Advances in Psychiatric Treatment (1997), vol. 3, pp. 174–181

Substance misuse: aspects of treatment and service provision

Roger Farmer

The problems associated with alcohol and drug misuse are diverse and make a major impact on the health of the nation (Anderson, 1991; Royal College of Psychiatrists, 1992). A recent survey showed that the prevalence of alcohol dependence in the population (aged 16–64 years) was 47 in 1000 and of drug dependence 22 in 1000. (This compares with a prevalence for functional psychosis of 4 in 1000) (Office of Population Censuses and Surveys, 1994).

In this article some ways of understanding, providing services for, and treating substance misusers will be discussed. After looking at theoretical models of substance dependence I will move to service provision, counselling methods, and the subject of stress in staff.

Models of substance dependence

A model provides a means of conceptualising substance dependence in order to improve our understanding of the problem and to suggest solutions. The validity of any model and the extent to which it accurately represents reality can be tested in experimental studies, as well as being judged in terms of its clinical usefulness. The ideal clinician is perhaps one who is flexible enough to integrate the most relevant elements of different models to individualise treatment for any substance misusers. Conversely, clinical work may be compromised by rigid adherence to any one model at all times for all patients. Different patients may benefit from emphasising one model over another, and the same patient may benefit from different models being emphasised during different phases of treatment. More detailed accounts are provided in Brower *et al* (1989) and Lindstrom (1992) but the following is a brief outline of the basic models (see Table 1).

According to the *moral model*, the substance misuser is an individual with a weak or bad character. A person is held fully accountable for the consequences of their substance misuse, and control of substance-related behaviours is best achieved through deterrent punishments. The *spiritual model* is a variant, which attributes substance misuse to misalliance with God and the universe.

The conception of alcoholism as a progressive, addictive disease – the *disease model* – dates from the late 18th century (see Levine, 1978), and in the first half of the 19th century the Swede, Magnus Huss introduced the term 'alcoholism'. It was, however, not until after the Second World War that the public and legislators began to conceive widely of habitual drinking as a disease.

Jellinek's *The Disease Concept of Alcoholism* was published in 1960. Of his five species of alcoholism, three types were provisionally designated as diseases: the Gamma (loss of control), the Delta (inability to abstain) and the Epsilon (episodic use) types. Although Jellinek presented his theory as a working hypothesis, many people accepted his preliminary thesis as established truth. The disease concept has been espoused by the alcohol industry, in that it holds that any alcohol problem has its roots in the individual and not in the bottle. The disease model led to more compassionate treatment but arguably had the disadvantages of tending to absolve the substance misuser of the

Roger Farmer is involved in a variety of degree and diploma courses run by the Department of Addictive Behaviour, St George's Hospital Medical School (Cranmer Terrace, Tooting, London SW17 0RE); research; and clinical work in Richmond, Twickenham and Roehampton in alcohol misuse and general adult psychiatry. His current interests within substance misuse include theoretical models, pharmacotherapy, relapse prevention, occupational health of staff, and service provision.

Table 1. Basic models of substance dependence

	Model				
	Moral	Disease	Symptomatic	Learning	Social
Aetiology	Weak or bad character	Biological factors (? genetic)	Another primary mental disorder	Learned, behavioural disorder	Environmental factors
Focus of treatment	Control of behaviour via deterrant punishment	Abstinence to arrest progression of disease	Improved mental functioning	Learning behaviour alternative to or incompatible with substance misuse	Improved social functioning
Advantages	Responsibility for change lies with user	Not blaming or punitive	Not blaming or punitive. Emphasis on importance of diagnosing and and treating coexisting mental disorders	Not blaming or punitive. Holds user responsible for new learning	Easily integrated into other models
Disadvantages	Punitive	Absolves user of responsibility to change. Ignores psychological, cultural and environmental factors	Implies treatment of mental disorder is sufficient	Tends to ignore personality – disabling consequences of substance misuse and human irrationality	Implies change of social situation is sufficient

responsibility for his or her substance-related behaviour, and of minimising the importance of psychological, cultural and environmental factors in the aetiology and maintenance of substance misuse.

Earlier this century the *symptomatic model* was prevalent, which holds that substance misuse is symptomatic of a primary mental disorder and that the rational treatment, therefore, is insight-orientated psychotherapy or pharmacotherapy of the causal mental disorder. Vaillant & Milofsky (1982), from their own study and a critical review of the literature, however, concluded that:

> Available prospective studies suggest that if one controls for antisocial childhood, cultural attitudes towards alcohol use and abuse, for alcohol heredity, and most especially for the *effects* of alcohol abuse then many of the childhood and adult personality variables to which adult alcoholism has traditionally been attributed will appear as carts and not horses.

Vaillant in his own studies found that alcohol dependence tended to evoke pessimism, passivity, self-doubt, dependence and other 'oral' traits – traits that had been previously considered to characterise the pre-alcoholic personality. In other words, whereas retrospective studies had suggested alcohol misuse and dependence were a consequence of certain psychological symptoms or personality traits, well-conducted prospective studies indicated that such clinical features were more often subsequent and consequent to the development of alcohol problems.

The *learning model* is concerned with how behaviour is acquired, maintained and changed. It assumes that there is no sharp borderline between social use of substances and substance dependence. Both deviant and normal behaviours are held to be learned. Aetiological theories are derived from classical conditioning, tension-reduction, operant conditioning and expectancy theories. An influential classical conditioning-based theory of Ludwig & Wikler (1974) proposed that exposure to cues which had previously been associated with either heavy drinking or alcohol withdrawal (conditioned stimuli) elicits an anticipatory 'mini-withdrawal' (conditioned response), which is often interpreted as craving by the dependent drinker. The tension-reduction theory postulates that alcohol is taken as a means of reducing tension or stress. Studies have failed to support consistently this view, which may

https://doi.org/10.1192/apt.3.3.174 Published online by Cambridge University Press

anyway be too simplistic given the likely multifactorial basis of substance misuse. Operant conditioning offers a more comprehensive model whereby alcohol or drug misuse is maintained by physiological, psychological or social reinforcers. Reinforcement may be positive or negative: examples of the former would be the pleasant early psychopharmacological effects of alcohol, such as feelings of euphoria or calmness. Negative reinforcement and the removal of an aversive experience would be exemplified by alcohol drinking relieving withdrawal symptoms or feelings of boredom. Expectancy theories have emphasised the role of cognitive processes in predicting substance-related behaviour so that the effects of taking drugs or alcohol may not be merely the result of pharmacological action, but also culturally learned. Recent models of relapse prevention such as that of Marlatt (Marlatt & Gordon, 1985) – at least as stated initially – have emphasised cognitive–behavioural theories and treatment approaches.

The *social model* emphases the relations between individuals in the social context where substance misuse develops and is maintained. Certain treatment studies have at least partly adopted this model, such as Azrin's studies of the Community Reinforcement Approach which included helping problem drinkers to find employment, improving family or marital relations, enhancing social skills and encouraging non-alcohol-related social activities (e.g. Azrin *et al*, 1982).

Integrative or *multi-focused* models include that of Alcoholics Anonymous (AA), which includes elements of the moral, spiritual and disease models. Another is the *biopsychosocial model* which takes into account biological, psychological and social factors in the aetiology, assessment and treatment of addictive behaviours. Even if working within a treatment setting which follows a particular basic model, the most effective therapist is likely to be multi-focused in his or her approach. To take an example, a disease model therapist may be addressing family issues in terms of co-dependence or using relapse prevention techniques based on social learning theory. Clinicians need to be aware of the main models and be flexible enough to exploit the advantages of each in different patients at different times. The patient's beliefs about their addictive behaviour will be an important consideration. If, for instance, a patient has accepted the AA model, it is likely to be best for a therapist, even if their theoretical leanings are behavioural, not to disabuse the patient of his or her views.

Buddhist doctrines may be particularly relevant, as they deal in detail with craving and attachment. Addictive behaviour would be seen as a false refuge and a source of attachment, which unwittingly but inevitably leads to suffering (Groves & Farmer, 1994). From this perspective, the root of addictive behaviour would be regarded as ignorance, so that there would be no question of disapprobation for 'sinful' behaviour. The context for treatment would be one of therapeutic optimism based on viewing everything as impermanent, and of compassion towards those addicted. The aim would be to move on to more skilful behaviour in general, rather than merely reversion to 'normal'. Overcoming addictions would ideally be within a broad lifestyle framework, which took into account vision, ethical behaviour, positive emotion to enhance motivation, livelihood, as well as meditation as a means of transformation.

A network of services

The report of the Task Force to Review Services for Drug Misusers (1996) has advocated a coordinated response to tackling drug misuse, with a variety of different treatments and facilities available. A range of alcohol (Fig. 1) and drug (Fig. 2) service provision should be accessible to substance misusers and their relatives in a district. All the components need not actually be located within the district, but could be sited in neighbouring areas or further afield and purchased as appropriate.

Community Drug and Community Alcohol Teams (in some places amalgamated in a single team) will be pivotal, not only in direct service provision, but in advising, liaising with, and training staff in other agencies, generic and specialist. Some patients will benefit from residential placement, which may permit containment and rehabilitation in a supportive environment away from familiar cues and high-risk situations for substance misuse. However, increasingly day programs are being established as a means of providing relatively frequent therapeutic input, rehabilitation and support in the person's own community with ongoing cue exposure.

It should be possible to detoxify the majority of substance misusers in the community without recourse to relatively expensive in-patient or residential facilities. Indications for in-patient alcohol detoxification would include a history of delirium tremens or epileptic seizures, very limited social support including homelessness, previously failed community detoxification, and serious

https://doi.org/10.1192/apt.3.3.174 Published online by Cambridge University Press

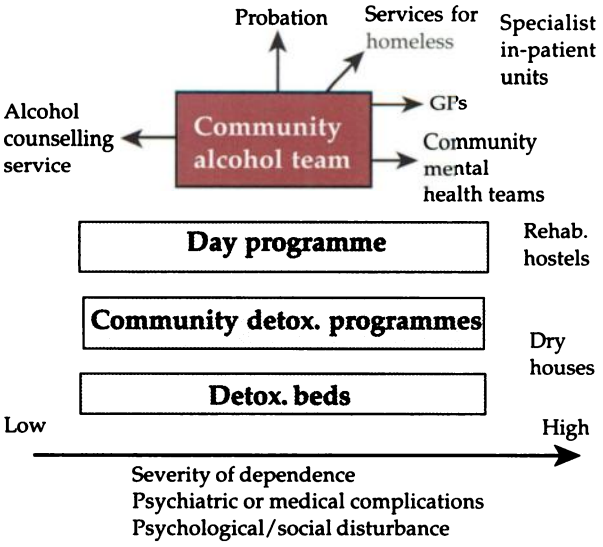

Fig. 1 Network of alcohol services

psychiatric or medical conditions. In-patient drug detoxification may be required for those taking high doses of benzodiazepines or very high doses of opiates, or for those with relatively severe psychological or medical problems In-patient treatment may be a precursor to longer term residential rehabilitation in a hostel. In the Royal College of Psychiatrists (1992) Mental Health of the Nation document, three beds for substance misuse per 100 000 population was recommended, with adjustments according to socio-demographic factors, the geography of the area and other facilities which might be available. A requirement for 0.6 whole time equivalent of consultant time for substance misuse work per 100 000 population was recommended. Again, the actual figure required in a particular area would depend on the levels of social deprivation (which is associated with substance misuse) and on geography (in rural areas, for instance, there may be difficulties in relation to accessibility and the time needed for clinical assessments and travel). The consultant specialising in substance misuse should be a member of a community team, and one of such a team's main roles would be advising and liaising with general practitioners (GPs) and other primary care workers.

The Task Force report (1996) recommended that 'shared care' between primary health care and specialist services should be widely available, and emphasised the need for appropriate support for GPs.

General practice is said to be a key resource in the treatment of substance misuse. Users have been found to perceive GPs as unsympathetic and negative, and lacking in interest and knowledge. However, in a recent survey of 145 misusers attending a private drug clinic, a community drug team, a drug dependency unit, and street agency, the majority expressed a preference for substitute prescribing to be undertaken in a general practice setting (Hindler *et al*, 1995). Primary care services were regarded as more accessible and responsive to their needs than hospital-based services. As part of the same project but including a general practice with a special interest in treating drug misusers (Hindler *et al*, 1996), it was found that the majority of these London-based drug misusers attending treatment centres were registered with a GP,

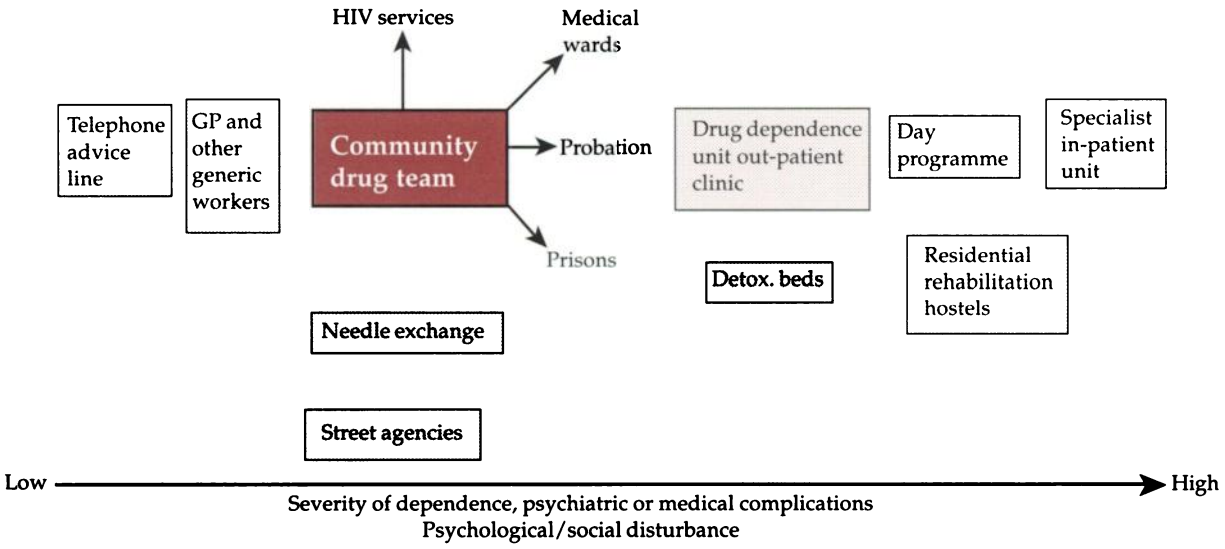

Fig. 2 District drug services

https://doi.org/10.1192/apt.3.3.174 Published online by Cambridge University Press

although 42% of the subjects had sought out a GP who was prepared to treat them, rather than registering with a local family doctor. Most GPs were reportedly aware of the patients' drug problems, but half of them were not prescribing for drug misusers, with almost 20% of those users claiming that this was because of lack of knowledge or trust on the part of the doctor. Sixty per cent of the drug misusers perceived their GP as holding negative or neutral views about them. Most of the drug misusers interviewed in the general practice with a special interest in drug misusers, viewed their GP more favourably than drug misusers in the other centres. The relationship between doctor and patient is, therefore, not always easy or productive. There is a need to clarify the role of GPs in the management of drug misusers and to provide them with better opportunities for continuing education.

In a recent study in which the author was involved, a small group format was utilised in the education of GPs in the management of drug users. A small group format, with facilitation by peers who have appropriate knowledge, skills and experience, may be the preferred method of educating GPs, encouraging their involvement in the management of drug misusers and providing ongoing support. Some input from staff from specialist drug treatment services also may lead to optimal care shared between specialist and primary care services.

Counselling for substance misuse

Different counselling approaches will be applicable in the different stages through which substance misusers may go (Farmer & Ghodse, 1993). For instance, after screening, when someone with a substance-related problem has been identified, motivational strategies may be the most appropriate, involving health and substance-related education, advice and counselling designed to evoke a dissonance between someone's substance misuse and their knowledge of its actual and potential harmful consequences for themselves and others (Miller & Rollnick, 1991). But it is often after someone has taken some remedial action and made progress in overcoming their substance-related problems that a therapist can be unclear as to how to help such a person maintain that positive change and avoid relapse. It is often at this stage that a therapist lacks a mental map or structure for a therapeutic approach. The relapse prevention model of Marlatt (Marlatt & Gordon, 1985) has provided such a counselling model. Some of the practical aspects of relapse prevention work are described by Wanigaratne *et al* (1990). Counselling of this kind is not a therapy prescribed for the patient. Rather, the therapist or counsellor is more like a co-investigator, helping the patient in looking at his or her situation and coming up with appropriate strategies for the future. While the therapist adopts an empathic, helping approach, the substance-related problem lies squarely with the patient, who very much retains responsibility for whether or not positive change continues.

There are three main aims to this relapse prevention approach: first, to increase awareness of what circumstances have led to substance misuse in the past and which are likely to put someone at risk of relapse in the future. High-risk situations are frequently related to pressure from others to take drugs or alcohol; interpersonal conflict, often with a partner; and emotional states, most often negative such as depression, anxiety, anger, resentment, envy and so on.

Second, to develop cognitive–behavioural skill to anticipate, avoid or cope with high-risk situations. For instance, if social anxiety has been a high-risk situation, then an appropriate strategy might be participation in social skills and anxiety management training. Originally, techniques derived from behaviourism and cognitive and social learning theory were emphasised most, but other approaches such as pharmacotherapy may be utilised to prevent relapse. This might include the use of a deterrent drug such as disulfiram (which is most effective when administration is supervised). In preventing relapse to opiate use, the long-acting opiate antagonist naltrexone may be used, the rationale being that cravings for opiates, and opiate-seeking and using behaviour, if viewed as conditioned responses, should die out if not reinforced by experiencing the effects of taking the drug. Again, if more major mood disturbance has been related to relapse into substance misuse, antidepressant or lithium medication might be tried, although this would have to be reconsidered if substance use were to become problematical once more.

Third, to facilitate more global lifestyle change. This involves assisting someone in identifying sources of stress, replacing unhealthy habit patterns with healthy activities, learning more effective time management, and achieving a lifestyle which is more balanced between activities seen as obligatory and those viewed as recreational or self-fulfilling. Although cognitive–behavioural approaches have been emphasised in the past, other approaches, such as psychodynamic therapy,

https://doi.org/10.1192/apt.3.3.174 Published online by Cambridge University Press

Box 1. Parameters of 'burnout'

- A global feeling of emotional and physical exhaustion
- A detached, cynical, unfeeling attitude to patients
- A loss of confidence in one's ability to continue doing the job and a tendency to evaluate oneself negatively, especially in regard to clinical work

may be appropriate as a means of personality change (for example, the 12-step methods of AA and Narcotics Anonymous to promote mutually supportive relationships and possibly also enhanced spiritual values; marital and family therapy when family dynamics are considered pertinent to relapse; and community-based intervention to change someone's social context). Substance dependence may amount to a very strong attachment with deeply engrained modes of thinking and behaving. It may be likened to a relationship with a long-term lover. To relinquish substance misuse may involve relatively radical and global changes to the way someone lives, and coping with the loss of that 'lover', about whom such ambivalent feelings are held.

Stress and working with substance misusers

The term 'stress' has been applied inconsistently and imprecisely. The provoking agents of stress are best referred to as stressors, so that the term stress is reserved for the experience of an individual which results from the interaction of stressors and that person's coping mechanisms. For example, a person who lacks time management skills (a coping mechanism) may experience stress when given a tight deadline for completion of a task (a stressor).

An overlapping (but not equivalent) term to stress is 'burnout', which describes:

> ... a process that comes about as a consequence of a depletion of energies as well as feelings of being overwhelmed with many issues that may confront an individual
>
> (Freudenberger, 1986)

Although accounts of burnout vary, three main parameters are summarised in Box 1.

The symptoms of stress may be associated with impairment of functioning at work and there may be an increased risk of substance misuse or gambling. Stress may seriously affect organisations themselves, either while stressed individuals are employed by the organisation, or as a result of the loss of experience, expertise and skills when professionals leave their posts. The term 'institutional burnout' has been coined to denote burnout of a whole agency.

Although it is unclear which occupations are most associated with stress, high levels have been frequently described among individuals whose work brings them into close contact with other people. It is a common belief that working with substance misusers is relatively stressing and, indeed, Freudenberger first described burnout in workers in clinics for alcoholics. But there is very little empirical evidence for or against this contention. In a study in London (Farmer, 1995), 60 staff working in 10 inner-city drug dependency treatment clinics were assessed by questionnaire for burnout levels, work satisfaction, perceived causes of stress, and strategies or situations to prevent or alleviate stress. While scores of emotional exhaustion and depersonalisation (meaning, in this context, a more detached attitude to patients) were expressed, self-ratings of personal effectiveness remained high and about half were satisfied with their job. Factors relating to high work load, superiors and management were perceived as highly pressurising, but at the other extreme, conflict between work and home demands raised few problems. Relationships with relatives, partners or friends were rated as most protective against stress.

Emotional exhaustion and adopting a more unfeeling attitude towards patients may adversely affect clinical effectiveness. The opposite – empathic, empowering and optimistic counselling styles – appear to be components of effective brief interventions for substance misuse (Bien *et al*, 1993).

It has been suggested that certain factors such as supportive relationships, having a spiritual component in one's life, and certain activities especially if practised regularly, such as exercise or meditation, may have a global role in protecting against stress across a variety of situations, as it were inoculating the individual against stress (Marlatt & Gordon, 1985). When staff in a London drug dependency treatment clinic were given an introductory course on meditation, including some experience of meditating, the majority found it an acceptable method (Farmer & Ramsey, 1992). Staff training programmes at all levels from basic

https://doi.org/10.1192/apt.3.3.174 Published online by Cambridge University Press

awareness to specialist, should include a module on recognising and dealing with stress. Early recognition seems to be important and applies not only to identification of signs of stress in others, but also to recognition of one's own responses to stress.

References

Anderson, P. (1991) The health of the nation: responses. Alcohol as a key area. *British Medical Journal*, **303**, 766–769.

Azrin, N. H., Sisson, R. W., Meyers, R., *et al* (1982) Alcoholism Treatment by disulfiram and community reinforcement therapy. *Journal of Behaviour Therapy and Experimental Psychiatry*, **13**, 105–112.

Bien, T. H., Miller, W. R. & Tonigan, J. S. (1993) Brief interventions for alcohol problems: a review. *Addiction*, **88**, 315–336.

Brower, K. J., Blow, F. C. & Beresford, T. P. (1989) Treatment implications of chemical dependency models: An integrative approach. *Journal of Substance Abuse Treatment*, **6**, 147–157.

Farmer, R. (1995) Stress and working with drug misusers. *Addiction Research*, **3**,113–122.

—— & Ramsay, R. (1992) Stress and working with addicts: A role for meditation? *Psychiatric Bulletin*, **16**, 80–81.

—— & Ghodse, A. H. (1993) Therapies for substance misuse. In *Recent Advances in Clinical Psychiatry*, vol. 8 (ed. K. Granville-Grossman). Edinburgh: Churchill Livingstone.

Freudenberger, H. J. (1986) The issues of staff burnout in therapeutic communities. *Journal of Psychoactive Drugs*, **18**, 247–251.

Groves, I. & Farmer, R. (1994) Buddhism and addictions. *Addiction Research*, **2**, 183–194.

Hindler, C., Nazareth, I., King, M., *et al* (1995) Drug users' views on general practitioners. *British Medical Journal*, **310**, 302.

——, King, M., Nazareth, I., *et al* (1996) Characteristics of drug misusers and their perceptions of general practitioner care. *British Journal of General Practice*, **46**, 149–152.

Jellinek, E. M. (1960) *The Disease Concept of Alcoholism*. New Haven, CT: Hillhouse Press.

Levine, H. G. (1978) The discovery of addiction. Changing conceptions of habitual drunkenness in America. *Journal of Studies on Alcohol*, **39**, 143–174.

Lindstrom, L. (1992) *Managing Alcoholism. Matching Clients to Treatments*, pp. 47–112. Oxford: Oxford University Press.

Ludwig, A. M. & Wikler, A. (1974) 'Craving' and relapse to drink. *Quarterly Journal of Studies on Alcohol*, **35**, 108–130.

Marlatt, G. A. & Gordon, J. R. (eds) (1985) *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours*. New York: Guilford Press.

Miller, W. R. & Rollinck, S. (1991) *Motivational Interviewing. Preparing People to Change Addictive Behaviour*. New York: Guilford Press.

Office of Population Censuses and Surveys (1994). *OPCS Survey of Psychiatric Morbidity Among Adults in Great Britain. Bulletin No. 1*. London: OPCS.

Royal College of Psychiatrists (1992). *Mental Health of the Nation: The Contribution of Psychiatry*. Council report CR16. London: Royal College of Psychiatrists.

Task Force to Review Services for Drug Misusers (1996) *Report of an Independent Survey of Drug Treatment Services in England*. London: HMSO for the Department of Health.

Vaillant, G. E. & Milofsky, E. S. (1982) The aetiology of alcoholism: A prospective viewpoint. *American Psychologist*, **37**, 494–503.

Wanigaratne, S., Wallace, W., Pullin, J., et al (1990) *Relapse Prevention of Addictive Behaviours. A Guide for Therapists*. Oxford: Blackwell Scientific.

Multiple choice questions

1. The following is true:
   a the ideal therapist should be able to work according to different theoretical models of substance dependence
   b a therapist should always be true to his own beliefs about the aetiology of substance dependence and should disabuse a patient of misguided views
   c prospective studies have tended to confirm the validity of the symptomatic model
   d according to the learning model, substance dependence and social use of substances are quite distinct
   e views consistent with the moral model are hardly ever heard nowadays.

2. The following is true:
   a on the available evidence nearly all drug misusers want their treatment provided in a specialist unit
   b GPs seem to appreciate most a didactic approach to education
   c drug misusers often perceive their GPs as having neutral or negative views about them
   d community psychiatric nurses in a community alcohol team are well placed to assist GPs in the detoxification of dependent drinkers
   e in-patient detoxification should be considered when there is a history of epileptic fits.

3. The following are recognised features of burnout:
   a gaining confidence in yourself
   b a feeling of exhaustion
   c adopting a more detached attitude to patients
   d becoming overly empathic in your counselling of patients
   e viewing your clinical abilities more negatively.

4. According to the disease model of substance dependence:
   a a drug addict is viewed as bad
   b the disease cannot be cured
   c the addictive behaviour is largely learned
   d treatment may include controlled use of alcohol
   e someone may be genetically predisposed to addiction.

https://doi.org/10.1192/apt.3.3.174 Published online by Cambridge University Press

5. The following are consistent with the relapse prevention approach:
   a repeatedly confronting the patient over his denial
   b facilitating lifestyle change in the patient
   c telling the patient where he has gone wrong using your greater knowledge about addiction
   d helping the patient gain specific skills to cope with high-risk situations
   e taking some of the responsibility for change off the shoulders of the patient.

MCQ answers

1	2	3	4	5
a T	a F	a F	a F	a F
b F	b F	b T	b T	b T
c F	c T	c T	c F	c F
d F	d T	d F	d F	d T
e F	e T	e T	e T	e F

https://doi.org/10.1192/apt.3.3.174 Published online by Cambridge University Press