A South African outpatient drug treatment centre

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Abstract **The Cape Town Drug Counselling Centre is an outpatient drug treatment service which has been operational since 1985. Statistics obtained from 1990 are detailed, describing patient characteristics in respect of referral sources, age, sex, occupational status, educational level and drugs abused. The typical client profile that emerges is of a young employed male of limited education, referred from a non-professional source, who smokes cannabis alone or with methaqualone (Mandrax). Management of clients, which includes psychotherapy with an emphasis on group-work and medical intervention, is described, and proposed areas for further research are outlined.**

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In the early 1980s there was a growing awareness that drug abuse in Cape Town was a problem that was not receiving sufficient attention from the provincial and state authorities. A group of concerned citizens and medical professionals came together and established an organisation to deal with drug abuse problems. From this arose the Cape Town Drug Counselling Centre, which was opened in February 1985 and by the end of 1990 had treated 3 783 clients. It offers an outpatient service providing assistance to individuals and their families with problems of drug abuse and dependence.

This paper describes the facilities offered by the Centre and presents detailed statistics reflecting the characteristics of its clients.

The Centre makes an initial assessment of the client's drug problem, involves the family/spouse if possible, and develops a management plan. This may include individual sessions, group therapy, family/couple counselling, and group teaching of social skills and relaxation techniques. Education and advice is offered to clients and family members where indicated. The clinical staff includes 4 therapists, who are either social workers or clinical psychologists, a part-time psychiatrist, and a part-time medical practitioner.

The walk-in assessment service operates each weekday morning so that new clients can be assessed immediately. After assessment, the client may be involved in the services provided by the Centre or alternatively he or she may be referred either for inpatient drug treatment or to another outpatient facility more suited to his or her needs. Clients who are not dealt with are those needing acute detoxification, those with pending crimimal charges which are not drug-related, those with major psychiatric disorders or marked antisocial personality traits, and adolescents in crisis who require containment at an adolescent facility.

Once a client is assessed as being suitable and motivated for outpatient management, he enters a therapy programme designed to meet his particular needs. The Centre views drug taking within the disease concept model, where drug dependence is a condition, at times beyond the conscious volition of the person, who is also seen as more susceptible to dependence/addiction than a non-affected person.

All programmes have as their core the cessation of the drug taking, maintenance of drug-free status and the goal of a chemical-free lifestyle. They all assume that behavioural and psychological changes can lead to recovery and that the client can achieve this through the activities of the programme.

In addition to the various individual and group therapies offered, most clients are also assessed by the medical practitioner for physical disorders (Berelowitz,[1] for example, found a high prevalence of respiratory illness among clients attending the Centre) and to provide medication for withdrawal symptoms. Associated psychiatric symptoms or disorders (most notably depressive disorders) also occur, and a comprehensive psychiatric evaluation is done when required.

Clients attend regularly (1 - 3 sessions per week) for an initial period of approximately 4 - 6 months, and when they have been abstinent from drugs for at least a month and are functioning well they move on to an aftercare phase. This involves less frequent follow-up sessions, drug testing if required, and may include attendance at a community support group such as Narcotics Anonymous (NA).

Findings

During 1990 a total of 703 new clients attended the Centre. Since 1989 there has been an increase of approximately 200 clients per year, which can be accounted for by several factors, including increasing drug use, increasing community awareness of the harmful effects of drugs, and the favourable reputation which the Centre has developed in the local community. The intake figure reflects only initial assessment sessions. Therapists conducted a further 2 110 therapy sessions during 1990, and 606 medical or psychiatric examinations were conducted by the doctors.

Of the clients seen at the Centre 25% were self-referred, while 22% were referred by family members, 14% by employers (reflecting a growing trend towards offering employees treatment rather than dismissal) and 6% by schools, bringing the total of non-professional referrals to 67%. This trend, also noted in previous years, indicates that the service is accessible to the general public. Referrals were made by a wide spectrum of social welfare agencies, a large proportion of clients being referred from the Department of Health and Welfare. The latter clients had pending drug charges or were on probation. The remaining 14% were referred by hospitals and general practitioners.

Most clients (72%) fell into the younger age groups (15 - 30 years). Incidence peaked in the late teens/early 20s, and remained high throughout the 20s. Figures tended to be somewhat lower in the 30s (21%), tapering off to minimal representation in the over-40 age groups (6%). The fact that the majority of the clients were under 30 years old underlines the necessity of involving the family in treatment, since people in this age group often still live at home and are either dependent or partially dependent on parents financially and emotionally. Parents are thus important in: (*i*) providing information

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contributing to an accurate diagnosis and management plan and; (*ii*) being involved in the therapeutic process with a view to learning about the disease concept of the disorder, understanding the developmental stages of their children and improving communication skills if they are to contribute to making effective changes in the family.

In 1990 male clients comprised 89% of the client population. Similar sex ratios were noted in previous years.[2] This reflects both South African and world-wide trends.

In previous years there has been concern about the high unemployment figures among the Centre's clients (40% were unemployed in 1988). However, the improvement noted in 1989 (only 31% were unemployed) was sustained in 1990, with 50% of clients being employed, and only 33% unemployed. (The remaining 17% were full-time scholars or students). The Centre encourages employers to offer drug-dependent staff treatment rather than dismissing them. The success of this effort is reflected in the increased percentage of referrals from employers.

Educational levels showed a spread from very limited schooling through to a tertiary education. Nearly a quarter of clients (23%) had either no education or primary school (< 7 years) education only. A further 59% had some level of high-school education without matriculation, and 14% had matriculated. The remaining 4% were involved in, or had completed, tertiary education.

Although intellectual ability should not be confused with educational level, it has been found that the majority of clients with lower educational levels responded best to a more practical approach in treatment. This is taken into account when designing group programmes for these clients, the focus being on practical issues related to drug dependence, peer confrontation and support.

The overriding drug abused was cannabis (dagga), smoked alone or in combination with methaqualone (Mandrax). This accounted for 90% of the client population. Relatively small percentages of clients abused other substances, including tranquilisers (benzodiazepines) (3%) and inhalants (e.g. glue, thinners and volatile hydrocarbons) (1%), analgesics (containing codeine or paracetamol) (1%), cough mixtures (containing codeine) (1%), and stimulants (e.g. diet pills, containing norpseudoephedrine) (1%); 2% abused 3 or more drugs (polydrug abuse, DSM-IIIR).[3] Six clients who abused opiates, including heroin and dipipanone (Wellconal), were treated in 1990 — a pattern not previously encountered at the Centre.

Management

After assessment, 75% of the clients were found suitable for the services offered by the Centre; 33% underwent a treatment programme at the Centre, 30% were found suitable for treatment but dropped out before completing 4 sessions, 8% received short-term educational counselling or drug testing to prove abstinence, and in 4% of cases the family only received advice. The remaining 25% were referred elsewhere for treatment more appropriate to their needs: 12% were referred for inpatient drug rehabilitation, or to hospitals offering psychiatric care or programmes for alcoholism, and 13% were referred to other outpatient facilities, e.g. various welfare organisations, private practitioners, or other outpatient drug centres.

It is pleasing to note that at 30% the drop-out rate for 1990 (defined as attendance for less than 3 sessions) was considerably lower than that for 1989 (48%). This issue of drop-out behaviour was researched at our Centre during 1990 by Rogers,[4] who identified the major factors to be: (*i*) inadequate motivation, e.g. legal coercion to attend which is not enforced by the courts; (*ii*) client factors, e.g. difficulty attending during office hours; (*iii*) treatment factors, e.g. unrealistically high expectations of treatment; and (*iv*) therapist factors, e.g. failure to delineate a clear treatment plan with the client.

Factors that may improve compliance and treatment include an empathic, individualised treatment approach with mutual goal setting and an anticipation of compliance difficulties right from the start. Because of this, the family must be included right from the outset of treatment, ready access to, and continuity of care by the therapist must be provided. Community self-help groups, e.g. NA or Alcoholics Anonymous (AA), should also be utilised.

Conclusion

The Cape Town Drug Counselling Centre was the first outpatient service specialising in drug treatment to be established in South Africa. It has been running since 1985 and appears to offer an appropriate and highly successful service in allowing drug-dependent individuals the opportunity to receive treatment without giving up their jobs or interrupting their studies. It also has the advantage over most inpatient programmes of offering problem-orientated and flexible treatment opportunities – each client has a treatment plan designed for his particular needs rather than being fitted into a standard programme. Increasing intake figures verify the favourable reputation which has been gained by the Centre. It was initially funded by donations and fund-raising but has gained sufficient credibility to have earned part-subsidisation by the Government. The Centre has also acted as a springboard for the establishment of similar services in other areas, and outpatient drug centres are now running in the northern suburbs of Cape Town and in Somerset West. Interest in setting up similar services has also been shown by groups of parents and professionals in other towns.

There is a need for research into outpatient drug treatment programmes, looking at outcome and the variables that influence it (as was done by Rogers[4]). Basic research into the epidemiology of substance abuse in South Africa, the description of the dagga intoxicated state, the dagga withdrawal states, and the currently controversial diagnosis of cannabis psychosis[5] is also needed. Similar emphasis should be placed on the phenomenological description of the syndrome associated with the smoking of the 'whitepipe' (a mixture of methaqualone and cannabis).

Because of its uniqueness, the Centre has had no model to follow and has had to develop and modify its own treatment methods — a combination of therapies with an emphasis on group-work, and medical intervention when required — which appears to be working effectively. The Centre is now diversifying into research covering various aspects of drug dependence and treatment in South Africa.

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