms of psychotherapeutic treatment. Hildebrand, for example, names a diagnosis of drug abuse as an excluding factor for brief reconstructive psychodynamic therapy (quoted in Malan 1979).

Brill (1977, in Rounsaville et al 1982) noted that the problems of psychotherapy with drug abusers included failure of the patient to become engaged in treatment, a high early drop out rate, relapse into illicit drug use and other types of impulsive behaviour.

Woody et al (1983) suggest that this widespread negative opinion originates from two lines of experience.

a) that numerous attempts to provide psychotherapy to abusers in private practice settings have been unsuccessful due to the patient's need for drugs and the acting out behaviours that develop around this need.

b) the idea that all drug abusers are sociopaths and that psychotherapy is ineffective with sociopaths. This idea may be due in part to studies done in penitentiaries where the frequency of sociopathy may be expected to be inflated.

O'Malley et al (1972) and Anderson et al (1972) attempted to evaluate the success rate of psychotherapy with drug abusers by empirical means. Outpatient individual and group psychotherapies were offered alongside medical regimes (psychotropic medication and methadone detoxification). The treatment was found to be unsuccessful on two counts - it failed to engage the large majority of abusers, and, where engagement did occur, there was no evidence of improvement over an eighteen month period. These results indicate that psychotherapy can be ineffective. However, analysis of the conditions under which this study was undertaken suggests particular reasons for this ineffectiveness. The treatment was administered by first-year "residents" who had had no special experience or training in dealing with drug abuse problems. It should be noted that older, more experienced therapists have been shown to function more effectively in short-term interpersonal therapy (Chevron et al 1983). Furthermore, these residents rotated often through different units thereby probably minimising the likelihood of good therapist-patient bonding. The results of this study, then, cannot necessarily be generalised to all treatment situations.

A further contention has been that psychotherapy cannot improve on the success rate of methadone maintenance treatment with opiate abusers. Dole and Nyswander (1967, in Karkus 1973) contended that formal psychotherapy was unnecessary in a carefully supervised maintenance program. Similarly, Karkus (1973) described an in-patient methadone maintenance program where informal group and individual discussions were emphasized. He concluded that "formal

psychotherapy has little place in a methadone program, even with serious problem patients, provided that patients receive help in solving day-to-day problems and are allowed to develop self-confidence and respect" (p.433).

This statement is, however, undermined by the fact that the author does not adequately define "formal psychotherapy" nor indicate the difference between this and "informal group and individual discussions". Thus this report could equally be used to support the position that certain types of psychotherapy are useful, especially when used alongside appropriate medical regimes.

4.2.2.2 Support for effectiveness

Many studies have supported the effectiveness of psychological treatment of drug abusers. Few studies employ psychotherapy as the only form of treatment, presumably since ethical considerations mitigate against this. That is, researchers are unwilling to deprive patients of other potentially useful treatments (for example, methadone maintenance) merely to suit research purposes. Many of the studies reviewed below therefore investigate the importance of psychotherapy as an adjunct to medically-oriented treatment.

A few introductory studies of psychotherapy with alcoholics are discussed briefly below. The reader is reminded of Chapter One's discussion of the usefulness and limitations of consulting such studies.

Emrick (1974 and 1975) reviewed outcome studies of psychologically oriented treatment of alcoholism. The first part of the review

(1974) concluded that psychologically oriented treatment (unspecified) leaves some alcoholics abstinent, some improved though not abstinent, some unchanged and some worse. "But the vast majority (about two-thirds) are improved or abstinent, indicating that once an alcoholic decides to do something about his drinking and accepts help, he stands a good chance of improving". (1974, p.534).

The 1975 review attempts to discover whether the alcoholic has as good a chance (or better) of improvement if he had no formal treatment. That is, does psychotherapy improve on the spontaneous remission rate and does it precipitate a deterioration effect? Results showed little difference in abstinence rates between no treatment groups (those having no contact with treatment centres), minimal treatment groups (those receiving less than five outpatient sessions or two weeks inpatient treatment) and treatment groups (those receiving more than minimal treatment). The latter group, however, had a higher rate of "improvement". Emrick suggests that the following conclusions can be drawn from his studies:

(a) Alcoholics are as likely to stop drinking completely for 6 months or longer with no or minimal treatment as when they have more than minimum treatment.

(b) However, treatment increases the alcoholic's chances of at least reducing his drinking problem.

Emrick's study thus provides some evidence that alcoholics can improve without treatment but that psychotherapy does help.

Gillis and Keet (1969), in a Capetonian study of prognostic factors and treatment results in hospitalised alcoholics, found that even prognostically less hopeful groups showed improvement in this psychologically-oriented treatment regime, thus providing further support for such treatment.

Studies of psychotherapeutic outcome amongst opiate abusers are also useful in this discussion. Opiate abuse or dependence, as used here, implies the use of narcotic substances such as opium, morphine, heroin, methadone and codeine (Brecher et al 1972 notes that these are the most important opiates used). The following studies generally attempt to determine the success rate of psychotherapy with opiate abusers although other-drug users are sometimes included. These studies, generally carried out in the USA under federal funding schemes, often have a high level of methodological sophistication and reflect the concern with which the U.S. government regards opiate and other-drug abuse.

Woody et al (1983) discuss seven outcome studies carried out since 1970 with methadone-treated opiate dependents (Willet 1973, Abrams 1979, Stanton et al 1982, La Rosa et al 1974, Connet 1980, Resnick et al 1981 and Rounsaville et al 1982). In these studies opiate dependents were randomly assigned to psychotherapy or to a treatment control condition (usually drug counselling). Five of the studies (71%) showed a better outcome in the psychotherapy condition than in the control condition. Woody et al (1983) conclude from this that there is evidence to indicate that psychotherapy can be beneficial to opiate dependent patients. They further note that this conclusion is similar to that reached by Luborsky et al 1975 in their overviews of psychotherapeutic effectiveness with psychiatric patients in general. This review found that 65% of patients in the psychotherapy

outcome studies showed a positive treatment effect.

The Veterans Administration Medical Centre, Philadelphia, USA has been actively engaged in very useful research into the treatment of drug abuse. The following two studies derive from this centre.

McLellan et al (1982) initiated a study aimed at addressing three questions - (a) do patients improve following treatment for substance abuse; (b) are improvements confined to alcohol or drug use or are they more pervasive; and (c) are these improvements a result of treatment? The sample used comprised of all male veterans admitted to the two Veterans' Administration Centres in 1978 - 742 patients of whom 460 were drug abusers. Further details of methodology, treatment, and patient characteristics are provided in Table V. Only data regarding drug abusers is reported here for the sake of brevity.

Table V Summary of Study: McLellan et al 1982

A Methodological considerations		
i)	Randomised/matched control group used?	Neither. However, used a comparison group of short-term (ST) patients - i.e. all patients from the treated population who had received a favourable discharge but had less than 15 days treatment. Not randomly selected. Justification for these procedures discussed in the paper.
ii)	Prospective research design?	Yes
iii)	Multi-dimensional outcome criteria?	Yes. Addiction Severity Index provided data in seven areas of functioning.
iv)	Follow-up data obtained?	Yes. Data gathered by independent research technicians in 1 hour interviews using ASI at 6 months after termination.
B Treatment conditions		
Drug abusers were assigned to one of the following programs: i) Psychological treatments offered: Combined Treatment - 45-day program that delivers intensive addiction management therapy to both alcoholics and drug abusers. Treatment is based on principles of AA or Narcotics Anonymous with ancillary individual therapy and education. Inpatient program. Drug Abuse Rehabilitation - Offers personal and social treatment in a 60-day program designed to "habilitate" the patient to society using individual and group psychotherapy, educational and vocational counselling, and the social structure of a self-governing therapeutic community. Inpatient program. ii) Medical treatment offered: Methadone Maintenance - offers MM in combination with a full program of psychiatric and social work counselling. Chemotherapeutic and individual psychotherapy interventions are used to treat associated psychological problems. Outpatient program.		
C Therapist characteristics		
Not detailed		
D Characteristics of patient sample		
1. Demographic data:	All male veterans who were admitted for drug abuse treatment at two Veterans' Administration centres during 1978 were eligible	
2. Details of their disorders:	80% were heroin abusers, averaging six years of daily use. Remaining abusers were regular users of amphetamines, benzodiazepines or hallucinogens.	

The Addiction Severity Index (ASI) was developed and used by the authors of this study as an information-gathering tool at admission and at six-month follow-up. The ASI, further discussed in Chapter Seven, is a structured interview schedule which provides data on seven areas - alcohol and drug use and medical, legal, employment, family and psychological problems. Appendix IV provides a copy of the ASI administration form.

Results indicated significant improvements on virtually all criteria. The improvement was most significant in the target symptoms of drug abuse but was also considerable in the areas of employment and psychological function. When compared with the short-term treatment group the longer-term treatment group showed significantly better post-treatment outcomes in all seven criterion areas and especially in drug use and legal status. The authors conclude that drug abusers do improve with current treatment regimes and that these improvements seem to be the result of treatment.

This study, while valuable, may not be directly relevant to our purposes here since it deals with the effectiveness of various types of drug abuse treatments, including medical treatments. The authors of the study note, however, that there was no evidence for any general outcome superiority from any single treatment program. This suggests that the psychological and medical treatments offered were of approximately equal effectiveness. However, since patients were not randomly assigned to different treatments, selection factors may operate here - one can conclude only that the different treatments have approximately equal outcomes when patients are selected by mental health professionals for each program.

Woody et al (1983) report on a further study relevant to the purposes of this thesis. This aimed to determine whether professional psychotherapy can provide benefits over and above those which result from standard methadone maintenance or drug counselling services.

Opiate addicts beginning a new treatment episode on a methadone maintenance program were offered random assignment to drug counselling alone or to counselling plus six months of either supportive-expressive or cognitive-behavioural psychotherapy. The study was carefully controlled with regard to randomization procedures, level of therapist experience and outcome measures and care was taken to specify terms used. Results demonstrated that a moderate proportion of opiate addicts receiving methadone maintenance treatment are interested in professional psychotherapy and are able to benefit from it. All three treatment groups showed significant improvement but patients receiving psychotherapy and methadone maintenance showed improvement in more areas and to a greater extent with less use of medication than those receiving only drug counselling and methadone maintenance. More than one-third of the methadone maintenance patients, then, were interested in and benefitted from psychotherapy. The authors feel, however, that certain administrative procedures used in the study are necessary to maximise the chances that psychotherapy can be used effectively with drug abusing patients. These include attention to patient compliance (patients were contacted immediately if they missed an appointment), use of therapists interested in drug abusers and on-going supervision of therapists.

The point may be raised here that only patients who expressed interest in psychotherapy were included in this study. This again constitutes a form of selection of patients - one would expect that those patients expressing interest in psychotherapy might be more likely to benefit from it. It is therefore important to note that the positive results of psychotherapy relate only to abusers who expressed interest in psychotherapy and not necessarily to the general population of abusers.

The Drug Abuse Reporting Program (DARP) forms another major contribution to drug abuse treatment evaluation research. DARP, initiated in 1968 with funding from the United States' National Institute on Drug Abuse (NIDA), provided information on almost 44 000 admissions to 750 drug treatment centres during the period 1969 - 1973 (Sells et al 1976). A comprehensive compilation of the major studies in this research is available in five volumes edited by Sells (1974) and in DARP Research Programme (1975), a special edition of the American Journal of Drug and Alcohol Abuse. These studies deal with issues such as client characteristics, definition of treatments and evaluation of during-treatment and post-treatment outcomes.

Due to the extensive nature of this research it is impossible to reproduce all relevant details within the scope of this thesis. Some detail is provided on Table VI regarding methodological treatment and patient characteristics. Discussion centres on the results of during-treatment and post-treatment outcomes.

Table VI Summary of Study: DARP (Sells et al 1976)

A Methodological considerations	Details of method
i) Randomised or matched control group used?	Neither - no control group since random assignment of patients to treatments not practised. Used an "Intake Only" (IO) group (completed only intake procedures) as comparison group. Also compared a patient's performance post-DARP with pre-DARP performance (see iii below)
ii) Prospective research design?	Yes - in addition, baseline data was gathered for 2 months prior to entry into DARP
iii) Multi-dimensional outcome criteria?	Yes - includes measures of drug and alcohol use, employment, criminality and re-entry into treatment
iv) Follow-up data obtained?	Yes - data was gathered by trained interviewers in one hour interviews at one year after termination for a large stratified random sample of those seen. Data was gathered for up to six years after termination.
B Treatment conditions	
Drug abusers were assigned to one of the following programs:	
1. Psychological treatment offered:	Average time in treatment
Therapeutic community (TC)	103 days
Outpatient drug-free (DF)	69 days
2. Medical treatments offered:	
Methadone maintenance (MM)	190 days
Outpatient detoxification (OD)	29 days
C Therapist characteristics	
1. All therapists were mental health professionals	
D Characteristics of patient sample	
1. Demographic data:	Almost equal numbers of Black and White males; average age 25 years.
2. Details of their disorders:	Majority regular opioid users; also non-opioid users.

The results of follow-up procedures at one year after treatment indicated that outcome criterion measures (drug use, employment, criminality and treatment readmissions) were more favourable in the MM TC and DF groups than in the OD and intake only (IO) groups. During-treatment evaluations and further follow-up evaluations (up to six years after termination) indicated similar results (Simpson et al 1979). MM, TC and DF are therefore seen to exert a treatment effect.

Once again, as in the McLellan et al study (1982), MM, TC and outpatient DF treatments were shown to have approximately equal outcomes with patients selected by mental health professionals as appropriate for each treatment condition. Further analysis (Simpson et al 1979) of outcomes in the three conditions showed that opiate dependents had better outcomes in MM and TC than in outpatient DF treatments; other-drug abusers and dependents had better outcomes in outpatient DF treatment.

This finding will be further discussed in relation to patient-treatment matching (Chapter Seven). It is sufficient here to note that both opiate and non-opiate users were found to benefit from psychotherapeutic treatment.

It is unfortunate that the outcome of psychotherapy with non-opioid users has not been subjected to the close scrutiny applied to outcome amongst opioid users. However, such work as has been done (for example, that discussed above) has indicated that psychotherapy can be effective with both opioid and non-opioid users as well as with alcoholics and the psychiatric patient population in general.

The basic rationale for continued research in the area has, therefore, been established - it remains for further research to specify all the patient, treatment and therapist variables which maximise the potential for successful outcome. This thesis touches on some of these issues in future chapters (Five, Six and Seven).

4.3 Evaluation of and suggestions for the Cape Town treatment system

This chapter has indicated that psychotherapy can be effective in the treatment of drug abuse. The following discussion briefly evaluates the existing system in the light of this finding and states its implications for expansion of the system.

The existing system is able to provide both psychotherapeutic and medical treatment (at the DCC and Ward K4 respectively). This is appropriate, according to the above discussion. However, neither centre alone can provide a comprehensive medical-psychological service and many patients are therefore managed by two separate centres. The importance of combined medical and psychological treatment has not been specifically stressed in this chapter. However, it is suggested that this separation of the two services may be both inconvenient and detrimental to the outcome of treatment. Staff at the two centres may not be in close enough liaison regarding the patient's treatment and the patient may effect a "split" between the two centres, thus undermining the effectiveness of both treatments.

For this reason the establishment of one centre able to provide both services may be helpful. Alternatively, basic medical services

(consultation, examination, prescription and dispensing) could be incorporated into the existing DCC. The incorporation into this centre of inpatient detoxification and stabilisation services, however, would probably involve much expense. For this reason Ward K4 will probably be retained as the detoxification centre unless patient load and financial resources should increase sufficiently to warrant the establishment of a new and larger detoxification unit.

Any expansion of Cape Town's drug abuse treatment system would be well advised, according to this chapter's discussion, to retain psychotherapy as a major component in spite of the expense involved. Research should aim to identify and develop the most effective psychotherapeutic methods and orientations.

4.4 Summary and comment

This chapter addressed the first in a series of questions designed to guide planning for extension of the treatment system in Cape Town - can psychotherapy be effective enough to warrant inclusion in the treatment system? The rationale for further investigation was established by a brief overview of psychotherapy outcome research with the general psychiatric patient population. When it was shown that psychotherapy can be effective, the focus was narrowed to evaluate its effectiveness with alcoholics and with drug (mainly opiate) abusers. Studies (for example, McLellan and Luborsky et al 1982 and the DARP) were noted; these show that psychotherapy can produce positive treatment results.

The inter-relationship between psychotherapeutic and medical treatments was discussed in passing. Detoxification alone has been shown to be ineffective (Simpson et al 1979) and detoxification with outpatient drug free psychotherapeutic treatment has been established as an effective treatment of non-opiate drug abusers. This finding is of importance in consideration of the Cape Town treatment system since most abusers here use non-opiate drugs (see Chapter Two).

The issue is somewhat different when one considers the treatment of opiate dependent patients since an effective medical treatment (methadone maintenance) is available (Simpson et al 1979). However, McLellan and Luborsky et al (1982) have shown that the use of psychotherapy in conjunction with a methadone maintenance program can produce more benefits in motivated patients than methadone maintenance alone. Thus the use of psychotherapy is supported in this group as well.

The cost of providing psychotherapeutic treatment to drug abusers in Cape Town is expected to be fairly high since this treatment probably demands considerable staff resources. It would seem, however, on the basis of the studies discussed in this chapter that it can be an effective treatment. It is suggested that, according to the present state of research, psychotherapy may provide a cost effective treatment of choice for Cape Town's drug abusing population, particularly as this consists largely of non-opiate dependents. It should be noted, however, that discussion has concluded only that psychotherapy can be effective. Research should continue the search to identify the therapist, patient and

treatment variables which affect outcome and thus to develop the most cost-effective treatment possible. The remaining chapters of this thesis address some of the broader treatment and, to a lesser extent, patient variables which may influence the outcome of psychotherapy amongst drug abusers in Cape Town.

CHAPTER FIVE

SHOULD DRUG ABUSERS BE TREATED SEPARATELY?

5.1 The status quo in Cape Town

5.2 The rationale for separate, specialized treatment of drug abusers

- 5.2.1 Drug abusers have certain characteristics in common
- 5.2.2 Drug abusers differ significantly from other diagnostic groups

5.3 The rationale for combined treatment

- 5.3.1 Practical concerns
- 5.3.2 The prevalence of drug abuse
- 5.3.3 Similarities between drug abusers and alcoholics
- 5.3.4 Symptoms should not be awarded undue importance
- 5.3.5 Differences need not hamper treatment
- 5.3.6 Combined treatment may take different forms

5.4 Summary and comment

CHAPTER FIVE

SHOULD DRUG ABUSERS BE TREATED SEPARATELY?

This chapter aims to determine the relative merits of specialized drug abuse treatment centres and of general centres (those which treat drug abusers alongside alcoholics and other psychiatric patients). The conclusion reached in this discussion is of importance in any planned expansion of Cape Town's drug abuse treatment system - should new and specialised centres be established or should existing centres, which presently treat very few drug abusers, be modified to allow for such treatment? The most cost-effective alternative will be the most attractive here?

Discussion commences with an outline of the existing system in Cape Town regarding the issue of specialization of drug abuse treatment (section 5.1). The views of some mental health professionals in Cape Town will be mentioned. The chapter then continues with an overview and discussion of the relevant arguments for and against specialized treatment (sections 5.2 and 5.3). The summary (section 5.4) includes suggestions regarding future expansion of the treatment system in Cape Town.

5.1 The status quo in Cape Town

Chapter Three indicated that Cape Town's drug abuse treatment system consists mainly of the Drug Counselling Centre and Ward K4. In addition, however, many general centres exist which may treat a small number of drug abusers alongside alcoholics or psychiatric patients from other diagnostic groups. The question

here is whether to encourage these general centres (particularly the alcohol treatment centres) to accept more drug abusers for treatment or to establish and expand specialized centres (such as the DCC) to treat drug abusers.

Table IV indicated that 11 of the 14 mental health professionals who responded to the questionnaire felt that drug abusers should be treated in a specialized unit and/or that specialized facilities and techniques were unnecessary for successful treatment. (This belief is perhaps reflected in the low admission rate of drug abusers to many of these centres). It is important, however, to question this belief as unnecessary expense may be incurred if new centres are established where modification of existing centres may produce equivalent treatment outcomes. It is not possible within the scope of this thesis to analyse the relative costs involved in these two alternatives. This procedure should, however, be carried out prior to implementation of any conclusions reached in this chapter.

5.2 The rationale for separate, specialized treatment of drug abusers

Proponents of separation in treatment might argue that resources in a separate centre can be specifically used to facilitate the best possible treatment regimes for drug abusers. This means that staff can be trained to a high level of proficiency in assessment, diagnosis and in the most useful treatment methods and orientations for this group. In addition, treatment methods particularly effective with drug abusers can be investigated and improved and general research facilitated.

It might be further argued that, in group therapy, homogeneity of members regarding diagnostic grouping is preferred over heterogeneity. Homogeneity in this respect may help to avoid the scapegoating and lack of identification with the group which may occur when a member (for example, a drug abuser) is in obvious minority (Yalom 1975).

Another advantage may be raised - homogeneity may allow the group and the facilitator to focus on the problems of drug abusers rather than devoting time to problems which may pertain specifically to other diagnostic groups. The disadvantages of a homogenous group composition will be outlined later (section 5.3.5).

All of the above arguments for separate treatment facilities presuppose commonalities between drug abusers which distinguish them as a group from other psychiatric patients. These assumptions form the focus of any discussion (and of any conclusions reached) regarding the relative merits of separate and combined treatment facilities. They are discussed as follows.

5.2.1 Drug abusers have certain characteristics in common

Can drug abusers be said to possess enough significant commonalities to distinguish them as a separate, homogenous group? The DSM III (APA 1980) attempts to separate substance abusers from other diagnostic groups on the basis of certain criteria, including the pathological use of a substance. However, such a diagnosis does not exclude the ascription of additional diagnostic labels. Substance abusers, therefore, may differ markedly from each other since they may have various additional psychiatric (and/or physical) disorders.

Furthermore, within the wider category (substance abuse), different types of substances may be abused in differing degrees and with different effects. Thus Glatt (1970) notes that, just as there are various types of alcoholism and alcoholics, so there are also many differences between the various forms of drug abuse and dependence and between drug abusers themselves (p.303). It would seem, then, that drug abusers, far from constituting a group united by many commonalities, may have only a few of the most obvious characteristics in common. It may be that their shared symptoms (pathological substance use of at least one month's duration and a decline in functioning) are possibly not their most important characteristics. That is, they may be seen as symptoms of a disturbance where the latter may be the true focus of treatment. Thus any overt commonalities between drug abusers may in fact be relatively unimportant in the treatment situation. This point is further discussed in section 5.3.4.

5.2.2 Drug abusers differ significantly from other diagnostic groups

Arguments for separate, specialized treatment of drug abusers assume that abusers, in addition to sharing certain characteristics, are also distinguished from other diagnostic groups by these characteristics. As previously noted, the DSM III (APA 1980) distinguishes this group purely on the basis of pathological substance use and the effects of this. Other distinctive characteristics of drug abusers have been suggested and are discussed below. Most of the literature to be discussed here compares drug abusers with alcoholics since the question most often addressed is whether drug abusers and alcoholics (rather

than other diagnostic groups) should be treated in combined settings. The literature used also often refers to narcotic abusers. Many of the conclusions reached, however, may be valid for abusers of non-narcotic illegal drugs (Huberty 1973; see also Chapter One's discussion of this issue). However, it may be that these alleged differences are less evident in any comparison of alcoholics and abusers of legal drugs (for example, analgesics and certain minor tranquillizers). This suggestion is supported by Glatt's opinion (1970) that alcoholics and middle-aged abusers of other legal drugs had many characteristics in common (see section 5.3.6).

The illegality, and resultant social disapproval, of non-medical drug use is held to clearly distinguish the drug abuser from the alcoholic (Huberty 1973, Glatt 1970). The narcotic abuser tends to adopt a life-style which diverges greatly from that of the alcoholic whose drug use is legal and, to some extent, socially acceptable (Huberty 1973). The most distinctive aspect of the lifestyle of one who abuses illegal drugs is perhaps criminal involvement - he or she is at the very least involved regularly in the crime of possessing drugs (ibid):

> "Multiply the narcotic addict's style of daily living by a number of years and the result is a person who takes for granted the daily risk of a felony conviction and a number of years in prison as an integral part of his existence. Thus, the addict is often risking his freedom and his very life in many ways in addition to his abuse of drugs" (ibid, p.344).

Familiarity with such a lifestyle may give rise to particular problems in the treatment situation since drug abusers may be more inclined to misbehave, to break rules and to "act out" (Ottenberg and Rosen 1971, Glatt 1970). Alcoholics, in contrast, are traditionally considered to be more withdrawn and passive (Ottenberg and Rosen 1971). These differences may prompt staff to consider separate treatment, with stricter external control, as appropriate for drug abusers. This conclusion is debated later in this discussion - at present it is sufficient merely to highlight some of the difficulties which may arise when drug abusers and alcoholics, with all their differences are treated in a combined setting.

A further problem may arise out of the disparity between the alcoholic's and the drug abuser's lifestyle. They may be hostile towards each other with the alcoholic regarding the drug abuser as a "dropout" and "junkie" and the drug abuser regarding the alcoholic as "square" (Huberty 1973, Ottenberg and Rosen 1971).

Some authors have noted differences in the age of onset of the abuse syndrome. Most narcotic addicts become dependent prior to their twentieth birthday (Brill and Lieberman 1969, de Lemos 1972) whereas, for most alcoholics, dependence occurs in their twenties or thirties (Winkur et al 1970).

Huberty (1973) notes the implications of this for psychological development and for the combined treatment of drug abusers and alcoholics.

> "It means that, while most alcoholics to some degree successfully complete normative tasks of adolescence, most addicts do not. Rather, the addict has short-circuited his emotional growth process during adolescence by his reliance on mood-altering narcotic drugs. One implication for treatment of the addict is to help the addicted person regress to the point of fixation in adolescence and provide a therapeutic milieu in which he can safely work through and often act out his adolescent conflicts...Despite this theory, many alcoholic treatment centres experimenting with treatment of narcotic addicts are not accustomed to the adolescent-level acting out behaviour of the addict and often...(discharge) him from the treatment centre prior to completion of the ... program" (p.344, brackets mine).

Other differences between alcoholics and drug abusers have also been noted. Once the drug is withdrawn, the abuser must often completely change his daily style of living if he is to remain free of drugs (Huberty 1973). Alcoholics, in contrast, often have a constructive lifestyle established and partially intact - that is, they may have a job, a home, friends, identity and status (ibid). Thus alcoholics and drug abusers may differ here regarding treatment needs since the alcoholic may not have to change his lifestyle as dramatically as the narcotic dependent person (and possibly other drug abusers as well) may have to.

These differences seem to have been recognised by many Capetonian mental health professionals (Table IV). However, they may have been appropriated as reasons for creating separate and specialized treatment units for alcoholics, drug abusers and other psychiatric patients. The available literature in this area does not seem to support this conclusion. Huberty, for example, while noting the differences between alcoholics and drug abusers, states that there are enough similarities between drug abusers and alcoholics to provide a basis for a common approach to treatment. The goal, according to this author, should be to recognise and deal with differences in combined treatment centres. The rationale for combined treatment is discussed as follows.

5.3 The rationale for combined treatment

5.3.1 Practical concerns

Drug abusers and alcoholics have traditionally been treated separately (Huberty 1973). This may be due in part to the above differences between the two groups and the perceived difficulty in dealing with these in a combined treatment setting. The recent growth in and awareness of drug abuse problems (see Chapter Two) seems, however, to have resulted in increased demand for treatment facilities. Many alcohol, and other, treatment centres have in consequence been subjected to pressure to become involved in treating the problem in the absence of specialized drug abuse treatment centres (see, for example, Ottenberg and Rosen 1971). It is probably for this reason that the possibility of combined treatment has become important since this would, quickly and presumably cheaply, increase the availability of treatment to drug abusers.

5.3.2 The prevalence of dual abuse

A further factor prompting the merging of drug and alcohol treatment is the prevalence of dual abuse (both alcohol and drugs) in many patients (Ottenberg and Rosen 1971, Glatt 1970). McLellan et al (1980) is of the opinion that the traditional alcoholic-drug user dichotomy is over-simplified and does not correspond to actual patterns of abuse. For this reason the Veterans' Administration Hospital treats both alcoholics and drug abusers.

5.3.3 Similarities between drug abusers and alcoholics

Many authors have contended that despite differences noted earlier, persons with problems related to other drugs are similar to alcoholics in many ways. Glatt (1970) notes many similarities between the two groups in the areas of causation, development of the addiction, social complications, treatment goals, prognosis and in administration of treatment. Only the most relevant of these can be further discussed here. Glatt notes that "A number of principles hold good almost equally for the treatment of all forms of drug dependence, including alcoholism" (p.337). These include the need for early diagnosis and treatment, long-term treatment and after-care, a multi-disciplinary approach and team-work. In addition, according to Glatt, similar therapeutic methods (individual, family and group therapy) and orientations (short-term psychodynamic therapy with a social approach) should be used with both alcoholics and drug abusers.

5.3.4 Symptoms should not be awarded undue importance

Section 5.2.1 argued that alcoholism and drug abuse could be viewed merely as symptoms of the underlying disorder with the latter being the true focus of treatment. According to this argument, drug abusers may be seen to have much in common with other disturbed people (alcoholics as well as other psychiatric patients). It could be contended that the creation of separate treatment centres for drug abusers merely draws undue attention to the symptom, thus deflecting the treatment effort from its true centre (the underlying disorder).

Systems theorists (for example, Minuchin 1974) might further argue that the creation of separate drug abuse treatment centres merely collides with the family in labelling the young drug abuser as "the problem". The family as a whole is thus allowed to escape their involvement in and responsibility for the family problem. This argument would support the merging of drug abusers into general psychiatric treatment centres (for example, the Psychiatric Day Hospital in Cape Town).

5.3.5 Differences need not hamper treatment

Section 5.2.2 described differences between alcoholics and drug abusers. These differences have been named in support of specialization of treatment. However, others have noted the positive effects of these differences in combined treatment settings.

Ottenberg and Rosen (1971) describe their one-and-a-half year old experiment in introducing drug abusers into an alcoholic inpatient program. Treatment consisted of confrontationary group techniques

and a therapeutic community atmosphere. The initial effect of this change was divisive - the two segments of the population viewed each other with suspicion, disdain and occasionally open hostility. In group therapy, the drug abusing minority tended to dominate the group while the older alcoholics became increasingly angry. The latter eventually expressed this anger and, as a result, became more actively involved in the group process than they had previously been.

As interaction developed the alcoholics and drug abusers began to find areas of identification with each other. They were able to provide insights for each other into the problems of parents and of children respectively. The emphasis in the groups began to shift from the substance used to the person using it -

> "We have always found alcoholics using their self-conceived difference from other people as a defence against recognition of their drinking problem and attempts to help them overcome it. Addicts, with their intense allegiance to a culture of their own, exhibit the same defense. Forcing both groups to interact as persons unlabelled 'addict' or 'alcoholic' has been therapeutic" (p.102).

Drug abusers *were* found to be more likely to misbehave and to break rules. This created tensions in the community which were dealt with in group and community discussions. Ultimately, the authors conclude that the merger has been a rewarding experience where advantages have outweighed disadvantages. The presence of the drug

abusers resulted in a more stimulating atmosphere and the two-generation population was found to be advantageous in that it created tensions and provided caring. The treatment outcomes with alcoholic patients remained the same as before the merger and the outcome with all but that older "hard core" drug abusers appeared promising.

Cautions are sounded, however - the initial period was extremely difficult for staff and patients alike. The authors suggest that staff should be carefully prepared for such a merger.

Glatt (1970) agrees that differences may aid rather than hamper treatment of alcoholics and drug abusers. He notes the dangers associated with forming homogenous therapy groups consisting purely of young drug abusers.

> "...the ideals, ideas and often the asocial attitudes and activities of the subculture to which these youngsters belonged in the past might continue even while in the hospital" (p.344).

Furthermore, while difficulties are bound to arise when young drug abusers share a ward with older alcoholics,

> "...many young drug addicts admit that they receive a great deal of help from the older, more experienced, more mature, usually better educated, and often highly skilled alcoholic co-patients. In fact, certain alcoholics take much interest in, and show a great deal of empathy for the problems of the young drug takers" (p.344).

It would seem that the obvious differences between alcoholics and drug abusers may not be sufficient reason to segregate them in treatment. The differences may, in fact, have a beneficial effect on outcome.

5.3.6 Combined treatment may take different forms

Combined treatment need not always mean that alcoholics and drug abusers are treated together in all possible therapeutic activities. Instead, the nature and degree of mixing may be tailored and modified to suit the particular centre, treatment population and staff resources. Some workers, for example, have found it necessary to treat young narcotic abusers separately from other substance abusers. Archibald (in Glatt 1970), for example, found that young narcotic abusers did not mix well with other substance abusers and that, while they could be treated by the same institution, separation in group therapy was advantageous.

Cameron (in Glatt 1970), also a proponent of integration of treatment programmes, points out that

> "...there is a very vast difference between treating all drug dependent persons in a single ward or in a single hospital or outpatient setting, and having several different, closely co-ordinated treatment sources that may serve different patients according to their drug dependence underlaying psychopathology, social background and legal status" (p.36).

Glass (1970) is also of the opinion that, while alcoholics and young narcotic abusers can be successfully treated in the same wards,

they should not be treated in the same therapeutic groups. Middle aged drug abusers (who generally abuse legal drugs) and alcoholics, on the other hand, were found to have greater functional proximity and could be treated in the same group.

It is probable that the optimal nature and extent of mixing in a combined treatment centre depends largely on the characteristics of the particular centre. Thus, in a city such as Cape Town, where the majority of drug abusers use non-narcotic drugs (Chapter Two), the difficulties noted above with narcotic abusers may not be as obvious. It may therefore be possible to treat alcoholics and drug abusers in the same therapeutic groups. Further research is necessary in this area before any dogmatic statements can be made. At present it would seem advisable to carefully experiment with and document variations of combined treatment.

5.4 Summary and comment

This chapter aimed to assess the possibility of combining the treatment of drug abusers with that of other psychiatric groups, particularly alcoholics. This was recognised as an important issue in the consideration of methods of establishing an adequate and cost-effective treatment system in Cape Town. It seems possible that dealing with drug abuse treatment within existing psychiatric treatment facilities may reduce the expense and time involved in making adequate treatment available. However, since a feasibility and cost analysis could not be carried out within the scope of this thesis, conclusions can only be drawn with respect to the clinical advisability or otherwise of combining treatment facilities.

It was pointed out that many of the Capetonian mental health professionals who completed the questionnaire (Table IV) were of the opinion that drug abusers should be treated in separate centres, or at least in separate specialized programs. With this as a starting point, discussion continued with an analysis of the arguments for and against separation in treatment. Very little statistical or verifiable data was available, unfortunately.

It was shown that arguments for separation in treatment rest on the assumptions that drug abusers are similar to each other and significantly different from other psychiatric patients. Doubt was cast on both of these arguments at different points in the chapter - neither enjoy unmitigated support. The differences between alcoholics and drug abusers, which are named in support of separation in treatment, were detailed. These differences (for example, differences in age and lifestyle) are presumed by some to negate combined treatment efforts.

The rationale for combining treatment efforts was then put forward. Similarities between drug abusers and other psychiatric patient groups were suggested. At the most basic level this involves the argument that, although overt symptoms may differ, the underlying distress may provide common ground. Differences may well exist between alcoholics and drug abusers but some clinicians and authors (for example, Ottenberg and Rosen 1971) note that these differences may have beneficial and stimulating effects in the treatment situation. Furthermore, combined treatment situations can be modified to suit particular local needs. That is, a single institution may assume responsibility for substance abuse treatment

but the degree of mixing may be modified (for example, alcoholics and drug abusers need not necessarily be treated in the same therapeutic groups).

This suggests that combined treatment in some form is at least worth considering in Cape Town. A full feasibility and cost anlaysis would, of course, be necessary before any more definite statement may be made here. It may, for example, be impractical and more expensive to modify and expand existing general facilities than to establish new centres. (Even in this instance, however, the issue of whether to combine or separate patient groups is important). It is possible, for example, that William Slater Hospital (presently treating only alcoholics as inpatients) may be able, with appropriate changes, to absorb some drug abusers into its inpatient program. Psychiatric Day Hospital, as well, could possibly accept more adolescent drug abusers into its program. (The questionnaire response indicated that this centre does accept a number of drug abusers). This chapter has indicated that these and other options should be given due consideration.

The following chapter addresses another issue of importance in the creation of an adequate and cost-effective drug abuse treatment system in Cape Town - is outpatient treatment sufficiently effective or should inpatient units be preferred?

CHAPTER SIX

CAN OUTPATIENT PSYCHOLOGICAL TREATMENT OF SUBSTANCE ABUSE BE EFFECTIVE?

6.1 The status quo in Cape Town

6.2 The trend towards outpatient treatment and reasons for this

6.3 Doubts regarding the effectiveness of outpatient psychological treatment

6.4 Evidence for the effectiveness of outpatient psychological treatment

6.4.1 Evidence from studies of alcoholics

6.4.2 Evidence from studies of drug abusers

6.5 Summary and comment

CHAPTER SIX

CAN OUTPATIENT PSYCHOLOGICAL TREATMENT OF SUBSTANCE ABUSE BE EFFECTIVE?

Chapters Two and Three indicated the need for expansion of Cape Town's drug abuse treatment system. Chapters Four and Five have addressed two questions important in the planning of any expansion - should psychological treatment be included in the system (Chapter Four) and should future facilities be specialized drug abuse centres or general psychiatric or combined alcohol-drug abuse centres (Chapter Five)? The present chapter discusses a third important issue - should expansion favour outpatient or inpatient facilities? This question is, once again, important in the provision of a cost-effective and adequate treatment system in Cape Town. An outpatient program, as will be discussed shortly (section 6.2), is far less expensive to establish and to run, in comparison with an inpatient program. For this reason it is useful to investigate the effectiveness of outpatient treatment - can this produce outcomes comparable to those produced in more expensive inpatient programs? If so, it may be the most cost-effective alternative for the treatment system in Cape Town.

The chapter commences with an outline of the existing treatment system in Cape Town regarding the availability of in- and outpatient treatment for drug abusers and the relevant attitudes of some local mental health practitioners. Thereafter (section 6.2), the widespread trend towards outpatient treatment, and the reasons

for this, is discussed. Sections 6.3 and 6.4, respectively, outline the arguments and evidence for and against the effectiveness of outpatient treatment.

6.1 The status quo in Cape Town

The Drug Counselling Centre, the primary centre for psychological treatment of drug abuse in Cape Town, has no facilities for residential treatment. Ward K4 (Groote Schuur Hospital), the major centre for detoxification and medical treatment of drug abusers, has resources for outpatient and short-term (up to about one week) inpatient treatment only. No other centres accept significant numbers of drug abusers for inpatient psychological treatment.

It is clear, then, that inpatient psychological treatment is not freely available to drug abusers in Cape Town and that the system relies heavily on the outpatient services provided, primarily, by the DCC.

The Drug Action Committee, being of the opinion that the existing outpatient centre (the DCC) can appropriately treat only young experimental and occasional drug users, considers the provision of inpatient facilities important (Appendix I). The questionnaire (Table IV) indicates, in addition, that staff of both the DCC and Ward K4 concur with this. This chapter seeks to determine the validity of this belief by reviewing the literature on the effectiveness of outpatient psychological treatment of alcoholics and drug abusers. Firstly, however, the trend in other countries (for example, the USA) towards the provision of outpatient rather than inpatient facilities is discussed.

6.2 The trend towards outpatient treatment and reasons for this

The modern trend in general psychiatric as well as substance abuse treatment seems to be towards outpatient rather than inpatient care (Demone and Schulberg 1966). This may be linked to the community mental health movement which seeks to deinstitutionalise care (Ozarin and Levenson 1969). Knowles (1983) provides a clear example of this trend when he notes that, in the years 1975 - 1980, there was a consistent trend in American hospitals away from inpatient and towards outpatient services for substance abuse. This does not necessarily mean that outpatient treatment is desirable, however. Reasons for this trend are discussed below; its desirability forms the focus of discussion in the rest of this chapter.

The most obvious reason for this may be financial - outpatient services cost far less to establish and to run than inpatient services (Stinson et al 1979, Amini et al 1982, Knowles 1983, McLellan 1983b). Financial considerations are important in the development of the Cape Town drug abuse treatment system. This is especially so since State funding is not assured - further treatment centres may have to be publicly funded as is the case in the Drug Counselling Centre. For this reason, the establishment of a predominantly outpatient treatment system is attractive. However, cost-effectiveness must be established as a higher price may be paid in the long-term if outpatient services prove inferior to inpatient services regarding outcome. This chapter aims to determine the relationship between outpatient treatment and outcome

(that is, the effectiveness of outpatient treatment) in order that a cost-effective treatment system be established.

Further advantages of outpatient treatment have been noted and are listed as follows:

a. Outpatient treatment allows the patient to continue with his job and other relationships in the community thus avoiding the dislocation and re-entry problems which may occur with inpatient treatment (Stein et al 1975). Patient preference is important here - not all patients will commit themselves to inpatient treatment for fear of dislocation from all that is important to them.

b. Inpatient treatment may be disadvantageous in that it confines the patient in an institutional environment with a drug abusing population, thus confirming his identification with this population. Outpatient treatment may lessen these effects (Demone and Schulberg 1966).

c. Edwards and Guthrie (1967) note that outpatient treatment is advantageous in that the spouse can take credit for success "rather than having the wounding experience of having her husband being abruptly taken into hospital, later to return as the hospital's success and as a strange sober man suddenly demanding a new and dominant role within the home" (p.558).

d. Outpatient treatment may mobilise help from the community where institutionalisation may isolate such sources. Thus the GP, Alcoholics Anonymous, relatives, and friends, etc. can become key figures in successful outpatient care.

Thus considerable advantages may accrue to a predominantly outpatient treatment system. Advantages of inpatient over outpatient treatment also exist, of course, but are not dealt with here since the primary aim is to determine whether the cheaper outpatient alternative is as effective as inpatient treatment. If this is the case, an outpatient system will be proposed as the most cost-effective treatment response to drug use in the city. Alternatively, if outpatient treatment does not prove at least as effective as inpatient treatment, the latter will be proposed. A third alternative also exists - each treatment setting may prove effective in particular situations, that is, with particular types of patients and with particular types and levels of severity of drug abuse. In this case, a system consisting of both in- and outpatient centres will be proposed.

The following review of relevant literature in this area is presented in an attempt to reach a decision regarding the above alternatives.

6.3 Doubts regarding the effectiveness of outpatient psychological treatment of drug abusers

Many arguments against outpatient treatment of psychiatric patients originate in the early and middle years of this century and are based on opinion and clinical experience in unstandardized conditions rather than on empirical evidence. For example, Mapother (1934, in Edwards and Guthrie 1967) states that:

> "Personally I disbelieve in all treatment outside an institution, whether psychological or by drugs except in the very rarest instances" (p.555).

Moore and Buchanan (1966), similarly, argue that continued hospitalization after detoxification is the optimal setting to "massively confront" the alcoholic's denial.

Connell (1974), writing of adolescent drug users, is of the opinion that only in the very strongly motivated is it possible to initiate treatment of a regular drug user as an outpatient -

> "Most addicts will, when they have developed sufficient motivation, realize that they are not strong enough to resist the pressures from their friends to continue taking drugs, or the temptation of the presence of drugs accessible to them in the community. Inpatient admission is, therefore, usually necessary" (p.31).

Furthermore, outpatient treatment on discharge from hospital is, according to Connell, the "weakest link in the chain" since "the addict himself is difficult to help outside the supervision of the hospital or the controlled hostel because so many of them have a low tolerance for frustration and are poor in organising their lives in a consistent and structured way" (p.32).

The argument, therefore, is that the drug abuser has inherent weaknesses which make outpatient treatment very difficult at best. It is not possible, within the scope of this thesis, to fully discuss this point. Suffice it to say that no unitary drug abusing

personality profile has yet been uncovered even though this has been diligently sought (Glatt 1974). Of course, the characteristics noted by Connell above may be the result, rather than the cause, of drug abuse.

Two related empirical studies, previously discussed in Chapter Four (section 4.2.2.1), are of relevance to this analysis of the effectiveness of outpatient treatment. O'Malley et al (1972) and Anderson et al (1972) found that outpatient psychological treatment of heroin abusers and of amphetamine, barbiturate and hallucinogen abusers failed miserably. They were unable to engage young drug abusers in traditional outpatient psychotherapies with or without methadone maintenance. They conclude that further efforts similar to their own should be de-emphasised and that available resources should be directed towards "more innovative" modalities -

> "Self help programmes and residential treatment centres report some success and a systematic evaluation would seem warranted" (p.867).

As previously noted, however, the results of this study may be due to factors other than the ineffectiveness of outpatient psychotherapeutic treatment. For example, treatment was administered by fairly inexperienced first-year residents who rotated often through different units, thereby possibly interfering with the development of patient-therapist bonding.

Lordi (1979) and Meeks (1980) felt that adolescents could not be successfully treated as outpatients. Amini et al (1982) were also

convinced that delinquent adolescent drug abusers could not be successfully treated as outpatients due to low motivation for psychological change, chaotic home life and poor social functioning. These authors undertook to test their hypothesis that residential (milieu) treatment with intensive psychodynamic psychotherapy, though expensive, would produce long-term social and personal benefits unlikely to occur with outpatient treatment. The following table (VII) summarises the relevant preliminary information needed to evaluate this study.

Table VII Summary of study: Amini et al (1982)

A Methodological considerations	Details of method	
	n = 87 (60 males; 27 females)	
i) Randomized or matched control group used?	Random assignment of subjects to residential and outpatient treatment groups	
ii) Prospective research design?	Yes	
iii) Multi-dimensional outcome criteria?	Yes - 7 social functioning scales, the MMPI and Global Change Scale	
iv) Follow-up data obtained?	Above criteria measured at a year and 2 years after termination	
B Treatment conditions		
Drug abusers were assigned to one of the following psychological treatment groups:		
1. Psychological treatment offered:	OP Group	IP Group
	Reported regularly to probation officer; no "formal psychotherapy	(Mean stay 132 days). Intensive psychodynamic psychotherapy in a therapeutic milieu. Also family, group therapy.
2. Concurrent medical treatment offered:	Not mentioned	
C Therapist characteristics		
1. Mental health professionals?	OP Group	IP Group
	No probation officials	Yes
2. Years of experience	Not specified	
D Patient characteristics		
1. Demographic variables	Mean age: 16,1 years Race: 52% White, 22% Spanish, 16% Black Socio-economic status: Middle All referred through probation dept.	
2. Details of disorder	* Subjects screened to exclude psychosis, mental retardation, extreme violence. * Mostly Conduct Disorders, Dysthymic Disorders, Passive-aggressive and Borderline Personality Disorders.	

Results of follow-up procedures at one year after termination showed that both groups (outpatient and residential) improved to some degree. Amini et al (1982) present three alternative explanations for this finding. One is that both treatment methods are equally effective; a second is that changes are unrelated to treatment and a third is that the measurement scales used may not have tapped clinical variables on which the subjects do differ. These results, then, do not necessarily provide unequivocal support for the comparable effectiveness of both treatment types - further research would be necessary before such a statement could be made. However, at this stage outpatient treatment has not been shown to be inferior to in-patient treatment.

The results of this study are particularly interesting given the wide disparity in treatment modes - the residential treatment group received psychotherapy, which has been shown to increase the likelihood of successful outcome (Chapter Four). The outpatient group received minimal treatment with no "formal psychotherapy" yet yielded comparable outcomes. This inequality of treatment variables means that comparisons of the two groups must be limited.

6.4 Evidence for the effectiveness of outpatient treatment

6.4.1 Evidence from studies of alcoholics

Successful outpatient treatment of alcoholics in a psychiatric private practice setting was described as early as 1938 (Selinger). Feldman (1959, in Edwards and Guthrie 1967) had success with out-patient treatment and Lawrence (1969, in Edwards and Guthrie 1967) stated that:

> "While it is sometimes desirable and even essential that the alcoholic should be cared for in hospital, the definitive treatment of the vast majority should occur at the outpatient level...Frequently the alcoholic patient is maintaining a very tenuous adjustment that may be broken by a relatively brief period of hospitalisation and be very difficult to restore" (p.119).

Stein et al (1975) studied a group of alcoholic men randomly assigned to two groups on admission to an inpatient alcohol treatment centre. The following table (VIII) briefly describes the relevant procedures and elements of this study.

Table VIII Summary of Study: Stein et al (1975)

A Methodological considerations	Details of method	
1. Sample size	n = 58 (Males)	
2. Use of randomised or matched control group?	Yes. Subjects randomly assigned to 2 treatment groups. The 2 groups did not differ significantly in any respect.	
3. Prospective research design?	Yes	
4. Multiple outcome criteria?	Yes - measured psychological change, counselling readiness and post-hospital adjustment (i.e. social, financial, employment, legal, drinking behaviour).	
5. Follow-up procedures?	Yes. Measured at 5 intervals over 1 year period.	
B Treatment considerations		
Alcoholics were assigned to one of the following psychological treatment groups:		
Psychological treatment offered:	Short-stay group	Long-stay group
	Hospitalised for detoxification only (+ 9 days), thereafter OPs. "No structured psychosocial treatment".	Detoxification plus + 25 days "intensive psychosocial" IP treatment
Concurrent medical treatment offered	Not specified	
C Therapist variables		
1. Mental Health professionals?	Not specified	
2. Years of experience	Not specified	
D Patient variables		
1. Demographic characteristics	Mean age: 42,7 years SES: Middle to low	
2. Details of disorder	*Primary diagnosis of alcoholism *No other severe psychiatric or physical disease	

No significant differences were found between the two groups on any measure, suggesting that hospitalisation beyond detoxification is not indicated. Stein et al concluded that:

> "...the hospital has a very limited role to play ...that role is limited to treating the medical sequelae of this disabling addiction with no untoward results stemming from early discharge back to the community. In these days of spiralling medical costs...our findings can be interpreted to have direct and immediate implications for treatment programs for alcoholic persons" (p.252).

Edwards and Guthrie (1967), noting that in the United Kingdom the treatment of alcoholism had been based more in inpatient than on outpatient care, set out to discover whether this trend was justified. Details of this study are given on Table IX.

Table IX Summary of Study: Edwards and Guthrie (1967)

A Methodological characteristics	Details of method
1. Sample size	n = 40 (males)
2. Use of randomised/matched control group?	Yes - subjects agreed to (i) random assignment to two treatment groups. Characteristics of the two groups did not differ significantly in any respect.
3. Prospective research design?	Yes
4. Multiple outcome criteria?	No - assessed on a 2-point scale re level of alcohol intake each month.
5. Follow-up procedures?	Yes. All followed-up to one year with monthly assessment of progress being made by independent raters.
B Treatment considerations	
Alcoholics were assigned to one of the following psychological treatment groups:	
1. Psychological treatments offered:	OP Group: Seen at least once fortnightly for 8 weeks. Thereafter at least once a month. / IP Group: 8 weeks IP treatment, thereafter seen once a month as OPs.
	Similar individual psychotherapeutic (eclectic) and social work management
2. Concurrent medical treatments offered:	Short-term use of tranquillisers if necessary for withdrawal symptoms.
C Therapist variables	
1. Mental health professionals?	Not specified
2. Years of experience	Not specified
(i) This prerequisite for acceptance as a subject may be a source of bias. However, only 2 patients refused to accept this condition; the authors, therefore, feel that this clause does not bias the sample towards over-representation of the more co-operative subjects.	
D Patient variables	
1. Demographic characteristics	*Marital and socio-economic status variables evenly distributed in the two groups
2. Details of disorder	*Alcohol dependent *No other serious physical or mental disorder

No significant differences were found between the two groups at six months or at one year follow-up and the authors conclude that a certain type of outpatient treatment gives, on average, as good results as a certain type of inpatient treatment. Their caution against over-generalisation of these results is commendable - extrapolation to other treatment regimes is not justified.

Ritson (1968) also compared inpatient with outpatient treatment of alcoholism. 100 alcoholic men were assigned non-randomly to the two treatment groups; the outpatient group consisted of patients who refused admission, who denied that they were alcoholic and/or who would not accept other requirements for inpatient status. In spite of the less favourable prognosis of the outpatient group thus constituted, they did as well as the inpatient group at one year follow-up. This does not mean that inpatient treatment was more or less effective than outpatient treatment as the two groups differed. It does imply, however, that it is not necessary to hospitalise all alcoholic patients and that the method of treatment should be chosen to "fit" a particular patient. For this to be done successfully prognostically significant patient characteristics in outpatient and inpatient treatment must be clarified (see Chapter 7).

Finally, Stinson et al (1979) randomly assigned patients to four (two inpatient, two outpatient) systems of care which differed on the grounds of the intensity of contact with staff members. Outcome data, collected at three, six, twelve and eighteen months after admission, showed no significant differences relevant to this discussion. The authors conclude that:

"At present, we must recommend simpler and less expensive alcoholic treatment programmes that de-emphasise hospital care" (p.539).

6.4.2 Evidence from studies of drug abusers

An anecdotal case report of successful outpatient psychoanalytic treatment of a drug abuser was reported by Savitt in 1954. More verifiable evidence for this was provided when Nyswander et al (1958) reported on a year's research with outpatient psychoanalytic treatment of drug abuse. Of the 70 drug addicts who voluntarily contacted the project for help, 35 actually effected initial contact with a therapist and 13 remained in treatment beyond 1 year. All 13 had improved (10 were abstinent) after 1 year in treatment. The authors, surprised by what they considered to be a very positive result, tentatively suggest that:

"...some narcotic addicts may be treated on an outpatient basis by psychoanalytically trained psychotherapists who used procedures which do not differ significantly from those used in treatment of other emotionally disturbed persons...Some drug addicts will voluntarily present themselves for psychotherapy and...they do not seem to present untoward hazards. They may be treated on an ambulatory basis while still addicted. Withdrawal for some patients can be accomplished on an ambulatory basis, although the lack of appropriate hospital facilities presents certain practical problems" (p.727).

The final study to be discussed here is the DARP follow-up evaluation study by Sells et al (1976) outlined in Chapter Four (section 4.2.2.2). This study is of central importance to this discussion since it represents an extensive and methodologically sophisticated attempt to determine the effectiveness of different treatment types.

The study involved comparison of post-DARP outcomes in four treatment modalities (methadone maintenance, residential therapeutic community, outpatient drug free and detoxification only). Outcomes were compared with each other and with a no-treatment (intake-only) comparison group. The results of this study provided strong positive evidence for the effectiveness of the methadone maintenance (MM), therapeutic community (TC) and outpatient drug free (DF) modalities. Strong negative evidence questioning the effectiveness of detoxification only (DO) was forthcoming and outcomes for the intake only (IO) sample were unfavourable, this indicating that treatment by MM, TC and DF was generally beneficial when compared to detoxification or intake only procedures.

The study went on to subdivide the TC and DF groups into addict and non-addict categories where the latter were defined as users of illicit drugs who had never used opioids daily at the time of DARP admission (they included some who had used opioids as well as non-opioids but not daily, also users of non-opioids only).

MM and TC were found to be effective for opioid addicts but not for non-addicts. Outpatient DF treatment was effective for non-addicts (both former and current) but not for addicts.

The important point for this discussion is that both psychological treatments investigated (inpatient TC and outpatient DF) proved successful but that, on further analysis, effectiveness was shown to vary within these groups with details of the patient's disorder. This finding supports the suggestion made earlier in this section that patients should be matched to a particular treatment type in order that the likelihood of successful outcome be increased. Factors involved in accurate matching of drug abusers to outpatient treatment are discussed in the following chapter.

In summary, it may be said that the effectiveness of outpatient treatment of substance abuse has support. However, certain studies (the DARP in particular) have indicated that some patients (for example, opioid dependents) may be better suited to inpatient treatment. This conclusion may provide support for the convictions held by some Capetonian mental health professionals that outpatient treatment can successfully treat some but not all drug abusers. A decision as to the degree to which outpatient treatment can be effectively utilized in Cape Town therefore depends on knowledge of the specific characteristics of drug abusers who can be successfully treated as outpatients. This is discussed in Chapter Seven of this thesis.

6.5 Summary and comment

This chapter noted the trend towards outpatient, rather than inpatient, treatment of substance abuse. It was suggested that this is predominantly due to the relatively lower cost of providing outpatient facilities. This advantage prompted investigation of the effectiveness of outpatient treatment - if this proves as

effective as more costly inpatient treatment it may provide a cost-effective solution to Cape Town's drug abuse treatment problems. It was noted that Cape Town relies heavily on outpatient psychological services in drug abuse treatment (in fact inpatient psychological treatment is not readily available to drug abusers) but that some mental health professionals consider the provision of inpatient services important.

A brief survey of the relevant substance abuse literature indicated that outpatient treatment can be effective. Where studies have attempted to compare outcomes in in- and outpatient treatment groups, the latter produced results as favourable as the former (Amini et al 1982, Stein et al 1975, Edwards and Guthrie 1967, Ritson 1968, Stinson et al 1979 and the DARP reported in Sells et al 1976).

Few studies have adequately controlled all treatment, patient and therapist related variables over the two treatment groups, thus rendering direct comparison problematic. For example, in Amini et al (1982) the treatment offered to in- and outpatient groups differed considerably in content and in Ritson (1968) patients were not randomly assigned to treatment groups; in Stein et al (1975) patients were randomly assigned to treatment groups but therapist variables were not specified. It may, therefore, be wise to interpret results of this survey cautiously - outpatient and inpatient treatment have both proved effective under particular treatment conditions with particular patients and when administered by certain mental health professionals.

The DARP study (reported in Sells et al 1976) supports this careful interpretation of the literature. Certain variables were shown to affect the effectiveness of both in- and outpatient psychological treatment - the latter was effective with non-opioid but not with opioid users while inpatient treatment was effective with opioid users but not with non-opioid users. Outpatient treatment, therefore, may be cost-effective with certain patients but inpatient treatment, even though more expensive, may be more effective with others. It would seem, then, that the most cost-effective alternative would be to match each patient to the treatment situation most likely to produce a successful outcome.

For this concept of matching to have practical application the relevant patient characteristics must be specified. Specific treatment and therapist variables are, of course, also important in maximisation of effectiveness but these cannot be dealt with within the scope of this thesis. The following chapter examines the patient variables involved in accurately matching an individual to the most appropriate treatment situation.

SECTION THREE

MAXIMISING EFFECTIVENESS OF ESTABLISHED CENTRES

Chapter Seven: Matching patients to treatment situation

CHAPTER SEVEN

MATCHING PATIENTS TO TREATMENT SITUATION

7.1 The status quo in Cape Town

7.2 Deficiencies in informal dispositional decision-making strategies

7.3 Guidelines for accurate matching of patient to treatment situation

- 7.3.1 Factors relating to the disorder
  - 7.3.1.1 Diagnosis
  - 7.3.1.2 Severity of the disorder
- 7.3.2 Other factors relating to the patient
  - 7.3.2.1 Demographic characteristics
  - 7.3.2.2 Personality characteristics

7.4 Methods of data-gathering for accurate matching

- 7.4.1 The traditional clinical interview
- 7.4.2 Structured interviews and scales

7.5 Summary and comment

CHAPTER SEVEN

MATCHING PATIENTS TO TREATMENT SITUATION

Outpatient programs may provide the most cost-effective situation in which to treat many drug abusers (Chapter Six). For others, however, inpatient treatment, although more expensive, may be more effective. Chapter Six indicated that accurate matching of patient to treatment situation could produce the most cost-effective treatment outcomes. The present chapter attempts analysis of the patient characteristics associated with accurate matching procedures.

The chapter begins with an overview of existing matching strategies used in Cape Town (section 7.1). Thereafter (section 7.2), the pitfalls of informal dispositional decision-making strategies are outlined, indicating that well-researched guidelines and strategies are preferable in the facilitation of accurate matching. These guidelines are then presented (section 7.3) in the form of a review of the relevant literature. This focusses on variables relating to the patient and the disorder which are associated with outcome in inpatient and outpatient treatment situations. As mentioned previously (section 6.5), therapist- as well as treatment-related variables also influence the likelihood of a particular patient succeeding in an out-patient treatment situation. However, as it is beyond the scope of this thesis to deal with these, they are suggested as important considerations for future research attempting to maximise potential for successful outcome.

The fourth major section of this chapter (7.4) attempts to relate the preceding guidelines to clinical practice by outlining useful methods of gathering the data on which the dispositional decision is to be made. The advantages and pitfalls of the traditional clinical history-taking interview are outlined and useful structured interviews and scales are suggested.

7.1 The status quo in Cape Town

Table II (section 2.2.4) indicated that the Drug Counselling Centre, the major centre for psychological treatment of drug abuse in Cape Town, had assessed 182 patients only six months after opening. This large and growing (see Drug Counselling Centre, Monthly Statistics 1985) patient load occurs against limited and relatively static staff and financial resources, thus implying that, in the future at least, only a certain proportion of patients referred to and assessed at the DCC will be treated.

For this reason, it is important that those patients most likely to derive benefit from the treatment offered by the DCC be accurately identified, in order that limited resources be utilized in the most beneficial manner possible. Patients unlikely to benefit from this treatment should be referred to more appropriate treatment centres. While such centres for referral are not readily available in the existing system, it is hoped that expansion and modification will increase the availability of these.

Regarding existing strategies for dispositional decision-making, it has been mentioned (section 6.1 and Appendix I) that only young experimental or occasional drug users are considered suitable for outpatient treatment at the DCC. Extent, duration and frequency of drug use are, therefore, apparently considered of central importance in dispositional decision-making. As far as I have been able to ascertain, these and other factors important in accurate patient-treatment matching have not been formally united in a dispositional decision-making strategy. This chapter aims to provide this strategy.

Staff at the DCC base dispositional decisions on information gathered in a semi-structured clinical interview (Appendix III). The history-taking schedule used was developed at the Maudsley Hospital, London and is recommended for use in the Department of Psychiatry, University of Cape Town, by Professors Gillis and Ben-Arie. A copy of this is included in the Appendices to this thesis (Appendix III). This schedule provides a structure within which to investigate the presenting problem (which at the DCC usually includes drug use), the patient's mental status and family and personal history. Sub-sections of these general areas of investigation are also specified. Administration time is approximately one hour and family and employer reports of the patient, although suggested, are not obligatory. Conclusions are therefore based largely on the patient's self-reports.

In view of the fact that the schedule is proposed as a general guide (Appendix III) to investigation, it is presumed that clinicians use the structure with different degrees of rigidity depending on personal style, level of experience and time available for the interview. For this reason, the DCC is said to rely on a semi-structured clinical interview method of data gathering.

7.2 Deficiencies in informal matching strategies

Research into dispositional decision-making strategies in psychiatric emergency centres has elicited a number of determinants of the decision to hospitalize. The results of these studies, which are discussed below, may well be of relevance to the DCC as the emergency centres studied approximate the DCC in function (for example, referral and further management decisions are made (Gerson and Bassuk 1980). They differ from the DCC in that they deal with general psychiatric (rather than purely drug abuse) crises and form part of a general hospital, whereas the DCC forms a separate centre (ibid).

A worrying finding in research of this nature is that many factors not necessarily related to appropriate placement influence dispositional decisions. These are discussed as follows. A central problem interfering with good decision-making in a crisis centre may be the pervasive sense of pressure of time. Gerson and Bassuk (1980) note that:

> "In the emergency room, which is designed to enhance the containment and resolution of life-threatening problems, rapid assessment is given a high premium. Similarly, rapid dispositions are encouraged so that space may be available for the next emergency. The emphasis on speed is also, of course, a function of the nature of the patient's problem. Many patients, having waited until they could no longer tolerate their problems, arrive at the emergency room communicating a sense of urgency" (p.2).

The effect of this may be to shorten the time spent with each patient. Thus Baxter et al (1968) found that dispositional decisions for over half of the patients seen at a large urban hospital were made in less than 15 minutes.

Gerson and Bassuk (1980) further note that the result of rapid assessment is that therapist-patient rapport is neglected and interaction focusses on diagnostic concern with overt psychopathology rather than on the dynamics of the problem, its social context and the possibility of immediate treatment in the crisis centre. A number of studies, quoted in Gerson and Bassuk (1980), have shown that extended evaluations lead to decreased hospitalisation rates and increased patient acceptance of the treatment prescribed. It is suggested that greater personal involvement by the therapist lowers the rate of hospitalization (Gerson and Bassuk 1980).

A further factor which may lower the accuracy of dispositional decision-making is the crisis centre therapist's tendency to assume total responsibility for the patient who, being in crisis, needs and expects help (Gerson and Bassuk 1980). This may cause the therapist to make hasty dispositional decisions without evaluating and enlisting the support of the family and community (ibid). Similarly, Caplan (1964, in Gerson and Bassuk 1980) notes that

> "People in a state of crisis tend to elicit unorganised helping reactions from others" (p.3).

A crisis centre, then, may not provide an environment conducive to cost-effective decision-making since rapid assessment tends to inappropriately inflate hospitalization rates. In addition, therapist-related factors (discussed below) have been found to influence dispositional decision-making - the therapist's professional orientation, level of experience and personality style may exert influence unrelated to objective accuracy. Psychologists tend to hospitalize patients less often than psychiatrists do (Gerson and Bassuk 1980) and the inexperienced, novice clinician may inappropriately recommend hospitalization, possibly due to a fear of inadequacy in dealing with the problem (Feigelson et al 1978). Gerson and Bassuk (1980) note that therapists exhibit stable response styles that are relatively independent of the stimulus condition and which affect information processing, clinical judgement and treatment recommendations.

The above indicates that dispositional decisions made by mental health professionals in a crisis centre setting may often be inaccurate. For this reason the following section provides guidelines from the literature for more accurate decision-making. Clear guidelines and, if possible, measurement techniques should increase the accuracy of necessarily rapid management decisions thus increasing the efficient use of treatment resources and maximising benefits to patients.

7.3 Guidelines for accurate matching of patient to treatment situation

These guidelines are discussed here under two headings - those relating to the disorder and those relating to other characteristics of the patient. Literature regarding general psychiatric, alcoholic and drug abusing populations will be used in an attempt to define the characteristics of the potentially successful outpatient.

The scope of this discussion is limited to the variables involved in matching of patients to treatment situation. Various authors (for example, Luborsky et al 1971, Malan 1979, Dickman 1983) have studied the variables involved in matching patients to certain psychotherapeutic methods and orientations. The reader is referred to such studies for further discussion of appropriate matching techniques.

7.3.1 Factors relating to the disorder

7.3.1.1 Diagnosis

A patient presenting in Cape Town's drug abuse treatment system will presumably usually receive a diagnosis of substance abuse or dependence although some, as was discussed in Chapter One, may be using drugs and feel the need for treatment without meeting the DSM III's criteria (APA 1980) for substance abuse or dependence. This section, then, deals firstly with the effect or outcome of the particular substance abuse diagnosis (that is, whether substance abuse or dependence exists and the type of substance abused). Thereafter, the effect of any additional psychiatric diagnosis on outcome in outpatient treatment is discussed.

Chapter Six (section 6.4.2) noted the DARP study's finding that outpatient psychological treatment, effective with non-opioid abusers and with non-regular opioid abusers, was ineffective in the treatment of opioid dependents (Sells et al 1976). The latter were more effectively treated in methadone maintenance and in-patient psychological treatment programs. Sells et al do not suggest reasons for this differential effectiveness and many factors are no doubt involved. One possible reason of interest here may be the high dependence-producing potential of opioids (Slater and Roth 1969). This line of reasoning would suggest, however, that physically dependent patients require more controlled, isolated treatment conditions than non-dependent abusers. This, in turn, assumes that physical dependence is more difficult to master than "psychological dependence" (drug abuse in the absence

of physical dependence). This contention is not accepted by most writers (for example, Pradhan 1977). There is thus no evidence to suggest that a diagnosis of dependence, as opposed to abuse, invariably constitutes grounds for hospitalization.

A second important question raised by the DARP findings concerns the relationship between the type of drug used and outcome in outpatient treatment - should a drug free outpatient program accept only non-opioid (or non-regular opioid) users for treatment? The DARP findings would support the use of such criteria but another study quoted in section 6.4.2 (Nyswander et al 1957) indicated that opioid (or narcotic) abusers and dependents can be successfully treated in outpatient psychotherapy. The solution to this seeming contradiction may lie in the position that the degree of success in outpatient psychological treatment of opioid dependents varies with treatment-, patient-, therapist-related factors as well as with characteristics of the patient's disorder. Thus a particular opioid dependent person may succeed in outpatient psychological treatment given optimal personal, treatment and therapist conditions.

According to the above discussion, the majority of Cape Town's drug abusers, being non-opioid users (see Chapter Two), may be effectively treated as outpatients. In the absence of unequivocal conclusions regarding the outcome of outpatient psychological treatment of opioid dependents, it may be advisable to conduct locally-based prospective outcome studies with opioid

dependents in treatment at the Drug Counselling Centre. This research would aim to provide relevant outcome data upon which plans for future expansion of the system could be made. If the DARP findings (Sells et al 1976) are corroborated by such research, an alternative (either inpatient or day patient) to outpatient treatment should be planned. The feasibility of offering a methadone maintenance program as well may be usefully investigated.

Regarding the effect of additional psychiatric diagnosis on outcome in outpatient psychological treatment, it may be said that the dispositional criteria governing co-existing diagnoses have implications for management of the drug abuser. For example, a diagnosis of organic brain syndrome or organic mental disorder generally implies that psychotherapy, whether in- or outpatient, is not appropriate, at least initially (Kaplan and Sadock 1981). Similarly, a diagnosis of Borderline Personality Disorder is widely considered an indication that the patient is at risk for a negative response to psychotherapy and exclusion should be considered, particularly if the patient has "acted out" in a previous therapeutic relationship (Dickman 1983). It is more specific to our present purpose to note that a patient who displays psychotic or depressive sympatomatology which is judged to render that patient a danger either to self or others, may be admitted, at least initially, to inpatient treatment (Slater and Roth 1969).

It is not possible to detail dispositional choices regarding all the diagnoses which may exist alongside a diagnosis of drug abuse.

It may be important, however, to note briefly that personality disorders are considered to often accompany drug abuse (Rosenberg 1969, Glatt 1974). Personality disorders, furthermore, have traditionally been associated with poor prognosis in short-term insight-oriented psychotherapy (Dickman 1983) due to the longstanding and inflexible nature of the maladaptive personality traits.

I permit myself only two comments on these assertions. Firstly, generalised conclusions as to the personality of drug abusers is unwarranted given the present state of research in this area (see section 6.3). Secondly, if personality disorders are indeed common in the substance abusing population, studies such as those described in Chapter Six must surely include a proportion of personality disordered substance abusers in their samples. Yet, even where randomised allocation of patients to in- and outpatient treatment groups was practiced (for example, Stein et al 1975), many substance abusers were shown to succeed in outpatient treatment. A diagnosis of personality disorder should, therefore, not automatically disqualify a drug abuser from outpatient psychological treatment. The severity of the personality or other, disorder may, however, legitimately affect the clinician's dispositional decision. This point is discussed below.

7.3.1.2 Severity of the disorder

Should outpatient treatment be recommended only for those patients who are slightly or moderately, rather than severely affected by drug abuse and/or other co-existing psychiatric disorders? The

DCC, as mentioned previously (section 7.1), subscribes to an informal strategy based on this tenet. Other clinicians and patients have supported this practice, as discussed below.

Pattison et al (1973) found that alcoholics choosing outpatient treatment above either private hospitalization or a residential rehabilitation centre were those whose lives were disrupted rather than destroyed by alcohol use. These patients were able to continue functioning in the community, albeit at a lower level of social and vocational competence. The authors note that the ability and desire to continue these functions may have prompted them to choose outpatient treatment. Skinner (1981), similarly, compared drug and alcohol users in in- and outpatient treatment programs and found that the severity of abuse and related problems was lower in the outpatient group. This meant that social maladaptation, withdrawal symptoms, "obsessive-compulsive drug use", daily drug use, loss of control drug use and prior help for drug use occurred less often or to a lesser degree among outpatients. Inpatients had more severe symptoms on several indices of psychopathology, including anxiety, self-depreciation, hypochondriasis, persecutory ideas and thought disorder.

This study does not allow comment on the appropriateness of such matching but merely observes and reports the match which has developed, presumably out of clinicians' and patients' perceptions of an accurate patient-treatment match. It is possible that accurate matching of treatment to patient develops naturally as centres may attract a certain type of patient and gradually develop treatment programs most suited to this.

Ritson (1968) compared treatment outcomes in alcoholics assigned non-randomly to in- and outpatient programs. He concluded that, while both situations could produce favourable outcomes, various factors known at admission characterised the successful outpatient. Success in outpatient treatment was more usually achieved by patients whose drinking pattern was less severe (a loss-of-control, rather that inability-to-abstain pattern). Assessment of the severity of co-existing psychiatric disorders was also found to be of importance in appropriate assignment. Patients with severely disordered personalities rarely benefitted from outpatient treatment but there was no such significant relationship for inpatients. Ritson notes that:

> "It was tempting to suggest that the period in hospital assisted a wider range of psychiatric disorders" (p.1028).

Furthermore, the impulsive young alcoholic with a severe personality disorder was not helped significantly by either treatment situation. Ritson felt that this group demanded more detailed study and the development of different treatment techniques.

The following studies by McLellan et al (1983 a & b) go further in evaluation of matching techniques. The retrospective portion of this work (1983a) used a sample of 742 male veterans (460 alcohol dependents, 282 drug dependents) treated in six separate treatment centres (including inpatient milieu therapy, out-

patient psychotherapeutic treatment and a rehabilitation program) in a metropolitan treatment network. The normal treatment setting was used - that is, there was no random assignment of patients to treatments (this was partially compensated for by statistical procedures - see the study itself for details of this).

Detailed data was gathered for each patient at admission and at six months after admission (patients spent an average of 51 days in treatment) by independent technicians using the Addiction Severity Index (see later discussion - section 7.4.2). These data revealed no significant patient-program matches. However, when patients were divided into three groups on the basis of the severity of their psychiatric symptoms at admission (see Appendix IV for details) it was found that patients with low psychiatric severity improved on every treatment program; patients with high psychiatric severity showed virtually no improvement on any program and patients with mid-range psychiatric severity (60% of the sample) showed significantly better outcomes from patient-program matching and different specific factors were predictive in each program. This level of psychiatric severity was found to be the single best predictor of outcome in different treatment situations.

These results were then tested in a prospective study (McLellan et al 1983b) and the following patient-program matches were validated:

In general the low psychiatric severity group (those scoring 0 to 2 on the ASI's 10-point psychiatric severity ratio) were treated as outpatients - approximately equal outcomes had been shown to occur in all treatments so the least expensive treatment was employed. However, significant family or employment problems mitigated against outpatient treatment in this group.

High psychiatric severity patients (those scoring 7 to 9) were considered "mismatched" in all programs as they derived little benefit at great expense of staff time. These patients were assigned to inpatient units or community clinics if they could not be referred out of the network.

Mid severity patients (those scoring 3 to 6) generally reported significant symptoms of anxiety, depression and/or confusion but no recurrent history of such problems. These patients were assigned to particular treatment programs based upon the pattern and severity of their other treatment problems (family, employment, medical and drug abuse) at time of admission. The greater the severity of these problems, the greater the likelihood of the patient's being admitted to inpatient treatment.

This study, then, indicates the importance of the severity of psychiatric disorder and of other problems in appropriately assigning patients to in- or outpatient treatment programs. This supports the limited findings of Pattison et al (1973), Skinner (1981) and Ritson (1968).

7.3.2 Other factors relating to the patient

7.3.2.1 Demographic characteristics

Ritson (1968) and Stinson et al (1979), working with alcoholics, noted that increasing age was correlated with better prognosis in both in- and outpatient treatment. Similarly, Skinner (1981), in his study of substance abusers assigned non-randomly to an in- or outpatient program or a primary care alternative, found no age or sex differences between treatment groups.

Socio-economic variables have been significantly associated with outcome but apparently, as with age and sex variables, do not differentiate potentially successful patients from those unlikely to succeed in this situation. Ritson (1968) found that middle to upper class status predicted a more favourable prognosis in both in- and outpatient groups. Similarly, Stinson et al (1979) found that class-related variables (higher educational and vocational level) predicted a more favourable outcome in both treatment situations. Pattison et al (1969) observed that patients assigned to outpatient treatment were generally of middle class. It has been suggested, on the basis of the above, that social class interacts with the treatment program entered - that is, that different socio-economic classes are attracted to different treatment types - rather than being an independent prognostic factor (Schmidt et al 1968, Pattison et al 1969, Edwards et al 1974, Cronkite and Moos 1978).

Married status appears to increase potential for success in outpatient treatment, particularly if the marriage is assessed by the mental health professional as stable (Mindlin 1959, Ritson 1968, Stinson et al 1979). In fact, maximum family involvement in treatment seems to be associated with better prognosis in outpatient treatment. Thus Kosten et al (1983) found that opiate abusers living with their families did better than others. Those who denied their abuse to their families remained drug free for significantly less time than those who admitted their abuse to their families; married abusers who admitted their abuse to their spouse but denied it to their parents were drug free for less time than those married abusers who also told their parents.

The beneficial effect of family involvement may be associated with another important prognostic sign - that of social stability. Social stability (defined by Skinner in 1981 by a composite index which considers present accommodation, family contact, work record and legal status) is held to increase the potential for success in outpatient treatment (Strauss and Bacon 1951, Baekeland and Lundwall 1975, Pattison et al 1969, Skinner 1981). It implies a level of community involvement and support which, according to Baekeland and Lundwall (1975), is necessary to sustain treatment on an outpatient basis. Conversely, social maladjustment, defined by factors such as a record of police arrests (Mindlin 1959), social and vocational malfunction and isolation in living conditions (Pattison et al 1969), is held to advise against outpatient treatment.

The studies quoted above provide observations on the type of patient generally assigned to outpatient as opposed to inpatient treatment. The prognostic significance of such variables, therefore, cannot be confidently asserted - they may merely represent the clinician's (and the patient's) reasons for choosing outpatient above inpatient treatment. However, the present lack of empirical evidence does not completely nullify the importance of such variables in matching procedures. It is probable that family and community involvement and support does increase potential for success in outpatient treatment since, at the most obvious level, the patient can then be cared for and encouraged when not in contact with the treatment centre. Furthermore, a modicum of competence in personal, social and vocational functioning is also likely to increase potential for favourable outcome in outpatient treatment as self-care and goal-setting activities are facilitated.

7.3.2.2 Personality characteristics

As with demographic characteristics, any conclusions regarding personality characteristics which may exclude a patient from outpatient treatment are based on observations and descriptions of in- and outpatients rather than on empirical data supporting their prognostic significance.

Seliger (1938) presented two case studies of alcoholics treated as outpatients. He concluded (without elaboration) that successful outcome in this situation depends on the patient's definite desire to abstain, average to above average intelligence and some degree of emotional maturity. Skinner (1981), in his descriptive analysis of outpatients as compared to inpatients, noted that, generally speaking, personality characteristics did not vary between treatment groups. However, outpatients tended to be of higher intellectual status and were less impulsive and more defended, psychologically speaking, than inpatients. The points raised by these authors are discussed below.

Firstly, fairly high motivation for abstinence (and for treatment) is regarded by Seliger (1938) as a prerequisite for successful outpatient treatment. Skinner (1981) apparently concurs to some extent here when he notes that a few days' abstinence immediately prior to the patient's contacting treatment sources bodes well for outpatient treatment - this circumstance seems to be associated with motivation for abstinence and treatment.

The reasoning here presumably relates to the degree of self-reliance demanded of outpatients - higher motivation may facilitate abstinence and continuation in treatment in an uncontrolled environment. However, Glatt (1974) notes that even abusers who are initially totally unmotivated for treatment (whether in- or outpatient) may, in the course of treatment, acquire insight into their need for help. Furthermore, McLellan et al (1983b) found that increased motivation for abstinence and for treatment was the result of accurate patient-treatment matching. It appears, therefore, that although higher motivation may facilitate outpatient treatment, its initial absence does not necessarily mean that outpatient treatment cannot succeed.

Secondly, Seliger (1938), Skinner (1981) and Ritson (1968) observe that outpatients are generally of higher intellectual status than inpatients. This may be associated with the generally higher socio-economic status of outpatients which, as previously discussed, is not necessarily of prognostic significance per se.

Thirdly, Seliger (1938) touts emotional maturity as essential for successful outpatient treatment and Skinner (1981), perhaps in similar vein, notes that outpatients tend to be less impulsive than inpatients. The reasoning behind such dispositional practices is apparently sound - clinicians are probably more likely to hospitalise patients who, being prone to impulsive action, may be unable to resist the temptation of drugs available in the community. Once again, however, empirical evidence for the usefulness of this characteristic in matching procedures is not yet available.

Similarly, and fourthly, Skinner (1981) notes the tendency for outpatients to be more psychologically defended and for in-patients to be more frank regarding their problems. Once again, this represents the development of a dispositional strategy but one for which empirical evidence of accuracy is lacking. More defended patients may prefer outpatient treatment and mental health professionals may respect this and choose to hospitalize less defended, more vulnerable patients.

In summary, this section (7.3) has attempted analysis of disorder- and patient-related variables which may be significant in accurate matching of patients to an outpatient treatment situation. Generally speaking, evidence for the significance of certain disorder-related variables is more forthcoming. Certain patient-related variables are apparently useful in accurate dispositional decision-making but empirical evidence for this is often lacking. Potentially significant factors are summarized in Table X.

Table X Summary of variables significant in patient-treatment matching

VARIABLE	SIGNIFICANCE IN MATCHING
A. FACTORS RELATING TO THE DISORDER	
1. Diagnosis (nature of the disorder)	
a) Abuse vs. dependence.	No evidence to suggest significance of this variable in matching.
b) Type of drug used	Non-opioid abuse/dependence or non-regular opioid use more suited to outpatient psychotherapeutic treatment (OPpsth).
	Opioid abusers may be successfully treated as OPs given optimal personal, therapist and treatment conditions. The latter may involve methadone maintenance.
c) Co-existing psychiatric (or physical) disorders	Nature of these influence the dispositional decision. Diagnosis of personality disorder should not automatically exclude patient from OPpsth.
2. Severity of the disorder	
a) Severity of drug use and related deterioration in social and occupational functioning	Less severe drug use and deterioration more suited to OPpsth.
b) Severity of global psychiatric impairment	May be best single predictor of outcome in OPpsth. Low severity (e.g. as measured on ASI) OP treatment. High severity inpatient (IP) or low cost alternative. Mid-range severity IP or OP treatment depending on other factors mentioned in this table.
B. FACTORS RELATING TO THE PATIENT	
1. Demographic characteristics	
a) Age and sex	Not significant
b) Socio-economic class, marital status, social stability	Mid to upper socio-economic class, married status and some level of social stability generally characterise OP's. However, prognostic value not established.
2. Personality characteristics	
a) Motivation and intelligence	Higher levels of both generally characterize OP's but prognostic value not established.
b) Impulse control and psychological defendedness	OP's generally less impulsive and more defended but prognostic value not established.

7.4 Methods of data-gathering for accurate matching

The preceding discussion outlines some of the patient-related data fundamental to accurate matching of the substance-abusing patient to treatment situation. The present section attempts to relate this to clinical practice by briefly reviewing some useful methods of procuring such data.

7.4.1 The traditional clinical interview

Many variations of an initial history-taking interview (such as that used at the DCC) are, presumably, followed by mental health professionals world-wide. It is also presumed that clinicians vary in the skill with which they conduct the history-taking interview and that the accuracy of the resulting dispositional decisions varies in consequence. Section 7.3's discussion of factors involved in accurate matching represents an attempt to guide and improve the clinician's skill in assessing the patient.

A second factor of importance in evaluating the usefulness of the clinical interview concerns the reliability and validity of the self-reported data thus obtained. The data may tend, particularly in a busy crisis centre, to rely heavily on patients' self-reports since procuring family- and employer-reports may be time consuming. This reliance on self-reports contradicts the stereotype of the substance abuser as being apt to minimise drug use and its effects. Do self-reports have sufficient reliability and validity to warrant this reliance on them?

Sobell and Sobell (1975) quote the following two studies which found self-reports to be unreliable. Robins (1966) conducted a 30-year longitudinal study of deviant behaviour. After comparing interview data with official records she concluded that:

However severe methodological problems (reported in Sobell and Sobell 1975) limit the validity of this study - for example, one-third of the subjects were intoxicated when first interviewed and 9 of the 14 questions put to the subjects were of an attitudinal nature thus rendering validation from official record data virtually impossible.

Other studies indicate that the self-reports of substance abusers are reliable. Guze et al (1963) and Sobell et al (1974) found that alcoholics not only give valid incarceration histories but tend to over- rather than under-report these as compared with official records. Sobell and Sobell (1975) conducted a study in which male alcoholics in voluntary outpatient treatment programmes were individually interviewed on two separate occasions regarding their social and drinking histories. The validity of these reports was assessed by comparing the information gained in the two interviews and validity was assessed through official records. Self-reports by this group under the specified interview conditions were highly reliable and valid; their validity was sufficient, according to the authors, to support their use as a primary source of life history data.

The authors further note that different types of questions are answered with varying degrees of validity - "embarrassing" crimes (for example, lewd behaviour, forgery) are less accurately reported. This finding supports the conclusions reached by other researchers (e.g. Parry and Crossley 1950, Robins 1966, Edwards et al 1973) and suggests that research should concentrate on specifying the conditions under which substance abusers' self-reports are more, or less, valid.

Ball (1972) compared the self-reports of 59 narcotic addicts regarding their drug use and arrest with hospital and arrest records and urinalysis. The self-reports were found to be highly reliable and valid.

Similarly, Cox and Longwell (1974) in a study of heroin abusers in a methadone maintenance programme, found that in 86% of the interviews patients truthfully reported the extent of current heroin use (whether low or high) to the interviewer. It should be noted however that the taking of weekly urine samples may have increased the accuracy of the self-reports since patients probably realised that the samples informed staff of drug use. Validity was probably also increased by the interviewer's efforts to gain trust and pledge that reports would in no way jeopardise the patient's position in the treatment centre.

Thus, this very brief and necessarily selective review of the literature on validity of substance abusers' self-reports indicates that self-reports can be used as the primary source of life history data. The accuracy of such data does however vary somewhat with the type of questions asked and the situation in which questions are posed. It would seem then that family and employer reports, when available, may be useful for validation purposes. Sobell and Sobell (1975) suggest the use of the double interview technique to test the accuracy of a patient's self-reports. The technique involves two separate interviews with the client in which critical test questions are identical but are embedded amongst different

filler items. In practice, this is probably similar to what normally occurs when a client is seen more than once by the same therapist. It seems, too, that situational and therapist variables increase validity or responses - an accepting, partially condoning clinic environment and a therapist who attempts to put the patient at ease may increase validity of responses.

It appears, therefore, that the clinical interview can provide valid and reliable data on which to base the dispositional decision. Its usefulness, however, varies with factors such as the particular structure used (that is, the degree to which this taps relevant variables) and the skill of the clinician using it (that is, in adequately probing relevant areas and in accurately assessing the data thus obtained). The following section (7.4.2) describes a structured interview which may be considered for use in a centre such as the DCC. This may either add to or replace the semi-structured schedule already in use.

7.4.2 Structured interviews and scales

Many advantages accrue to the use of a standardized instrument in evaluation of patients and their treatment needs. For example, adequate coverage and evaluation of information most relevant to dispositional decision-making can be optimised, thus facilitating good patient-treatment matching even by novice clinicians. Furthermore, such a structure may facilitate research into, for example, the evaluation of treatment and outcome.

The benefits of introducing such a structure depend, however, on factors such as its reliability, validity and relevance to the particular needs of the centre. To be of maximum usefulness it should be relatively short so that it can be employed in a busy crisis centre; it should not require specialized staff for its administration and scoring; interpretation should be as simple and rapid as possible to facilitate efficient decision-making while the patient waits. Only the most relevant of these structures are mentioned below.

Cohen and Klein (1970) devised the Severity of Drug Abuse Rating Scale for use in assessment of young psychiatric patients. This scale may be useful in accurately rating the nature and severity of drug use but does not provide for assessment of the overall level of psychiatric severity, shown in section 7.3 to be perhaps the single most important factor in accurate dispositional decision-making. This may be measured, in the general psychiatric population, by structures such as the Health-Sickness Rating Scale, the Global Assessment Scale and the Psychiatric Status Schedule, discussed by Luborsky and Bachrach (1974), Endicott et al (1976) and Spitzer at al (1970) respectively. However, use of such scales at a centre such as the DCC would not provide all the information necessary for accurate dispositional decision-making in a drug abusing population.

The Addiction Severity Index (ASI) is a structured clinical interview developed by McLellan, Cacciola and others under grants from the National Institute for Drug Abuse and the

Veteran's Administration, USA. It was developed to fill the need for a reliable, valid and standardized diagnostic and evaluative instrument in the field of alcohol and drug abuse. It is designed to provide information about aspects of a patient's life which may contribute to his substance abuse, thus facilitating consideration of the substance abuse problem in the context of other treatment problems. Administration time is 25 to 30 minutes and reliability and validity of the resultant problem severity ratings is high (McLellan et al 1980, Kosten et al 1983). It is now used in about 250 treatment centres across the USA (McLellan et al 1985).

From a structured interview the rater is able to obtain a problem severity profile of each patient through analysis of six areas which often result in treatment problems; medical, employment, legal, social, psychological and drug abuse. It is not possible to more fully describe the ASI here - the reader is referred to Appendix IV in which the ASI interview schedule, obtained from Dr McLellan, is reproduced. The manual for the use of the ASI, being lengthy, is not included.

The utility of the ASI lies in its comprehensive analysis of the total complex of problems found in the substance abusing patient. Its authors hoped that it would be able to "differentiate patients on the basis of their treatment needs and provide more directed forms of intervention to a more homogenous group of patients" (McLellan et al 1980, p.31). That is, improved patient-treatment matching was one of the objectives in the development of the ASI. A formal "matching"

strategy based on the ASI was described in section 7.3.1.2. It is suggested that the ASI, if adopted to either supplement or supplant existing intake procedures, would provide a tool highly useful in patient-treatment matching and in future research undertakings.

7.5 Summary and comment

Following on Chapter Six' conclusion that cost-effectiveness is maximised by accurate matching of patient to treatment situation, this chapter reviewed the relevant literature in an attempt to suggest an effective matching strategy.

Firstly, the rationale for the development of a well-researched matching strategy was established by discussion of the difficulties which might render dispositional decision-making in a crisis centre inaccurate. The trend here was to over-prescribe hospitalization, thus inflating treatment costs unnecessarily.

Thereafter, guidelines for increased accuracy in patient-treatment matching were proposed under the headings of disorder-related and patient-related factors. Treatment- and therapist-related factors also influence the prediction of outcome in a particular treatment situation; it was suggested that future research should investigate their influence as the scope of the present investigation did not allow this.

Disorder-related variables concerned the nature and severity of the drug abuse disorder and of any co-existing psychiatric disorders. It was suggested that opioid abusers should possibly

be treated as outpatients only when other factors (severity, demographic and personality characteristics) were optimal. Non-opioid users, on the other hand, might more often be treated as outpatients (Sells et al 1976). Severity of global psychiatric impairment was found to be perhaps the single most important factor in differentiating potentially successful outpatients from those unlikely to succeed in this situation (McLellan et al 1983 a & b). A matching strategy developed by McLellan et al (1983b) on the basis of this finding was reported and suggested for use in a centre such as the DCC. Patients rated low on psychiatric severity on the Addiction Severity Index are generally referred to outpatient treatment; patients rated high are referred to inpatient wards if possible (although no program is considered truly appropriate for these patients); patients of mid-range severity are assigned to either in- or outpatient treatment on the basis of the severity of other problems (for example, drug abuse, family and employment difficulties) - increased severity indicated the need for inpatient treatment.

Patient-related (demographic and personality) variables were shown to differentiate outpatients from inpatients but the prognostic significance of these has not been empirically established. It seems likely, however, that factors such as an increased level of family and community involvement and support as well as a level of social and vocational competence increase the potential for success in outpatient treatment. Patients may also be more likely to succeed in outpatient treatment if they are motivated for abstinence and for treatment

and exhibit some level of impulse control. The influence of these factors has not been definitely established, however, and their objective assessment is not yet possible.

Section 7.4 outlined useful methods of gathering data on which to base the dispositional decision. The traditional clinical history-taking interview was established as a fairly reliable and valid source of information provided the clinician was able to elicit and assess the relevant data. The Addiction Severity Index was suggested as a useful structured interview schedule for data collection.

It appears that accurate matching of patient to treatment situation is possible and that cost-effective treatment of drug abusers can be achieved. The strategy outlined here merely provides the basis for further experimentation and research into matching strategies in the Drug Counselling Centre.

CHAPTER EIGHT

CONCLUSION

CHAPTER EIGHT

CONCLUSION

Chapter One raised three questions, the answering of which has been the aim of this thesis -

(a) Does drug use in Cape Town constitute a problem?

(b) If so, are existing treatment facilities adequate in dealing with this?

(c) If not, what plans should be made for improving the effectiveness of the treatment system?

Conclusions regarding question (a) were necessarily tentative in view of the inadequacy of available data. However, it appears that drug abuse problems, defined by DSM III (APA 1980) criteria, exist in White and Coloured groups at least. This conclusion is based, firstly, on research studies which note the prevalence of drug use in these groups and the unacceptability of this to the community at large. A prevalence figure was estimated for drug use and for drug abuse in each of these groups in Cape Town but was proposed with extreme caution as it probably seriously under-estimates the true prevalence figure.

Clinical reports support the above contention that drug abuse is prevalent in White and Coloured groups in Cape Town. Ben-Arie (1984) noted that existing treatment facilities had, in recent years, become unable to meet the increased demand for treatment. The Drug Counselling Centre, recently opened in response to this perceived problem, already treats fairly large numbers of White and Coloured drug abusers.

Discussion of the existence of a drug abuse problem in Cape Town continued with an overview of trends in drug use amongst Whites and Coloureds in Cape Town in an attempt to describe the target population. No socio-economic group was exempt and the average age of first use appears to be decreasing from secondary to primary school level, as is the trend in other Western countries. Cannabis is the primary drug of abuse in both these groups. However, the proportion of poly-drug abusers seems to be increasing particularly amongst White Capetonians (Ben-Arie 1984).

Data on which to base discussion of Asian and Black drug abuse was even more scarce. Asian drug use could not be discussed at all, except to say that statistics of the Narcotics Bureau indicate that very few Asian abusers are apprehended by police. Drug use by Capetonian Blacks has not yet been adequately researched and clinical reports are of little benefit here as Blacks very rarely attend drug abuse clinics. This may be due to low prevalence of drug abuse (as opposed to drug use) or to non-alignment between such treatment facilities and Black culture - that is, Blacks may perceive such a treatment environment and method as inappropriate to drug abuse problems. Du Toit's work (1980) on cannabis use in Africa suggests that this drug is tradtionally and widely used in rural and (to a lesser extent) urban Black groups. Use prevalence, then, may be expected to be high in Cape Town. However, a prevalence figure for use and abuse cannot be estimated at present given the dearth of reliable data.

Regarding trends in drug use amongst Capetonian Blacks, it can only be tentatively suggested that drug (cannabis) use is less acceptable amongst urban Blacks than amongst their rural counterparts, that the age of first use is decreasing and that urban users may, in response to socio-economic and political frustrations, increase traditional drug use thus being more likely to become abusers.

Thus drug abuse problems do exist in Cape Town and treatment facilities are demanded. Question (b) addresses a related issue - can drug abuse treatment facilities in the city adequately treat these abusers? The Drug Action Committee, being of the opinion that existing facilities were inadequate established the Drug Counselling Centre early in 1985. This centre, established largely as a crisis management and referral centre, has come to form the major centre for psychologically-oriented treatment of drug abuse in Cape Town. The DCC acts in conjunction with Ward K4 (Groote Schuur Hospital) - a ward which provides detoxification and other medical aspects of drug abuse treatment. Other treatment centres in Cape Town may be reluctant to treat drug abusers for various reasons and therefore carry very little of the patient load. The drug abuse treatment system in Cape Town, therefore, is said to consist largely of the DCC and Ward K4.

Comparison of prevalence figures for drug abuse in Cape Town and the approximate number of drug abusers treated in 1984 indicates that, although a proportion can be treated in this

system, it is practically speaking, unable to treat all drug abusers in Cape Town who might be referred.

However, the treatment system was also found to be less than adequate on grounds other than its numerical capacity. Demographic variables (for example, race, socio-economic status and age) were found to be related to the potential effectiveness of treatment - middle class White, and to a lesser extent, Coloured and Black, adolescents and young adults seem to constitute the group most often accepted and most effectively treated by the system. Furthermore, experimental and occasional drug users are apparently more often accepted for treatment at the DCC than those exhibiting a more severe form of abuse.

This conclusion that the treatment system is not altogether adequate to the needs in Cape Town led on to consideration of question (c) - what direction should modification and expansion of the system take? Cost-effectiveness is held to be an important criterion in planning - the course of action which is likely to produce the greatest amount of desired outcome for a given cost (Des Jarlais 1981) constitutes the most attractive option. Cost-benefit analyses should be carried out on the basis of the suggestions made here prior to implementation.

Firstly, should psychotherapy be included in drug abuse treatment? Would the considerable resources, both financial and otherwise, demanded in the provision of psychotherapeutic treatment be more effectively expanded in other treatment efforts? A review of the relevant literature (Chapter Four) indicated that psychotherapy can be an effective treatment of

drug and alcohol abuse as well as of other psychiatric disorders. However, psychotherapy is not invariably effective and research should continue the search to identify the therapist, patient and treatment characteristics which affect outcome with a view to maximising effectiveness. The rationale for continued investigation in this area is, however, established.

Secondly, should drug abusers be treated separately? This question has relevance in Cape Town where a number of centres treat alcoholics and other psychiatric patients but are considered unsuited to drug abuse treatment. Discussion of this question (Chapter Five) suggested that merging of treatment facilities may be one option in the attempt to increase the availability of treatment for drug abusers. It appears that much of the support for the separate treatment model rests on the assumptions that drug abusers have characteristics in common which differentiate them from other psychiatric patients and demand different treatment conditions. Neither of these assumptions enjoys unmitigated support, however, and combined treatment experiments (for example, Ottenberg and Rosen 1971) have suggested that many advantages may accrue to a diagnostically heterogenous treatment group. Many variations of the combined treatment model have been used (Glatt 1970). It is suggested that combined treatment constitutes an option in the Cape Town treatment system which warrants further consideration and possible experimentation.

the Drug Action Committee in accurate assessment of and provision for the treatment needs of drug abusers in this city.

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APPENDICES

Appendix I

BRIEF DESCRIPTION OF THE DRUG COUNSELLING CENTRE

The following data was obtained by means of interviews with two members of the DCC professional staff. Few statistics are available as yet.

History: The Drug Action Committee, formed in 1983, established the DCC in February 1985. This new outpatient centre is intended to function as a crisis centre dealing primarily with assessment and referral of drug abusers. It is also able to undertake short-term psychotherapeutic treatment of a limited number of suitable patients (see later discussion).

The DCC, which is publicly funded, is viewed by the DAC as the first stage in the development of an adequate drug abuse treatment system in Cape Town. A detoxification unit and an inpatient program are planned and representation will be made to the State regarding financing of these proposed centres.

Staff: The DCC is staffed by three full-time professional staff members (two clinical psychologists and one social worker). Part-time consultants include a senior psychiatrist and a psychiatric social worker. Staff members are generally middle-class White and Coloured professionals.

Patient population: The number of patients seen at the DCC has risen steeply since February 1985. The majority of patients are males of between 17 and 24 years of age. All socio-economic groups are represented; most patients are White or Coloured and more than half are involuntary attenders (referred by parents or the courts).

Drugs of abuse most commonly include cannabis and mandrax combinations or cannabis alone. Other polydrug abuse includes barbiturates, LSD, Obex, Nobese, Wellconal and cocaine.

Treatment considerations: After initial assessment at the DCC (using the Maudsley History Schedule) some patients are referred to other agencies if felt to be unsuited to treatment at the DCC. Appropriate referral agencies are scarce, however. Patients are considered suitable for treatment at the DCC if they are young experiental or occasional drug users who are not deeply involved in a "drug subculture". Drug users of long standing and those in whom alcohol use predominates are not usually accepted. Regular or heavy drug users are considered better suited to inpatient treatment.

Medical aspects of treatment (detoxification, prescription of medication, etc.) are dealt with at Psychiatric Casualty, Ward K4 (Groote Schuur Hospital). No facilities for medical treatment are available at the DCC.

APPENDIX II

QUESTIONNAIRE RE TREATMENT FACILITIES FOR DRUG ABUSE IN CAPE TOWN

1. Name of centre:

2. Name and position of respondent:

3. What diagnostic groups does your centre assess and/or treat? Please tick appropriate block:

	Assess	Treat
Alcoholics		
Other substance abusers		
Other psychiatric disorders		
All the above		

4. How many patients presented at your centre in 1984? Approximations are acceptable if statistics are not available. Please place the figure in the appropriate box.

Statistical figure	
Approximation	

5. How many of these were given a diagnosis of substance (not alcohol) abuse as one of their diagnoses?

Statistical figure	
Approximation	

6. Do you feel that substance abusers (not alcoholics) are well suited to your centre?

Yes	No

APPENDIX III

DEPARTMENT OF PSYCHIATRY : UNIVERSITY OF CAPE TOWN

PSYCHIATRIC HISTORY AND EXAMINATION

The method outlined in the attached scheme should be followed for the sake of uniformity and accessibility, but the data may of course be collected in the most convenient way. Guidelines are given as to the areas of the person's life that should be investigated. Facts and evidence should be stated in plain language rather than technical terms, and verbatim reports of what the patient says should be included especially concerning auditory hallucinations. Also examples of abnormal speech. Subjective and objective data should not be mixed, nor should details of the history and psychiatric examination. A working formulation must be recorded at the end.

If information is gathered from relatives or friends, state the informant's name, relation to the patient, intimacy and length of acquaintance, impression of reliability, etc. Do not confuse such accounts with information obtained from the patient.

Date of interview Name of interviewer

IDENTIFYING DATA

Name, age, sex, race, occupation, marital status.

METHOD AND REASON FOR REFERRAL

Include the section of the Mental Health Act under which the patient is admitted if relevant. Name and address of the referring doctor or agent.

PRESENT ILLNESS

A detailed coherent account, in chronological order, of the illness from the earliest time at which a change was noticed until this interview or admission to hospital. Ask yourself the question "What has brought this patient to seek help at this time?" Let the patient tell his or her story in his or her own way where possible. Enquire specifically for depressive, neurotic and psychotic symptoms.

LIFE EVENTS: List the events (with dates) which have caused significant changes (impact or disturbance) in his or her life during the last few years. Include police or legal contact, work, health, love and marriage, financial, family etc.)

HIGHEST LEVEL OF ADAPTIVE FUNCTIONING achieved and during the last year. This should be described in terms of the breadth and quality of interpersonal relationships, occupational functioning and use of leisure time. Depth of involvement is the key note of this assessment. Also assess energy and initiative - sustained or fitful, easily fatigued, etc.

FAMILY HISTORY

Construct a geneogram including grandparents and close family members.

Biological parents (and adoptive parents, if any): Health, age, or age at time of death, and cause of death. Their personalities, relationships, occupations, social and cultural values.

Other significant family figures including grandparents, other relatives, foster parents, etc.

Siblings: Enumerate in chronological order of birth with first names, ages, marital status, personality, occupation, health or illness. Miscarriages and stillbirths to be included.

Home atmosphere and influence: Assess family functioning, relationships and values in patient's formative years. Note any source of stress, e.g. marital tension, uprooting.

Familial, Psychiatric and Medical Illnesses: Note particulars which might be required for further enquiries, e.g. names of hospitals where relatives might have been treated.

PERSONAL HISTORY

EARLY HISTORY

Pregnancy and birth: Mother's state during pregnancy. Date of birth and place. Full term birth? Normal delivery? Breast or bottle fed? Wanted baby or not? Illegitimate?

Early development: Health and setbacks. Milestones of development, e.g. sitting up, walking, talking, bowel control.

Neurotic symptoms in childhood: Night-terrors, sleep-walking, tantrums, bed-wetting, thumb-sucking, nail-biting, food-fads, stammering, mannerisms, fea. states, model child, etc.

Health during childhood: Infections, convulsions, operations.

EDUCATION - School: Age of beginning and adaptation. School changes. Standard reached and age of leaving. Evidence of ability, backwardness or disabilities. Hobbies, sports and interests. Relationship to teachers and schoolmates; nicknames.

Further education and training:

PSYCHOSEXUAL MATURATION

Sexual inclinations and practices: Heterosexual experiences apart from marriage. Sexual information, how received. Masturbation - age, frequency, guilt. Sexual fantasies. Homosexuality.

Menstrual history: Age at first period. How regarded. Regularity, duration and amount. Pain, premenstrual tension or psychic changes. L.M.P. Climacteric symptoms. Date of last period.

Marriage: Duration of acquaintance before marriage and of engagement. Wife/husband's age, occupation, personality. Compatibility. Mode and frequency of sexual intercourse, satisfaction, impotence or frigidity. Contraceptive measures. Chronological list of children and miscarriages, giving ages, names, personality, etc.

OCCUPATION: Age of starting work. Jobs held in chronological order with wages, dates, reasons for change. Longest job held. Present economic circumstances and highest level of employment in the previous year. Ambitions. Satisfaction in work or reasons for dissatisfaction. Ambitious.

ACTIVITIES: Religion and religious contact, leisure activities, hobbies, sports, etc.

HABITS: Alcohol, tobacco, drugs; specify amount taken (recently and earlier). Sleeping, excretory functions, appetite, eating fads, weight loss.

PRESENT DOMESTIC CIRCUMSTANCES: Where living, with whom, income, social supports including social agencies involved.

PREVIOUS ILLNESSES

Medical - Illnesses, operations, and accidents (chronological and in detail).

Psychiatric - (Detailed account). Dates, duration, symptoms, where treated and the psychiatrist concerned.

BASIC PERSONALITY

Aim at giving a flesh and blood picture of the person. Do not be satisfied with a series of adjectives and epithets. The following are guidelines on which to base this description.

Social and interpersonal relations in respect of family, friends, groups, workmates. Leader, follower, organiser, aggressive, submissive, adjustable, etc.

Intellectual activities and interests: Books, play, films preferred. Fantasy life - day-dreaming - frequency, content. Hobbies.

Mood: Cheerful, despondent, anxious, worrying, optimistic, pessimistic, self-depreciating, satisfied, over-confident, stable, fluctuating (with or without occasion), controlled, demonstrative, etc.

Personality type: Withdrawn, suspicious, cold, aloof, jealous. Resentful, unstable, aggressive, stubborn. Impulsive, egocentric, overly dramatic, exhibitionistic. Timid, selfconscious, poor self image. Dependent, passive, unconfident. Always happy, unstable mood, emotionally over-reactive. Strict, perfectionistic, rigid. Narcissistic, envious.

Values: Moral, religious, practical, etc. Attitude towards self, others, health, own body, interests, work and ambitions.

PSYCHIATRIC EXAMINATION (MENTAL STATE)

The aim of this Scheme is to enable you to elicit, record and present information in a clear, concise and systematic way. All observations should be included in your written account from the moment the patient enters your field of vision. The presentation should take a descriptive form and flow sequentially. Only relevant findings should be given.

GENERAL APPEARANCE, BEHAVIOUR AND SPEECH

A description as complete, accurate and lifelike as possible of what you observe.

Appearance - grooming, neatness, mode of dress and unusual features.

Behaviour - eye contact, posture, psychomotor activity such as agitation, excitement or abnormal slowness, irreverant or embarrassing behaviour, distractability, objective evidence of hallucinations, mannerisms or stereotypies, catatonic symptoms.

Speech - this refers to utterance and may range from muteness through slowness, delayed responses and restricted quantity to rapidity and pressure of talk. Note tone of voice, clarity and speech difficulties. Content of speech is covered under THINKING below.

AFFECT AND MOOD

Affect - the external manifestations of internal feeling judged from the patient's general demeanour, facies and expressed ideas. Note emotional responses during the interview. Also anxiety, depressive demeanour, hypomanic or histrionic behaviour, suspiciousness, perplexity. Restriction, blunting, flattening, lability or incongruity of affect.

Mood - pervasive feeling tone not related to an object. Ask "How do you feel in yourself?" "What is your mood?" "How does the future look?" Enquire for suicidal ideas.

THINKING

The capacity to manipulate symbols in the form of words, images and ideas.

Organisation of Thought

Flow - tempo: retardation, rapidity, flight of ideas, blocking, poverty of ideation, perseveration, echolalia.
Form - abnormalities of structure such as vagueness, incoherence, condensation, loss of direction, distortions, displacement of words and ideas, lack of association of ideas, overinclusiveness, talking past the point, idiosyncratic use of words, neologisms. Give verbatim examples.

Possession of Thought

Subjective experiences outside the person's control such as withdrawal, insertion, broadcasting or loss of control of thoughts, or thoughts being read or influenced by others. Obsessional thoughts i.e. ideas that enter the mind against the person's will and cannot be resisted although they are recognised as emotional.

Content of Thought

Delusions - false and unshakeable beliefs that can cover a wide variety of experiences including ideas, perceptions and moods. For example, a conviction og control by others, ideas of reference or influence, catastrophic delusions, etc.

Delusions may be partial if expressed with doubt or full if held with complete conviction. Note: Check for social and cultural appropriateness.

Perception

Distortions - changes in intensity, quality or form of sights and sounds. Derealisation and depersonalisation.

Deceptions and false perceptions (illusions) - misinterpreted perceptions arising from an external stimulus e.g. mark on the wall looks like a snake.

Hallucinations - These may occur in any sensory modality. Ask, "I should like to ask you a routine question which we ask of everybody: do you ever seem to hear noises or voices when there is no one about and nothing to explain it?"

Auditory hallucinations may occur in the form of non-verbal sounds or mutterings, as voices speaking to the person, discussing him/her in the third person, or commenting. Rate as a true hallucination if heard through the ears or a pseudo-hallucination if heard in the head. Give verbatim examples. Visual, olfactory, haptic (touch) and somatic hallucinations should also be enquired for.

COGNITIVE FUNCTIONS

AWARENESS. Assess level of consciousness and arousal. Are attention and concentration easily aroused and held? Tests (in order of difficulty) - Serial 7's, Serial 3's, or months or weeks backwards.

ORIENTATION. Test for identity, place and time.

MEMORY. Ask the patient if his/her memory is failing. Compare his account of his life with that given by others. Distinguish between different memory functions as follows:

- Immediate/short term recall - Ask the patient to remember 5 objects in the room or a shopping list and to repeat them immediately. Check for recall after a short period.
- Intermediate term recall - Ask about events of the previous day e.g. meals.
- Long term recall - Ask about remote or historical events in the person's past which could be expected to be known. Evidence of abnormality should be further tested by more specific tests.

SYNTHESIZING FUNCTIONS

CAPACITY FOR ABSTRACT THINKING. Note the use of abstract concepts or figures of speech. Seek specifically for concrete or idiosyncratic thinking. Test with proverbs:

e.g. "People in glass houses should not throw stones"
"A rolling stone gathers no moss"
"A stitch in time saves nine"

Can the person establish relationships between objects, e.g. similarity between orange and banana, orange and ball, etc.

INTELLIGENCE

Assess by school level achieved, speed of grasp, and range and quality of knowledge. An I.Q. test may be necessary.

INSIGHT

A conscious recognition by the person of his/her state of mental functioning and behaviour. Is he/she aware of any change or disturbance. Distinguish between "coarse insight" where there is recognition of such change and the more discriminating type where there is deeper understanding of causation and significance. Record what the person believes are his difficulties.

JUDGMENT

The ability to draw reasonable conclusions from information or material gathered from experience. This can be tested in terms of action to be taken in social, financial and ethical situations. Also realistic plans for the future.

FINALLY

Make a statement about the reliability and validity of the information obtained on history and examination. Motivation for treatment should be noted.

No psychiatric examination is complete without a thorough physical examination.

WORKING FORMULATION

The WORKING FORMULATION is the most important part of the work-up. It is not a summary but a synthesis of all relevant knowledge so that

(a) problems can be crystallised
(b) a diagnosis can be made
(c) management can be planned
(d) a prognosis can be stated.

Its whole purpose is to prepare for further action.

It should be presented in such a manner that the essential issues can be readily grasped by a third party. A good formulation should flow sequentially and take no longer than 10 minutes. Only relevant data should be given.

The WORKING FORMULATION should not be confused with the FINAL FORMULATION which can only be made after more facts are known, including the response to treatment.

IDENTIFYING DATA

Name, age, sex, race, occupation, marital status, present employment and residence (if a person lives in a rural area it may influence management).

HIGHLIGHTS OF PRESENT ILLNESS

Reasons for referral.
Main complaints and/or problems.

HIGHLIGHTS OF HISTORY AND EXAMINATION

Significant features of personal and family background.
Premorbid personality.
Socioeconomic and cultural factors.
Positive findings of the Psychiatric Examination.
Positive findings on Physical Examination.

DIFFERENTIAL DIAGNOSIS

Give the most likely diagnosis first. Include associated conditions and physical illness.

FURTHER INVESTIGATIONS

Medical (neurological investigations, endocrine studies, etc.)
Psychological (psychometric tests, etc.)
Social (collateral history, contact with employers, social support, etc.)

AETIOLOGICAL FACTORS

Predisposing
Precipitating (including life events)
Perpetuating.

PSYCHODYNAMIC FORMULATION

The purpose is to assist in understanding the patient's symptoms and situation at a psychological level, and in planning management. A good

psychodynamic formulation should include an assessment of ego strength, motivation, intelligence, and the capacity to form a therapeutically useful relationship. Also whether psychotherapy is indicated and its type and goals.

MANAGEMENT

This refers to the entire conduct of the case including specific treatments and the need for further or more specialised observation e.g. by admission. This should be laid out under the following headings:

Medical and psychiatric treatment.
Psychological, e.g. Psychotherapy.
Social, e.g. material assistance, work assessment, dealing with families, rehabilitation, etc.

PROGNOSIS

This should be made in terms of a particular manifestation or function such as symptoms, relapse, independent functioning, incapacity, interpersonal relationships, etc. rather than as a global evaluation. These should be measured against the previous best level, and expressed in terms of the short and long term.

FINAL FORMULATION

This will be derived from the WORKING FORMULATION which should be revised in terms of additional information, further investigations and the progress of the case. Aetiology should be reconsidered. It should include a final diagnosis and specify the degree and nature of residual impairment if any. Future management should be indicated.

Department of Psychiatry
5th July 1982.

LSG:cy

APPENDIX IV

ADDICTION SEVERITY INDEX

Third Edition

INSTRUCTIONS

1. Leave No Blanks – Where appropriate code Items: X = question not answered
   N = question not applicable
   Use only one character per item.
2. Item numbers printed in red are to be asked at follow-up. Items with a red asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional pertinent information.

SEVERITY RATINGS

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual.

SUMMARY OF PATIENT'S RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

I.D. NUMBER [1] [ ][ ][ ][ ]

LAST 4 DIGITS OF SSN [ ][ ][ ][ ]

DATE OF ADMISSION [ ][ ][ ][ ][ ][ ]

DATE OF INTERVIEW [ ][ ][ ][ ][ ][ ]

TIME BEGUN [ ][ ] : [ ][ ]

TIME ENDED [ ][ ] : [ ][ ]

CLASS: [ ]
1 – Intake
2 – Follow-up

CONTACT CODE: [ ]
1 – In Person
2 – Phone
3 – Mail

ORIGIN: [ ]
1 – PVAMC – DDTS
2 – Carrier Foundation
3 – Eagleville

TREATMENT EPISODE NUMBER [ ][ ]

INTERVIEWER CODE NUMBER [ ][ ]

SPECIAL: [ ]
1 – Patient terminated
2 – Patient refused
3 – Patient unable to respond

GENERAL INFORMATION

NAME _____

CURRENT ADDRESS _____

_____

_____

GEOGRAPHIC CODE [ ][ ]

1. How long have you lived at this address? [ ][ ] Yrs. [ ][ ] Mos.
2. Is this residence owned by you or your family? [ ]
   0 – No 1 – Yes
3. DATE OF BIRTH [ ][ ][ ][ ][ ][ ]
4. RACE [ ]
   1 – White (Not of Hispanic Origin)
   2 – Black (Not of Hispanic Origin)
   3 – American Indian
   4 – Alaskan Native
   5 – Asian or Pacific Islander
   6 – Hispanic – Mexican
   7 – Hispanic – Puerto Rican
   8 – Hispanic – Cuban
   9 – Other Hispanic
5. RELIGIOUS PREFERENCE [ ]
   1 – Protestant 4 – Islamic
   2 – Catholic 5 – Other
   3 – Jewish 6 – None
6. Have you been in a controlled environment in the past 30 days? [ ]
   1 – No
   2 – Jail
   3 – Alcohol or Drug Treatment
   4 – Medical Treatment
   5 – Psychiatric Treatment
   6 – Other _____
7. How many days? [ ][ ]

TEST RESULTS

Shipley

C.Q. [ ][ ][ ]

I.Q. [ ][ ][ ]

Beck

Total Score [ ][ ] 62

CARD [1] 80

SEVERITY PROFILE

	PROBLEMS	MEDICAL	EMP/SUP	ALCOHOL	DRUG	LEGAL	FAM/SOC	PSYCH
9								
8								
7								
6								
5								
4								
3								
2								
1								
0								

I.D. 1 ☐☐☐☐

1. How many times in your life have you been hospitalized for medical problems? *(Include a.d.'s, d.t.'s, exclude detox.)* 9 ☐☐

2. How long ago was your last hospitalization for a physical problem? ☐☐ YRS. ☐☐ MOS.

3. Do you have any chronic medical problems which continue to interfere with your life? ☐
   0 – No 1 – Yes

4. Are you taking any prescribed medication on a regular basis for a physical problem? ☐
   0 – No 1 – Yes

MEDICAL STATUS

5. Do you receive a pension for a physical disability? *(Exclude psychiatric disability.)* ☐
   0 – No
   1 – Yes_____
   Specify

6. How many days have you experienced medical problems in the past 30? ☐☐

FOR QUESTIONS 7 & 8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE.

7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐

8. How important to you *now* is treatment for these medical problems? ☐

INTERVIEWER SEVERITY RATING

9. How would you rate the patient's need for medical treatment? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

10. Patient's misrepresentation? ☐
    0 – No 1 – Yes

11. Patient's inability to understand? ☐ 20
    0 – No 1 – Yes

COMMENTS

---

1. Education completed *(GED = 12 years)* 21 ☐☐ YRS. ☐☐ MOS.

2. Training or technical education completed ☐☐ MOS.

3. Do you have a profession, trade or skill? ☐
   0 – No
   1 – Yes_____
   Specify

4. Do you have a valid driver's license? ☐
   0 – No 1 – Yes

5. Do you have an automobile available for your use? *(Answer No if no valid driver's license.)* ☐
   0 – No 1 – Yes

6. How long was your longest full-time job? ☐☐ YRS. ☐☐ MOS.

7. Usual (or last) occupation. ☐
   _____
   (Specify in detail)

8. Does someone contribute to your support in any way? ☐
   0 – No 1 – Yes

9. (ONLY IF ITEM 8 IS YES)
   Does this constitute the majority of your support? ☐
   0 – No 1 – Yes

EMPLOYMENT/SUPPORT STATUS

10. Usual employment pattern, past 3 years. ☐
    1 – full time (40 hrs/wk)
    2 – part time (reg. hrs)
    3 – part time (irreg., daywork)
    4 – student
    5 – service
    6 – retired/disability
    7 – unemployed
    8 – in controlled environment

11. How many days were you paid for working in the past 30? *(Include "under the table" work.)* ☐☐

How much money did *you* receive from the following sources in the past 30 days?

12. Employment *(net income)* ☐☐☐☐
13. Unemployment compensation ☐☐☐☐
14. DPA ☐☐☐☐
15. Pension, benefits or social security ☐☐☐☐
16. Mate, family or friends *(Money for personal expenses).* ☐☐☐☐
17. Illegal ☐☐☐☐

18. How many people depend on you for the majority of their food, shelter, etc.? ☐☐

19. How many days have you experienced employment problems in the past 30? ☐☐

FOR QUESTIONS 19 & 20 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

20. How troubled or bothered have you been by these employment problems in the past 30 days? ☐

21. How important to you *now* is counseling for these employment problems? ☐

INTERVIEWER SEVERITY RATING

22. How would you rate the patient's need for employment counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

23. Patient's misrepresentation? ☐
    0 – No 1 – Yes

24. Patient's inability to understand? ☐ 71
    0 – No 1 – Yes

CARD 2 80

COMMENTS

I.D. [ ][ ][ ][ ]

CODE #

		PAST 30 DAYS	LIFETIME USE YRS.	LIFETIME USE MOS.
*01	Alcohol - Any use at all			
*02	Alcohol - To intoxication			
*03	Heroin			
*04	Methadone			
*05	Other opiates/ analgesics			
*06	Barbiturates			
*07	Other sed/ hyp/tranq.			
*08	Cocaine			
*09	Amphetamines			
*10	Cannabis			
*11	Hallucinogens			
*12	Inhalants			

CARD 3

Note: See manual for representative examples for each drug class.

		DAYS	YRS.	MOS.
*13	More than one substance per day *(Incl. alcohol).*			

DRUG/ALCOHOL USE

14. Which substance is the major problem? *(Please code as above or 00-No problem; 15-Alcohol & Drug (Dual addiction); 16-Polydrug; when not clear, ask patient).* [ ]

15. How long was your last period of voluntary abstinence from this major substance? *(00 - never abstinent).* [ ] MOS.

16. How many months ago did this abstinence end? *(00 - still abstinent).* [ ]

*17. How many times have you:

Had alcohol d.t.'s [ ]

Overdosed on drugs [ ]

*18. How many times in your life have you been treated for:

Alcohol Abuse [ ]

Drug Abuse [ ]

*19. How many of these were detox only?

Alcohol [ ]

Drug [ ]

20. How much would you say you spent during the past 30 days on:

Alcohol [ ]

Drugs [ ]

21. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? *(Include NA, AA).* [ ]

22. How many days in the past 30 have you experienced:

Alcohol Problems [ ]

Drug Problems [ ]

FOR QUESTIONS 23 & 24 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

23. How troubled or bothered have you been in the past 30 days by these:

Alcohol Problems [ ]

Drug Problems [ ]

24. How important to you *now* is treatment for these:

Alcohol Problems [ ]

Drug Problems [ ]

INTERVIEWER SEVERITY RATING

25. How would you rate the patient's need for treatment for:

Alcohol Abuse [ ]

Drug Abuse [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Patient's misrepresentation? 0 – No 1 – Yes [ ]

27. Patient's inability to understand? 0 – No 1 – Yes [ ]

CARD 4

COMMENTS

22a. Has your mother or father ever been treated for a drug problem?

0 = NO 1 = YES [ ]

22b. Has your mother or father ever been treated for an alcohol problem?

0 = NO 1 = YES [ ]

I.D. [1] [ ][ ][ ][ ]

1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.)? [ ]
0 – No 1 – Yes

2. Are you on probation or parole? [ ]
0 – No 1 – Yes

How many times in your life have you been arrested and charged with the following criminal offenses:

CODE #	
*03 – shoplifting/vandalism	[ ][ ]
*04 – parole/probation violations	[ ][ ]
*05 – drug charges	[ ][ ]
*06 – forgery	[ ][ ]
*07 – weapons offense	[ ][ ]
*08 – burglary, larceny, B & E	[ ][ ]
*09 – robbery	[ ][ ]
*10 – assault	[ ][ ]
*11 – arson	[ ][ ]
*12 – rape	[ ][ ]
*13 – homicide, manslaughter	[ ][ ]
*14 – other	[ ][ ]

LEGAL STATUS

*16. How many of these charges resulted in convictions? [ ][ ]

How many times in your life have you been charged with the following:

*17. Disorderly conduct, vagrancy, public intoxication [ ][ ]

*18. Driving while intoxicated [ ][ ]

*19. Major driving violations (reckless driving, speeding, no license, etc.). [ ][ ]

*20. How many months were you incarcerated in your life? [ ][ ]

21. How long was your last incarceration? [ ][ ] MOS.

22. What was it for? *(Use code 3-14, 16-18. If multiple charges, code most severe)* [ ][ ]

23. Are you presently awaiting charges, trial or sentence? [ ]
0 – No 1 – Yes

24. What for? *(If multiple choice, use most severe).* [ ][ ]

25. How many days in the past 30 have you engaged in illegal activities for profit? [ ][ ]

FOR QUESTIONS 26 & 27 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

26. How serious do you feel your present legal problems are? *(Exclude civil problems)* [ ]

27. How important to you *now* is counseling or referral for these legal problems? [ ]

INTERVIEWER SEVERITY RATING

28. How would you rate the patient's need for legal services or counseling? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

29. Patient's misrepresentation? [ ]
0 – No 1 – Yes

30. Patient's inability to understand? [ ] 56
0 – No 1 – Yes

CARD [5] 60

COMMENTS

I.D. [ ]

1. **Marital Status**
   1 – Married 4 – Separated
   2 – Remarried 5 – Divorced
   3 – Widowed 6 – Never Married

2. How long have you been in this marital status? (If never married, since age 18). YRS. MOS.

3. Are you satisfied with this situation?
   0 – No
   1 – Indifferent
   2 – Yes

4. Usual living arrangements (past 3 yr.)
   1 – With sexual partner and children
   2 – With sexual partner alone
   3 – With parents
   4 – With family
   5 – With friends
   6 – Alone
   7 – Controlled environment
   8 – No stable arrangements

5. How long have you lived in these arrangements. (If with parents or family, since age 18). YRS. MOS.

6. Are you satisfied with these living arrangements?
   0 – No
   1 – Indifferent
   2 – Yes

FAMILY/SOCIAL RELATIONSHIPS

7. With whom do you spend most of your free time:
   1 – Family 3 – Alone
   2 – Friends

8. Are you satisfied with spending your free time this way?
   0 – No 2 – Yes
   1 – Indifferent

9. How many *close* friends do you have?

10. How many days in the past 30 have you had serious conflicts:
    A) with your family?
    B) with other people? (excluding family).

Have you had significant periods in which you have experienced serious problems with: (PAST 30 DAYS / IN YOUR LIFE)

0 – No 1 – Yes

11. Mother
12. Father
13. Brothers/Sisters
14. Sexual partner/spouse
15. Children
16. Other significant family _____
17. Close friends
18. Neighbors
19. Co-workers

FOR QUESTIONS 20-23 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

20. Family problems?
21. Social problems?

How important to you now is treatment or counseling for these:

22. Family problems?
23. Social problems?

INTERVIEWER SEVERITY RATING

24. How would you rate the patient's need for family and/or social counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

25. Patient's misrepresentation
26. Patient's inability to understand
    0 – No 1 – Yes

CARD 6

COMMENTS

What percentage of the people you associate with use opiates? [ ]

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1. How many times have you been treated for any psychological or emotional problems?
   In a hospital
   As an Opt. or Priv. patient

2. Do you receive a pension for a psychiatric disability?
   0 – No 1 – Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have: (PAST 30 DAYS / IN YOUR LIFE)

0 – No 1 – Yes

3. Experienced serious depression
4. Experienced serious anxiety or tension
5. Experienced hallucinations
6. Experienced trouble understanding, concentrating or remembering
7. Experienced trouble controlling violent behavior
8. Experienced serious thoughts of suicide
9. Attempted suicide
10. Have you taken prescribed medication for any psychological/emotional problem

PSYCHOLOGICAL STATUS

11. How many days in the past 30 have you experienced these psychological or emotional problems?

FOR QUESTIONS 12 & 13 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?
13. How important to you *now* is treatment for these psychological problems?

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of this interview, is patient:
0 – No 1 – Yes

14. Obviously depressed/withdrawn
15. Obviously hostile
16. Obviously anxious/nervous
17. Having trouble with reality testing, thought disorders, paranoid thinking
18. Having trouble comprehending, concentrating, remembering
19. Have suicidal thoughts

INTERVIEWER SEVERITY RATING

20. How would you rate the patient's need for psychiatric/psychological treatment?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

21. Patient's misrepresentation?
    0 – No 1 – Yes
22. Patient's inability to understand?
    0 – No 1 – Yes

CARD 7

COMMENTS

11a. Has your mother or father ever been treated for a psychiatric or emotional problem?

0 = NO 1 = YES [ ]

7 JUL 1986