

MODELS AND APPROACHES TO ALCOHOL AND DRUG ADDICTION REHABILITATION IN KENYA

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ABSTRACT : *Drug addiction is a complex illness. It is characterized by intense and, at times, uncontrollable drug craving, along with compulsive drug seeking and use that persist even in the face of devastating consequences. Counsellors therefore need to study and develop multi-faceted drug intervention models that are “drug specific” to the addiction at hand. One size does not fit all. This paper looks at the various approaches to rehabilitation used to enhance recovery of alcoholics and drug abusers in registered inpatient rehabilitation centres in Kenya. A descriptive study that used a qualitative approach was carried out. The study focused on all the residential drug rehabilitation centres in and around Nairobi. The Study Sample included the counselors directly dealing with the treatment of clients in these centres. A two level questionnaire was used to establish the treatment models used in the various in patient drug rehabilitation centres from the respondents, using a qualitative key informant interview. Data was analysed and presented using descriptive and inferential statistics. The study found out that various models of treatment were used for treatment of clients admitted in drug rehabilitation centres in Nairobi. The commonly used models included the 12 step program of the Minnesota model, Therapeutic community model, Medical model and in most places a mixture of the various models.*

KEYWORDS: *Addiction, Drug, Alcohol, Rehabilitation, Treatment models.*

INTRODUCTION

Addiction affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behaviour. Some individuals are more vulnerable than others to becoming addicted, depending on the interplay between genetic makeup and age. While a person initially chooses to take drugs, over time the effects of prolonged exposure on brain functioning compromise that ability to choose, and seeking and consuming the drug becomes compulsive, often eluding a person's self-control or willpower.

Drug and alcohol rehabilitation is intended to help addicted individuals stop compulsive drug seeking and use. This can occur in a variety of settings, take many different forms, and last for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment is process that involves multiple interventions and regular monitoring. There are a variety of evidence-based approaches to treating addiction. Drug treatment can include behavioural therapy (such as cognitive-behavioural therapy or contingency management), medications, or their combination. The specific type of model or combination of models will vary depending on the patient's individual needs and, often, on the types of drugs they use. Behavioural therapies can help motivate people to participate in drug and alcohol rehabilitation, offer strategies for coping with their cravings, teach ways to avoid abuse and prevent relapse, and help individuals deal with relapse if it occurs. Behavioural therapies can also help people improve communication, relationship, and parenting skills, as well as family dynamics. An individual who is addicted to meth should not be treated the same as an individual who is addicted to heroin. The craving or call for the drugs is similar, but the field has to be open minded enough to allow for individual variations within the addiction treatment model. To this end this paper seeks to identify some of the treatment models fit for rehabilitation among various drug and alcohol addicted persons.

LITERATURE UNDERPINNING

The 12-Step Model

Studies have shown that Alcoholic Anonymous (AA) and Narcotic Anonymous (NA) provide long-term benefits to youth, even if the adolescents stop attending after a time. Published in the journal 'Alcoholism: Clinical & Experimental Research,' one study followed 160 adolescents, with an average age of 16, through four- and six-week treatment programs based on a 12-Step model. After treatment ended, participants were re-assessed on a number of clinical variables at six months, and one, two, four, six, and eight years. (<http://www.drugrehabprogram/are-12-step-programs-beneficial-for-teens.php>)

John F. Kelly, associate director of the MGH-Harvard Center for Addiction Medicine at Massachusetts General Hospital said:

“We found that patients who attended more AA and/or NA meetings in the first six months post-treatment had better longer term outcomes, but this early participation effect did not last forever – it weakened over time, the best outcomes achieved into young adulthood were for those patients who continued to go to AA and/or NA. In terms of a real-world recovery metric, we found that for each AA/NA meeting that a youth attended they gained a subsequent two days of abstinence, independent of all other factors that were also associated with a better outcome.” (<http://www.drug-rehab-program.org>)

Researchers found that even small amounts of AA/NA participation (once per week) was associated with improved outcomes, and three meetings per week was associated with complete abstinence. Not surprisingly, severely addicted teens attended a greater number of meetings and benefited most from the AA/NA focus on complete abstinence. Krentzman *et al.*, (2010). Also in a survey by Massachusetts General Hospital, Centre for Addiction Medicine, teens reported that the group dynamic, support, and sense of hope they gained at AA/NA meetings were the most appealing aspects of the 12-Step program.

Addiction experts point to the following additional benefits of a 12-Step program for adolescents:

- a) The 12-Step program is focused specifically on abstinence and addiction recovery.
- b) Twelve Step meetings are widely available in most communities, and can be accessed any day, evening, or weekend.
- c) Services are free.
- d) The 12-Step program provides easy admission into a large social support network with fellow adolescents in recovery, meeting teens’ particular need for social affiliation and peer-group acceptance.
- e) Teens can attend regularly or on an as needed basis.
- f) Twelve Step meetings offer social activities and sober fun as an alternative to drinking, doing drugs, and partying.

Cognitive-Behavioural Approaches

Deficits in skills for coping with the antecedents and consequences of drinking/drug use are considered to be a major contributor to the development and maintenance of addictive behavior (Miller & Hester, 1989). As a result, considerable effort has been devoted to studying coping skills training, to determine whether it has practical utility as a means of reducing risk and curtailing addictive behavior. A large body of clinical research has been produced on this topic, and three meta-analyses have ranked coping skills training as either first (Holder *et al.*, 1991) or second (Miller *et al.*, 1995; Finney & Monahan, 1996) based on evidence of effectiveness, as compared to a variety of other treatments for alcoholism. Nevertheless, despite the high rankings in the meta-analyses, Longabaugh and

Morgenstern (1999) have questioned whether the research studies provide adequate grounds for concluding that coping skills training is superior to other forms of treatment. They outline steps that should be taken to resolve the matter, and it seems certain that the question will remain open for a number of years while further studies are conducted, before it is finally settled. In the meantime, coping skills training does receive strong support from the evidence currently available and it is widely employed in addictions treatment programs.

Similar questions have been raised regarding Relapse Prevention (RP) treatment studies (Carroll, 1996). Interventions that focus on relapse prevention have been found beneficial for maintaining the effects of treatment during follow-up periods and for reducing the severity of relapse episodes that do occur, but there are diminishing returns in as much as these benefits have been found to decrease with increasing time since treatment completion (Carroll, 1996; Allsop *et al.*, 1997).

A meta-analysis focused specifically on relapse prevention treatment outcome studies found that RP treatment was beneficial, but its impact on psychosocial functioning was greater than on substance use itself (Irvin *et al.*, 1999).

Another finding of clinical relevance from RP treatment outcome studies is that among the various categories of risk for relapse specified by Marlatt and Gordon (1985), negative emotions have been consistently identified as a major relapse precipitant (Longabaugh *et al.*, 1996). Based on that, coupled with findings that coping ability is related to treatment outcome (Miller *et al.*, 1996; Connors *et al.*, 1996), it has been recommended that skills training to foster improved coping with negative emotions be provided as a means of reducing relapse risk (Connors *et al.*, 1996).

The Biopsychosocial model

Outpatient Long-term Intensive Therapy for Alcoholics (OLITA) is a four-step biopsychosocial outpatient therapy program for severely affected alcohol-dependent patients, aiming at immediate social reintegration within the sheltered setting of psychotherapeutic treatment and medical care. Therefore, basic elements of psychiatric patient care, client-centered and cognitive-behavioral psychotherapy, as well as classical addiction therapy, are integrated into a comprehensive, intensive and long-term treatment approach. In order to take into account both the impaired stress tolerance of the patients during early abstinence and the chronicity of the disease, the OLITA concept combines high intensity (i.e., high frequency of therapy contacts) and long duration of therapy. Following inpatient detoxification, the treatment extends over 2 years (Krampe *et al.*, 2007). The OLITA pilot study started in 1993 and was terminated successfully in 2003 after 10 years and the completion of 180 patients assigned to recruitment cohorts 1-6. (Ehrenreich *et al.*, 1997) The main therapeutic elements of OLITA are: (1) frequent contacts, Initially daily, with a slow reduction of contact frequency up to the end of the second year; (ii) therapist rotation; (iii) support of social reintegration and aggressive aftercare; (iv) induction of alcohol intolerance through application of alcohol deterrents (inhibitors of acetaldehyde dehydrogenase); (v) explicit control: supervised intake of

alcohol deterrents and regular urine analysis for alcohol and other drugs of abuse. (Ehrenreich *et al.*, 1997)

The therapeutic phases of OLITA consist of the inpatient period (detoxification; 2 to 3 weeks, daily individual sessions, 15 minutes), the outpatient period (intensive phase, 3 months, daily individual sessions, 15 minutes), the outpatient period II (stabilizing phase, 3 to 4 months according to individual need, three times a week individual sessions, 15 minutes), the outpatient period III (weaning off phase, 6 months, twice a week individual sessions, 30 minutes), and outpatient period IV (aftercare phase, 12 months, once weekly group session, initially once weekly individual session, 30 minutes, which is gradually tapered off). After completion of the 2 years of therapy, patients participate in weekly to quarterly follow-up contacts and are offered to make use of both the emergency service and the crisis interventions of the therapeutic team (Krampe *et al.*, 2007).

Inclusion criteria for OLITA are alcohol dependence according to DSM-IV, residence nearby, and health insurance-covered treatment costs. Exclusion criteria are presence of moderate to severe dementia and acute concurrent abuse or dependence on substances other than alcohol (with the exception of caffeine and nicotine). Thus far, 180 alcoholics (144 men, 36 women) have been treated with a 7-year follow-up success rate of over 50% abstinent patients despite a “negative selection,” with regard to severity of alcohol dependence, co morbidity, and social detachment, upon entering the program (Krampe *et al.*, 2007). Patients who were on average 44 ± 8 years old, had a duration of alcohol dependence of 18 ± 7 years, approximately 7 ± 9 prior inpatient detoxification treatments, and 1 ± 1 failed inpatient long-term therapy. Almost 60% of the patients were unemployed. Psychiatric co morbidity amounted to 80%. About 60% of the patients suffered from severe sequelae of alcoholism, such as poly neuropathy, chronic pancreatitis, or liver cirrhosis. To illustrate addiction severity in our population, representative scores of the European Addiction Severity Index were 0.58 (± 0.38) for medical status, 0.56 (± 0.47) for economic status, 0.51 (± 0.37) for job satisfaction, 0.83 (± 0.11) for alcohol use, 0.59 (± 0.30) for family relationships, and 0.46 (± 0.21) for psychiatric status. (Gsellhofer *et al.*, 1999)

The disease model theory

The disease model view drug abuse as a disease influenced by genetic vulnerability which is reflected in the abnormality in brain chemistry (Jang *et al.*, 2000). The abnormalities create an altered response to drug abuse. The inability to control amounts, cravings and withdrawals are all pointers of a biological component of drug abuse.

The learning model theory

Learning theories encompass different schools of thought regarding learnt or conditioned behaviors. They include; classical conditioning, modeling theories as well as cognitive behavioral or social learning theories. They subscribe to the notion that substance abuse represents a learnt or modeled bad habit that is subject to change and thus can be analyzed and modeled by applying learning theory principles (Akers, 1977).

The psychoanalytic model theory

The psychoanalytic theories view drug abuse as an adaptive mechanism by which an individual attempts to cope with self-regulatory deficits arising from infantile deprivation and maladaptive child-parent relationship. The choice of a specific drug is based on the premise that it relieves the feeling they find particularly problematic or painful. Early childhood developments issues and trauma are primary in this theory (Alcoholics Anonymous, June 2001).

The family models theory

There are three family models used to explain the causation of drug abuse. They include family systems models, family behavioral models and family disease models. These models view drug abuse as a symptom of a dysfunctional family. In particular, the concepts of homeostasis, the rules that and goals that govern the interactions between family members and ways in which the rules are applied, may all contribute to drug abuse. This theory emphasizes the need to include family members in treatment and address family dynamics so that the drug abuser has a healthier, stable flexible and open family environment after treatment (McCrary & Epstein, 1996).

Therapeutic Communities

For three decades, National Institute on Drug Abuse (NIDA) has conducted several large studies to advance scientific knowledge of the outcomes of drug abuse treatment as typically delivered in the United States. These studies collected baseline data from over 65,000 individuals admitted to publicly funded treatment agencies. They included a sample of TC programs and other types of programs (i.e., methadone maintenance, out-patient drug-free, short-term inpatient, and detoxification programs). Data were collected at admission, during treatment, and in a series of follow ups that focused on outcomes that occurred 12 months and longer after treatment (*Hanson, 2002*).

These studies found that participation in a TC was associated with several positive outcomes. For example, the Drug Abuse Treatment Outcome Study (DATOS), the most recent long-term study of drug treatment outcomes, showed that those who successfully completed treatment in a TC had lower levels of cocaine, heroin, and alcohol use; criminal behaviour; unemployment; and indicators of depression than they had before treatment (*Hubbard et al., 1997*).

METHODOLOGY

The study took a descriptive qualitative approach seeking to establish some of the models used in rehabilitation centres in and around Nairobi. This involved participation of all the counsellors employed in these rehabilitation centres. The study population comprised all rehabilitation centres which deal with alcohol and drug abuse patients; but only those which consented to participate and staff who consented to participate were involved. A total of 25

rehabilitation centres in and around Nairobi area, as per NACADA website were therefore conveniently included to participate. A questionnaire guide and an interview schedule were used for data collection. Data on interviews was recorded using a voice recording device, it was later transcribed from voice to word format, En Vivo computer software was used, to group the transcribed data into pre-determined themes, the data was then thematically analysed. The results are descriptively presented in themes.

RESULTS AND DISCUSSION

Medical Approach

The interviewees indicated that a multi-disciplinary team of professionals is often needed to treat the chemically dependent persons. Psychiatrists usually play a key role in medical stabilization and facilitating treatment entry, but others are routinely needed beyond the initial management, for example addiction counselors, social workers, psychologists, family therapists, psychologists and pastoral counselors.

Treatment of addiction can be divided into three stages. Initially, the person has to undergo the detoxification process. Next, he or she must be stabilized followed by long-term abstinence and rehabilitation.

- a) *Detoxification:* This stage involves stopping alcohol consumption. This is very difficult for an alcohol-dependent person; it usually requires extreme discipline, and extensive support. It is often performed in an inpatient setting where alcohol is not available medical detoxification is necessary so as to manage withdrawal symptoms which can be very severe and at times life threatening.
- b) *Stabilization:* It is the treating doctor's responsibility to treat any medical conditions related or unrelated to alcoholism. Vast arrays of medical and surgical complications are associated with alcoholism including psychological and personality disorders.
- c) *Rehabilitation:* Short- and long-term residential programs aim to help people who are more severely dependent on alcohol to develop skills not to drink, to build a recovery support system, and to work on ways to keep them from drinking again.

Christian Approach

Majority of the respondents indicated that they always included Christian alcohol recovery programs. Christian alcohol recovery programs have become popular and effective because they embrace the best of both the religious and secular worlds. Most of these treatment methods are built upon the combination of scripture with the existing dimensions offered by the 12 Step Program of Alcoholics. The end result of this methodology is a rehab program that offers both physical and spiritual healing and is built upon a spirit of love and compassion. These treatment facilities are generally staffed with credentialed Christian men and women who are often in the long-term recovery stages of alcohol rehabilitation. Whereas many other alcoholism treatment options centre upon theories or philosophies,

Christian alcohol rehab facilities are Christ-centred and treat the person based on their personal identity and their communal identity in Christ with empowerment and accountability, viewing the world through the eyes of eternity, not merely the here and now. Furthermore, there are programs available not just for alcoholics, but the people around them as well.

One of the ways the Christian alcohol recovery programs can help individuals embrace the beauty of second chances. Healing and restoration are often brought to relationships that had once been given up as lost causes. Christian treatments allow the addicts to offer and seek forgiveness for past wrongs and to work at mending the fences. Marriages and families are often resurrected out of the ashes of their previous destruction through the hope and healing of faith and forward momentum.

Alcoholics are able to acknowledge the injuries and insults that they have perpetrated in the lives of the people they love and come to terms with how connected all people are in their lives, and how the things that affect them go on to affect others around them, whether intentionally or not. Along the way, they form new relationships with people who offer a fresh perspective and other tips, tactics and success strategies. Christian recovery programs, while not for everyone, have a lot to offer individuals committed to the message and ministry of God the Father, God the Son and God the Holy Spirit as revealed in the chapters and verses of the Holy Bible.

The 12 - step model

The twelve Steps, initially developed by Alcoholics Anonymous, is the spiritual foundation for personal recovery from the effects of alcoholism, not only for the alcoholics, but also for their friends and family. The interviewees in this study indicated that they mainly use this model to train their clients. It includes the following steps:

Step 1: Honesty- Being honest after many years of denial, recovery can begin with one simple admission of being powerless over alcohol, for alcoholics and their friends and family.

Step 2: Faith- Acknowledging that Faith is a spiritual truth (higher power), that before a higher power can begin to operate, one must first believe that it can.

Step 3: Surrender- A lifetime of self-will run riot can come to a screeching halt and change forever, by making a simple decision to turn it all over to a higher power.

Step 4: Soul Searching- There is a saying in the 12-step program that recovery is a process, not an event. The same can be said for this step in making a fearless self inventory and more will surely be revealed.

Step 5: Integrity- Probably, the most difficult of all the steps to face is step 5, it is also the one that provides the greatest opportunity for growth through admitting to God, to ourselves and to another human being about the exact nature of our wrongs.

Step 6: Acceptance- The key to Step 6 is acceptance, accepting character defects exactly as they are and becoming entirely willing to let them go and have God remove all these defects of character.

Step 7: Humility- The spiritual focus of the program is in humility, asking a higher power to do something that cannot be done by self-will or mere determination.

Step 8: Willingness- Making a list of those harmed before coming into recovery may sound simple. Becoming willing to actually make those amends is the difficult part.

Step 9: Forgiveness- Making amends may seem like a bitter pill to swallow, but for those serious about recovery it can be great medicine for the spirit and soul.

Step 10: Maintenance- Nobody likes to admit to being wrong. But it is absolutely necessary to maintain spiritual progress in recovery.

Step 11: Making Contact- The purpose of Step 11 is to discover the plan of God as you understand Him and what He has for your life through prayer and meditation.

Step 12: Service- For those in recovery programs, practicing Step 12 is simply “how it works.”

Therapeutic communities Model

Some of the respondents indicated that they also offer therapeutic community services. A therapeutic community exists to help people overcome an addiction, but also recognizes that many of the people suffering from a dependency to drugs or alcohol lack basic socialization and life skills, and that without first learning (or re-learning) these necessary skills, they are at great risk for a relapse back to abuse. The intensity of therapeutic programming does differ. An alcohol rehab facility aims only to teach the needed life skills and strategies to end drug or alcohol seeking behaviours, and as such the brief period of residency is therapeutically intense. Residents will participate in differing therapies and education classes exclusively, and will not be required to do anything during the period of recovery other than focus on self healing. A therapeutic community will offer the same types of therapies, but with a lesser intensity. First, because residents are expected to maintain participation for as long as two years, there is not the pressing need to teach all needed skills within a shorter duration of residency; and more importantly, the basic philosophical model of treatment has recovery and therapy occurring more out of participation and interaction in the community than through top down addictions programming (*Center for Substance Abuse Treatment (CSAT), (www.samhsa.gov)*)

It was indicated that planning for detoxification (Detox) was the first step to rehabilitation: Detox planning includes planning for the diet given to patients; planning needs should also be done in order to establish the psychiatrics who will offer the treatment and plan on the days they will come and treat the patient; this finding is supported by Hayes *et al.* (1993).

In their study, Hayes and others identify numerous models and approaches used to treat chemical dependency, stating Detoxification as the first step in rehabilitation. Some clients are first referred to a Detox centre so that they can go through that stabilization in the hospital setting before they are ready to come and settle down at the rehabilitation centres.

Treatment planning is also done to provide individualised care to the client. The client is engaged based on the assessment done earlier and the new information obtained as they continue associating with the clients. Here they are able to identify areas where the interventions are needed. They also look at their goals and what the patient wants to achieve especially in areas of education and vocation. Then they look at the legal issues, any family systemic issues and psychosocial issues that need to be addressed.

Alcohol treatment programs do not usually have a set length of time. This is because the unique nature of each individual client needs. However, most treatment programs will last no less than seven to ten days, and it will continue for as long as the patient requires the treatment and support that is provided; the average length of programs was 90 days. This is in line with findings of Condelli and Hubbard (1994); Simpson *et al.* (1997) which show that those populations who remain in treatment for at least 3 months have more favorable outcomes, a critical retention threshold of at least 90 days has been established for residential programs.

In another study, it was established that persons admitted to residential programs are likely have the most severe problems, and those remaining beyond the 90-day threshold have the most favorable outcomes (Simpson *et al.*, 1999).

The most common types of alcohol addiction treatment programs can be divided into four categories with an average length of time for each program. Often two or more treatment programs are combined to suit the patient's needs. These include the 12 step model, Therapeutic communities, medical model and Christian model. This is in line with several studies done in support of these models. The Therapeutic Community model for instance, has been adopted successfully in community residence programs for serious and persistent mental illness (Sacks *et al.*, 1998a), general hospitals (Galanter *et al.*, 1993), and substance abuse treatment programs, both nationally and internationally (Caroll, 1990).

IMPLICATION TO RESEARCH AND PRACTICE

Educating the client on how to develop coping strategies for substance use is necessary. This paper identifies various models and approaches as well as their effectiveness in the rehabilitation process. It will enlighten rehabilitation counsellors on what they should be doing and why they should be providing additional services. The paper will inform how various models /systems can enhance the Rehabilitation processes.

The Rehabilitation Counsellor therefore should understand the various models and principles of addiction and other issues that might relate to the substance use, scientifically endorsed models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related dilemmas.

CONCLUSION

The 12 step approach of the Minnesota model and the Therapeutic community model are the most commonly used treatment approaches, either individually, or in combination. Majority of the rehab centres used a mixture of these approaches and this depended on the needs of the clients, the competence of staffs and the ability of client to meet the costs. NACADA the Kenyan Government's Drug and Substance Abuse (DSA) regulatory agency has a non-specific policy guideline on how to manage DSA at in-patient level of care.

RECOMMENDATION

NACADA should improve its policy guidelines on in-patient management of DSA specifically as concerns the following areas:-

- a) What treatment models to be applied in different DSA categories
- b) Provide hierarchal classification of service providers

It is recommended that further studies to determine the local efficacy and cost-effectiveness of the various models in use be done so that these models can be appropriately domesticated in the Kenyan context.

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