Substance Abuse and Mental Health in Africa

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OVERVIEW

Substance use disorders cover complex behavioral disorders characterized by the preoccupation with obtaining alcohol or other drugs and a narrowing of the behavioral repertoire toward excessive consumption and loss of control over consumption. They are usually also accompanied by the development of tolerance and withdrawal, and impairment in social and occupational functioning,
affecting thoughts, feelings, and behavior. Most concerning are recent developments in the third world in terms of substance abuse. Poor counties have other priorities and fewer resources to resolve the problem, and as a result Africa now faces the risk of a public health disaster. Pharmacomedical, counseling, and rehabilitative interventions may include a mix of approaches, both modern and indigenous, encompassing assessment and diagnosis, self-help intervention, outpatient intervention, diversion and restorative justice, residential care, and harm reduction. In this section, various substance use disorder concepts; the history of substance use disorder practice and research; substance use disorder recovery theories; and cultural, legal, and professional issues related to substance use disorders within the African context are discussed.

INTRODUCTION

Substance use is perhaps as old as the history of humankind; for example, ancient societies used mind-altering substances for a variety of purposes, including trade, war (the history of opium use for example), and religion. A psychoactive is defined as a natural or synthetic substance that acts on the psyche and modifies its operation. It can result in changes in perception, mood, consciousness, and behavior.

Public health practitioners have attempted to look at substance abuse from a broader perspective than that of the individual, emphasizing the role of society, culture, and availability. Rather than accepting the terms alcohol abuse or drug abuse, many public health professionals have adopted phrases such as substance-type problems or alcohol-type problems or harmful or problematic use of substances. In the modern medical profession, the two most used diagnostic tools in the world, the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems (ICD), no longer recognize drug abuse as a current medical diagnosis. Instead, DSM has adopted substance abuse as a blanket term to include drug abuse and other drug related consequences. ICD refrains from using either substance abuse or drug abuse, instead using the term harmful use to cover physical or psychological harm to the user from use. Physical dependence, abuse of, and withdrawal from drugs and other miscellaneous substances is outlined in the DSM-IV-TR.

Shifting of the Problem to the Developing World

Most concerning are recent developments in the third world. Market forces have already shaped the asymmetric dimensions of the drug economy; the
world’s largest consumers of psychoactive substances (the wealthy countries) have imposed on the poor (the main locations of supply and trafficking) the greatest damage. However, poor countries have other priorities and fewer resources and are not in a position to absorb the consequences of increased substance use. The United Nation’s World Drug Report\(^4\) estimates that only 5% of problem drug users in Africa were treated in the previous year. As a result, the risk of a public health disaster now exists in developing countries that would enslave masses of humanity to the misery of substance dependence—another drama in lands already ravaged by so many other tragedies. The warning signs are already there, considering the boom in heroin consumption in eastern Africa or cocaine use in West Africa for example. The world’s drug problem will not be solved by shifting drug consumption from the developed to the developing world.\(^4\)

**Comorbidity**

It is not clear whether a common etiological factor contributes to both psychiatric and substance use disorders or whether psychiatric disorders increase vulnerability to substance use disorders. Epidemiological studies have shown that between 30 and 60% of all substance dependents have a concurrent or comorbid mental health diagnosis, including major depression, schizophrenia, bipolar disorder, anxiety disorders, PTSD, and personality disorders.\(^5\)\(^-\)\(^7\) These diagnoses describe only the related comorbidity and fail to shed light on the question of whether substance use is an adaptive effort of self-medication or whether those with psychiatric disorders are less able to cope with the effects of substance use and so are more likely to become dependent. A concurrent mental disorder can complicate substance use disorder treatment in a multitude of ways; for example, clinically depressed individuals have an exceptionally hard time resisting environmental cues to relapse. People with heroin dependence and mental illness comorbidity, for example, are more likely to engage in behaviors that increase the risk of HIV/AIDS, and injecting heroin dependents with antisocial personality disorder more frequently share needles. Misuse of opiates alone has been associated with a 14-fold increase in risk of suicide, the same order of increase that is found in severe mental illness.\(^8\)\(^,\)\(^9\)

**SUBSTANCE USE AS AN IMPORTANT CONCERN, HUMAN RIGHTS, AND INJECTION DRUG USE**

This section focuses on substance use concerns and related injection drug use aspects are addressed, as well as human rights.
Importance

Substance use disorders are unique among contemporary problems in the breadth of their social impact. No other condition has mobilized such a range of institutional responses nor involved so many professions and disciplines, including medicine, mental health, public health, education, legislature, the judiciary, law enforcement, and foreign affairs. These disorders have also, unfortunately, inspired irrational fear in the general public. Substance use disorders have become a symbol of the social disorder of the times, associated with materialism, poverty, crime, the problems of societies in transition, the disadvantaged, the affluent, the inner cities, and the rural communities.

Human Rights

Human rights need to be moved into the mainstream of drug control. Around the world, millions of people (including children) caught taking illicit substances are sent to jail, not to treatment. In some countries, what is intended to be drug treatment amounts to cruel, inhuman, or degrading punishment—the equivalent of torture. In several countries, people are executed for drug-related offenses. In others, drug traffickers are gunned down by extra-judicial hit squads. As fellow human beings, we have a shared responsibility to ensure that this comes to an end. Just because people take substances or are behind bars does not abolish their right to be protected by law.4

Injection Drug Use

The battle against injection drug abuse (IDU) has become more urgent than ever. Recent estimates from the United Nations indicate that about 10% of all HIV infections across the planet are contracted from contaminated needles or other injecting equipment; to be more specific, about 22% of the world’s HIV/AIDS population injects substances. In North America and Europe, intravenous (IV) drug abuse has long been one of the three major engines for the spread of the AIDS epidemic. Though Africa has not witnessed an IV drug epidemic as many other parts of the world have, the populations of Nigeria and the Ivory Coast—intermittent transit countries for heroin—as well as Gabon, Uganda, Zambia, and South Africa, are vulnerable. The growing number of injection drug users in Africa has the potential to provide a significant contribution to the spread of HIV/AIDS on this continent, arising within a context of an established and growing HIV epidemic. IDU has become the primary mode of HIV transmission in certain regions of North Africa, Asia, the Middle East, and South America.10 This is a concern given that the efficiency of HIV transmission per injection is six times higher than
that for heterosexual acts. IDU-driven epidemics tend to spread much more rapidly than those driven by sexual transmission. The prevalence of HIV/AIDS among IDUs can reach more than 50% of a given population, sometimes up to 90%, within a very short period of time. Such rapid transmission has been observed in both industrialized and developing countries. Sub-Saharan Africa contains only 10% of the world’s inhabitants yet is home to more than 60% of the global HIV-infected population.

Although the AIDS epidemic in sub-Saharan Africa is currently driven by heterosexual transmission, indications are that both IDU and non-IDU are becoming increasingly important modes of transmission in certain sub-Saharan African countries as the problem continues to grow. However, little information is available on IDU in Africa not only because it is a relatively new phenomenon in this region but also because many African countries simply lack the funds required to monitor substance use trends in a systematic way. Of particular relevance is the increasing use of heroin throughout Africa. While other substances are commonly injected among some populations, heroin is the substance that is perhaps most widely injected around the world. Because the use of opiates is not indigenous to Africa, the diffusion of heroin use across the continent is a direct consequence of drug trafficking. Weak detection controls and porous borders along the eastern, western, and northern coasts of Africa have facilitated the safe transport of heroin originating in Afghanistan, Pakistan, and Southeast Asia en route to Europe and the United States. The trans-shipment of heroin through Africa has increased dramatically since 1990, accompanied by the development of a local market for heroin in many African countries where it did not exist before. In general, the common occurrence of high-risk behavior, such as needle sharing and unsafe sex within the IDU populations surveyed in Africa, necessitates the consideration of employing harm-reduction strategies such as needle syringe programs, as well as diversion and restorative justice programs of heroin-dependent criminal offenders.

Injection Drug Use and Primary Health Care and Community-Based Outreach Programs in Africa

Recent changes in patterns of drug use and trafficking indicate that a shift from smoking to injecting heroin is taking place in a number of countries in Africa, including Kenya, Egypt, Nigeria, South Africa, Mauritius, and Tanzania. In addition, recent estimates of HIV infection in these countries indicate that the number of cases of HIV attributed to injection drug users is increasing rapidly. Most injectors use the same equipment to inject more than once, with some reporting use of needles that had become rusty from being stored
in damp hiding places. Few IDUs reported buying new equipment each time they used heroin but instead conceal needles and syringes in locations where drugs are consumed. Primary health care community–based outreach programs are an evidence-based model with a documented history of success in reaching difficult-to-access drug users and are an evidence-based model for delivering HIV prevention to difficult-to-access drug users in the United States and Europe. The primary function of African-based community outreach programs could be to provide street-based interventions to drug users, utilizing a risk-reduction approach to reduce HIV transmission through needle sharing and unprotected sex.20,21

HISTORY OF SUBSTANCE USE: COUNSELING, PRACTICE, AND RESEARCH IN INDIGENOUS AND MODERN AFRICA

Substance use is a practice that dates to prehistoric times. Archaeological evidence exists of the use of psychoactive substances dating back at least 10,000 years, and historical evidence exists of cultural use over the past 5000 years.22 While medicinal use seems to have played a very large role, it has been suggested that the urge to alter one’s consciousness is as primary as the drive to satiate thirst, hunger, or sexual desire.23 The long history of substance use and even children’s desire for spinning, swinging, or sliding indicate that the drive to alter one’s state of mind is universal.24 This relationship with psychoactive substances is not limited to humans. A number of animals consume various psychoactive plants, animals, berries, and even fermented fruit, becoming intoxicated, such as cats do after consuming catnip. Traditional legends of sacred plants often contain references to animals that introduced humankind to their use.25 Biology suggests an evolutionary connection between psychoactive plants and animals as to why these chemicals and their receptors exist within the nervous system.26

During the 20th century, many governments worldwide initially responded to the use of recreational substances by banning them and making their use, supply, or trade a criminal offense. A notable example to this is the 13-year prohibition era in the United States, during which alcohol was made illegal. However, many governments have concluded that substance use cannot be sufficiently stopped through criminalization.27 In some countries, health services have made a move toward harm reduction. In a harm-reduction approach, the use of illicit substances is neither condoned nor promoted, and services and support are provided to ensure users have adequate factual information readily available and to ensure that the negative effects of their use is minimized.
The history of substance use disorder intervention has repeatedly been characterized by fads and fashions. Some of the treatments that have been used have been at best ineffective and at worst harmful and occasionally even dangerous. It is a distressing reflection upon the field that practices and procedures for the treatment of substance use disorders can so easily be introduced and applied without (or even contrary to) evidence. This is illustrated by the extraordinary range of interventions that have been used to detoxify heroin dependents for example. Several of these treatments have been more dangerous than the untreated withdrawal syndrome.28

Next, we briefly consider the history of research and practice in substance abuse within the African context.

**Precolonial Period**

In addition to alcoholic drinks (especially beer, which has a very long history in Africa), cannabis, tobacco, and other substances of intercontinental importance, Africa has numerous psychoactive plants, many of which have been used by indigenous cultures. Unlike in other areas of the world, such as in Amazonia and Mexico, the use of hallucinogenic and narcotic plants in sub-Saharan Africa has received very little attention from researchers. According to a 1658 entry in the diary of Jan van Riebeeck (who was the first governor of a Dutch settlement at the Cape of Good Hope in South Africa), the Hottentots of southern Africa made use of “a dry powder which . . . [they] eat and which makes them drunk.”1 This powder was probably derived from *Leonotis leonurus*, the leaves of which were smoked alone or in conjunction with tobacco. The Basarwa of Botswana use a local plant they call *kwashi* (a bulbous perennial, *Pancratium trianthum*) as a hallucinogen. By rubbing the bulb into cuts in the head, visions are reported to be seen. The hallucinogenic bulb of the *Boophane disticha* has been used traditionally by the Basotho people of South Africa in male initiation rites because it is believed to aid communication with the ancestors. The Basotho also use its bulb in their medicine as an arrow poison and even as a way of committing suicide. Its use as a hallucinogen for contacting the spirits or ancestors is reported from Zimbabwe.1 The consumption of cannabis in the Binga District, an area of land on the Zimbabwe–Zambia international boundary, has been described as traditional in precolonial times and is considered to be an integral part of the Tonga culture.9,29,30 In Zaire, a plant called *niando* (*Alchornea floribunda*) is used for its aphrodisiac, stimulant, and narcotic properties. It is also used as a hallucinogen by the members of the Gabonese Byeri cult.1
Modern Period

The use of traditional substances, such as alcohol, cannabis, and khat (an evergreen shrub \textit{Catha edulis} native to tropical East Africa, having dark green opposite leaves, which are chewed fresh for their stimulating effects), remains prevalent in contemporary Africa. The introduction of prescription drugs to Africa drastically increased the availability and use of psychoactive substances. This notwithstanding, alcohol, cannabis, and khat still remain the most common substances of abuse in Africa. In more recent times, trafficking in heroin and cocaine has made narcotic drugs easily available across Africa despite the existing legal control measures. Complications arising from the use and abuse of psychoactive substances often draw public attention to their deleterious effects, which culminate in drug control policy formulation. The contribution of poverty, political instability, social unrest, and refugee problems to the rapid spread of psychoactive substance use and abuse in Africa, particularly among the youth, remains a concern. The possible link between psychoactive drug use and HIV infection has already been discussed.\(^{31}\)

Using data from the World Health Organization’s Global Alcohol Database, Roerecke et al.\(^{32}\) found considerable variation in levels of overall per capita alcohol consumption among sub-Saharan countries for the year 2002, ranging from 18.6L (Uganda), 14.1L (Nigeria), 14.0L (Burundi), and 13.5L (Zimbabwe) to 0.01L (Mauritania), 0.1L (Niger), and 0.2L (Guinea). The population-weighted average per adult capita alcohol consumption in sub-Saharan Africa was 7.4L, slightly above the global level of 6.2L, and, in terms of average consumption per drinker, sub-Saharan Africa, with 19.5L, was far above the worldwide estimate of 13.9L.\(^{32}\) According to World Health Organization\(^{33}\) estimates, the eastern and southern Africa regions have the highest consumption of alcohol per drinker in the world. In addition, the prevalence of hazardous drinking patterns in the region, such as drinking a high quantity of alcohol per session or being frequently intoxicated, is second only to that in Eastern Europe. Consumption of commercial beverages is expected to rise in the coming years as the economic conditions continue to improve in some countries and as a result of increasing marketing and promotion activities by the industry.\(^{33}\)

In Africa, between 1.5 and 5.2 million people are estimated to have used amphetamine-group substances in 2008, an increase from the 1.4 to 4 million people estimated for 2007. The wide range in the estimates is due to the lack of recent or reliable estimates in West, Central, and East Africa. Recent annual prevalence estimates in Africa are available from South Africa (0.7–1.4\% , 2008), Egypt (0.4–0.5\% , 2006), and Zambia (0.1\% , 2003). The higher range level in 2008 is due mainly to an increase observed in South Africa, where
the annual prevalence increased from a range of 0.5 to 0.8% in 2006 to 0.7 to 1.4% in 2008. Within South Africa, the use of methamphetamine remains particularly high in Cape Town, where methamphetamine remained the most common primary drug of abuse (more so than alcohol) reported by treatment patients in the second half of 2009. Due to the many negative side effects of methamphetamine, treatment services have been particularly challenged in Cape Town because a high proportion of methamphetamine users experience a methamphetamine-induced psychosis, requiring psychiatric intervention (often not readily available at outpatient services). Methamphetamine thus poses new challenges to the substance use disorder counseling and rehabilitation centers and their staff in Cape Town, requiring additional training and strategic planning.34

Substance Dependence Hinders Child Soldier Reintegration

Efforts to rebuild society in the war-ravaged east portion of the Democratic Republic of Congo are being hampered by the problem of substance abuse among former child soldiers, many of whom are struggling to readjust to civilian life according to experts working in the region. Child soldiers are drugged by militia leaders. They become violent and addicted, and their reintegration into society becomes difficult. As many as 95% of children used in armed conflicts are introduced to substances, the most common being cannabis, although khat is also used. The issue of substance use among child soldiers has surfaced in the International Criminal Court trial of Thomas Lubanga, the former president of the Union of Congolese Patriots, who faces charges of recruiting, conscripting, and using child soldiers during the 2002–2003 conflict in the east of the country. On January 17, 2010, a former child soldier, giving testimony anonymously, said that he had been “drunk and had smoked cannabis” during a battle that he was involved in at Bogoro. In 2008, the Coalition to Stop the Use of Child Soldiers reported that approximately 30,000 child soldiers had been reintegrated into society, but thousands more may have since been recruited during the 2007–2009 war between the National Congress for the Defence of the People, a former rebel group, and the army. Militia leaders often encourage child soldiers to take substances as a way of bringing them together and desensitizing them against the acts they are expected to carry out. Substance dependence can be a major problem when trying to reintegrate former child soldiers into society because it can increase their sense of isolation from the rest of the community. This is a particular concern given that a number of former child soldiers, who often feel insecure and rejected by society, end up returning to their former lives as combatants or turn to crime, linking up with local drug traffickers.35
CURRENT INTERVENTIONS IN AFRICAN SETTINGS

Current interventions for substance use disorders in African settings cover primary health care interventions and collaborative efforts between modern mental health and health professionals and indigenous healers, as well as the full range of modern psychotherapies within the context of African indigenous healing practices. This section concludes by considering various theories of substance use disorder recovery.

Primary Health Care Intervention

Despite the availability of effective treatments and treatment models for both mental illness and substance abuse internationally, most people who have co-occurring disorders are not receiving care, and even more so within the African context. Many of those who do receive care are not receiving effective care. Multiple reasons can be given for poorer treatment outcomes. In addition to the inherent difficulty of treating two problems rather than one, a variety of institutional, attitudinal, and financial factors have been posited as affecting the clinical processes of care within the African context, which in turn affect outcomes.36-39 What is particularly worrisome is the broad definitions of appropriate and comprehensive care used, which may explain why individuals with co-occurring disorders have poor treatment outcomes. Substance abuse and mental health treatment programs are also generally funded and managed separately, and coordination of treatment regimens across established bureaucracies has been difficult. The two treatment systems deal with clients in different ways that may conflict or may fail for clients who have multiple problems. Because resources in the public treatment system are scarce, each system tries to exclude individuals who are likely to require more resources, to fail in treatment, or to cause disruption to programs. Thus it has been difficult to respond to the needs of clients with dual diagnoses within the African context.

These systemic problems likely influence outcomes by affecting the delivery of appropriate care. However, no African studies have used a nationally representative sample to assess the delivery of care to individuals who have co-occurring disorders. It is not known what individual-level factors—such as demographic characteristics, perceived need for treatment, and type of health insurance—affect access to appropriate care or what type of care individuals who have co-occurring disorders receive. Current guidelines recommend that services for individuals who have co-occurring disorders be available regardless of the setting in which the individual enters the service system. The proportion of individuals who receive parallel or integrated care or who receive care for only one disorder remains unknown within the African context.
Weighed against the massive and growing need is a clear demand for well-developed, well-articulated, and aggressively implemented national health care policies designed to improve care and reduce the burden on those individuals suffering from mental health and substance use disorders. It may seem odd that something as simple as a set of documents can make a difference in the health of a population, but history shows that it does. Without essential statements of purpose covering a country’s vision and goals, programs to implement those goals with specific strategies, stated objectives and milestones, and finally legislation to provide for the protection of basic human and civil rights, it becomes difficult to engender action.40,41

According to Gureje,40 approximately half of the countries in sub-Saharan Africa have mental health policies in place, while few if any have comprehensive policies in place for mental health and substance use disorders. Of those that do have policies that address mental health, more than one-third of those policies were developed prior to 1990 and consequently are outdated by advances in the scientific understanding of these disorders. Similarly, only 37% of these policies address the special needs of children despite the fact that 42% of sub-Saharan Africa’s populations are minors. But even those countries that have health care policies may not be using them. In 2005, officials in Uganda performed a gap analysis of the Ugandan mental health system. A number of problems were identified, including the following: an inadequate and skewed pattern of distribution of mental health staff; poor health facilities with not enough capacity; the absence of a systematic continuing education program for mental health workers; low prioritization of treatment of mental health at most levels of care; and a low awareness and appreciation for mental health services and disregard for mentally ill patients, especially by the nonmedical administrators of health facilities. In addition, according to Ndyanabangi,41 the absence of a structured policy for use disorders, not just mental health disorders, has also been identified as a major gap. With these gaps identified, Uganda set about revising the resources, systems, and organization needed to implement its mental health policy. With regard to organization, at the top, the country established a mental health services coordinator at the Ministry of Health. The health system was also organized with a national referral hospital, which receives patients from mental health units at the regional hospitals. In the general hospitals are integrated services, each of which is to have a mental health, neurological, and substance use disorder focal person appointed by the district health officer.

South Africa does not have a new postapartheid national mental health policy as yet, and there is no mention of a health policy addressing substance
use concurrently. South Africa uses instead a set of national policy guidelines that were drafted in 1997, alongside a Mental Health Care Act that was developed in 2002 and enacted in 2004. The Mental Health Care Act enumerates the international human rights principles for the care, treatment, and rehabilitation of people with mental health disorders, as well as for mass, community-based care and treatment, while the national policy guidelines serve to inform provincial policies and plans. The nine provinces of South Africa are responsible for planning and implementing health services within each province—a very different organizational structure from Uganda’s more centralized branches-from-a-common-tree structure. The South African system has had both successes and failures. It remains critical to make the link between mental health and substance use disorders and other health care priorities, particularly HIV/AIDS, and socioeconomic conditions.

In South Africa, basic mental health care is the responsibility of primary health care nurses. But due to the heavy burden of HIV/AIDS and tuberculosis in the country, nurses are often able to provide counseling for only a few common mental disorders and a few other substance use disorders. To assist these nurses, the use of a mental health counselor at the primary care level is being piloted in two regions. The counselor’s duties include providing referrals, as well as assisting in the training and supervision of community health care workers, who may themselves supply treatment for common mental disorders such as depression and maternal depression. The following challenges remain within the South African context: continuing inequalities regarding human resources; allocating budgets at the discretion of the provinces; and not considering mental health and substance use disorders a priority, especially in the context of the heavy burden of treating HIV/AIDS in a resource-poor environment.

**Collaborative Efforts**

People who abuse substances in Africa typically seek help from mental health and health practitioners and indigenous healers. Typically, no formal referral system exists for patients from experts in the formal health sector (e.g., psychiatrists, psychologists) to those in the nonformal health sector (i.e., indigenous healers) or vice versa. It is, however, estimated that 70% of South Africans consult indigenous healers, who include diviners, herbalists, faith healers, and traditional birth attendants, and 61% of psychiatric patients had consulted indigenous healers during the past 12 months in a study by Robertson. Indigenous healers’ interpretations appear to be intuitive rather than based on phenomenological or physiological evidence of dysfunction.
In the study by Robertson, a client consulting an indigenous healer for alcohol dependence was diagnosed as having amafunyana (possession by evil spirits) while another was told that his beer had been poisoned, making him lose control over his drinking (idliso). Some of the treatment measures prescribed by indigenous healers make medical sense, whereas others appear to work on suggestion.

Corroboration between the formal sector and the informal sector is proposed because indigenous healers have been serving African communities since time immemorial, understand the belief system of their people, and enjoy a respected place in their society. By understanding and entering African religious and therapeutic expressions through its own language, important underlying, and possibly historic, commonalities and connections can be identified. The basis for variants and transformations can also be established more intelligibly.

In indigenous healing, the locus of control is often externalized, and intervention can only be through medication offered by the amagqirha (traditional healer), which is in contradiction to some of the Western approaches to the treatment of substance use disorders, for example, by mental health practitioners. Some traditional healers consider substance dependence as a spiritual house arrest that restricts creativity and enforces the substance dependent to ignorantly misuse the gift of creativity. Anyone, regardless of race, creed, color, social, ethnic, or cultural background, who has reached the stage where she or he sincerely desires to be free from substance dependence can find an answer in the power of the heart. The key to healing lies in the understanding that every problem that a person experiences is in fact a spiritual “fire alarm,” warning one to change her or his ways and to discontinue all forms of destructive behavior. The way to heal is through the heart, not through the head. Modern medicine insists on treating disease without understanding its spiritual cause. It is argued that the allopathic approach merely diverts each disease and causes it to morph and reappear in a slightly different guise. What must begin then are the natural healing impulses of the heart, which can purify the perceived sense of lack in the mind that causes the person to behave the way she or he does.

Unfortunately, Western medicine often ridicules this simple knowledge, and many people suffer and die each year just to sustain an allopathic industry that is specifically designed to sustain the illusion of healing. Notwithstanding, more knowledge needs to be gained, widely shared, and debated, specifically about how indigenous healers practice and what form of collaboration would be most appropriate. To proceed in any other way would be a disservice to clients and to the health profession in general.
Psychotherapy and Recovery Theories

Key psychotherapies in counseling substance use disorders, such as psychodynamic psychotherapy, transpersonal psychology, cognitive behavioral therapy, contingency management, motivational interviewing, and family therapy, are considered in this subsection, as well as theories of recovery from substance use disorders, such as the maturing-out hypothesis and the contextual factors and stages of recovery models.

Psychodynamic Psychotherapy

Psychodynamic psychotherapy is a form of depth psychology, the primary focus of which is to reveal the unconscious content of a substance dependent’s psyche in an effort to alleviate psychic tension. Most psychodynamic approaches are centered on the idea that some maladaptive functioning is in play and that this maladaptation is, at least in part, unconscious. The presumed maladaptation develops early in life, and it is posited that in later years clients will begin to feel some dissonance in their day-to-day lives as a function of this paradigm. It is accepted that what modern humans think and talk about, preliterate humans acted out in their dancing, singing, rituals, and ceremonies and that much can be learned about African society and humankind through an understanding of the deeper meaning of these rituals and ceremonies. To counteract the tendency of Western society to rely too much on thinking and intellectual functions, most of the schools of depth psychology encourage their clients to paint, model with clay, and sculpt or dance their dreams and fantasies when it seems appropriate. Such methods can make psychological abstract material that often seems chaotic, available and thus more concrete and easier to relate to and resolve. This may assist the client to accept and integrate what often seems foreign into the conscious mind where it can be subjected to scrutiny and assessment. Giving external and concrete form to fantasy and dream images allows them to become meaningful and in most instances less threatening. The cosmology of the amagqirha (traditional healer) relates to Jung’s phenomenological attitude to unknown psychic material (i.e., allowing material from the unconscious depth of the psyche to manifest itself without control or interference from the ego). The psychodynamic therapist first intervenes to treat the discomfort associated with the poorly formed function and then helps the substance-dependent individual acknowledge the existence of the maladaptation while working to develop strategies for change. Psychodynamic psychotherapy demands considerable introspection and reflection on the part of clients. It also relies on substance dependents’ desire to be helped to support its effectiveness, as well as clients’ willingness to reveal themselves and their level of insight.
Consequently, individuals must possess enough resilience and ego strength to manage the strong emotions this form of therapy may provoke.\textsuperscript{52}

The emergence of \textit{transpersonal psychology}, however, is more synergistic with the central tenants of African cosmology and healing.\textsuperscript{53} Transpersonal psychology is a school of psychology that studies the transpersonal, self-transcendent, or spiritual aspects of the human experience. Issues considered in transpersonal psychology include spiritual self-development, peak experiences, mystical experiences, systemic trance, and other metaphysical experiences of living. Transpersonal psychology attempts to unify modern psychology theory with frameworks from different forms of mysticism. These forms of mysticism vary greatly, depending on their origin, but include religious conversion, altered states of consciousness, trance, and other spiritual practices.

Transpersonal psychology is at the forefront of a shift in psychology from reductionist methods based on positivism to a human science based on holism in understanding the full range of human experiences. Despite the advances in mental health care, a relationship exists between transpersonal psychology and African traditional healing. The solution associated with these differences emerges from encouraging African health care systems and conventional psychological healing systems to function in a complementary fashion.\textsuperscript{9}

\textbf{Cognitive Behavioral Therapy}

Cognitive behavioral therapy (CBT) is psychotherapy based on modifying cognitions, assumptions, beliefs, and behaviors, with the aim of influencing disturbed emotions. \textit{Thoughts} influence \textit{feelings} and \textit{behaviors}, \textit{feelings} influence \textit{behaviors}, and \textit{behaviors} influence \textit{emotions} and \textit{thoughts}. Their modalities are therefore interrelated, and change in one modality will in all probability influence at least one of the others.\textsuperscript{54} CBT is an active, directive, time-limited treatment that focuses on identifying and understanding the relationship between underlying automatic thinking and attitudes to problematic feelings and behaviors. Recovering substance dependents can learn, with the help of a therapist, to correct negatively biased attitudes and beliefs about themselves and the world around them, and, with a more realistic perception of themselves and their future, learn to cope without the substance.\textsuperscript{55} The general approaches developed out of behavior modifications—CBT and rational emotive therapy—have become widely used to treat various kinds of neuroses and psychopathology, including substance dependence, mood disorders, and anxiety disorders. The particular therapeutic techniques vary according to the particular kinds of clients or issues but commonly include keeping a diary of significant events and associated feelings, thoughts and behaviors, questioning and testing cognitions, assumptions, evaluations, and beliefs that might
be unhelpful and unrealistic; gradually facing activities that may have been avoided; and trying out new ways of behaving and reacting. Relaxation and distraction techniques are also commonly included. CBT is widely accepted as an evidence- and empirically based, cost-effective psychotherapy for substance dependents. It is sometimes used with groups of people, as well as individuals, and the techniques are also commonly adapted for self-help manuals and increasingly for self-help software packages. Typically, the objectives of CBT are to identify irrational or maladaptive thoughts, assumptions, and beliefs that are related to debilitating negative emotions and behaviors and to identify how they are dysfunctional, inaccurate, or simply not helpful. This is undertaken in an effort to reject the distorted cognitions and to replace them with more realistic and self-helping alternatives (Corsini & Wedding, 1995).

CBT is not an overnight process. Even after clients have learned to recognize when and where their mental processes go awry, it can take months of concerted effort to replace any dysfunctional cognitive–affective–behavioral process or habit with a more reasonable, salutary one. The cognitive model especially emphasized by Aaron Beck’s cognitive therapy says that a person’s core beliefs (often formed in childhood) contribute to “automatic thoughts” that pop up in everyday life in response to situations. Arnold A. Lazarus developed what was arguably the first form of “broad-spectrum” CBT. Lazarus expanded the scope of CBT to include physical sensations (as distinct from emotional states), visual images (as distinct from language-based thinking), interpersonal relationships, and biological factors. The final product to Lazarus’s approach to psychotherapy is called multimodal therapy and is perhaps the most comprehensive form of CBT, in addition to rational emotive behavior therapy, which also shares many of the same assumptions and theorizing. CBT is most closely allied with the scientist–practitioner model of clinical psychology, in which clinical practice and research are informed by a scientific perspective: clear operationalization of the problem or issue and emphasis on measurement (and measurable change in cognition and behavior) and measurable goal attainment.

**Contingency Management**

Contingency management is a behavioral procedure based on the principle of encouraging previously agreed on behavior patterns by rewarding (positive reinforcers) when they occur and punishing when they do not or if other undesirable behavior patterns occur. In other words, specified rewards and privileges become contingent on continuation of agreed on behavior.

The key to successful contingency management is for the therapist to have control of appropriate positive reinforcers. When a heroin-dependent
individual, for example, attends a clinic regularly and frequently for a prescription for methadone (or another opiate medication), a variety of reinforcers can be utilized for contingency management, such as methadone take-home privileges (rather than having to take the methadone under supervision at the clinic). Frequency of clinic attendance, time of appointment, access to counseling and other helping services, and advantageous holiday arrangements can be made contingent on certain behaviors.

In practice, similar rewards are often given for good behavior but in a non-contingent way. The individual may ask for special arrangements, for example, to be made for opiate prescriptions while they are doing well, in other words, attending regularly with no evidence of illicit drug abuse and so on. Planned contingency management, however, means that substance misusers learn much more directly and therefore more easily and more quickly exactly what is expected of them. The deliberate adoption of contingency management procedures helps individuals to achieve defined and realistic goals for which they can be rewarded rather than punished for failure to make progress toward undefined targets. Equally, positive and nonpunitive attitudes on the part of the staff are more likely to attract clients to treatment and to retain them. Many clinics already have rules that effectively act as contingencies to control behavior, though, if they are not applied systematically, maximum benefit is not achieved. It is suggested that contingency management procedures are little more than training and that their efficacy lapses when contingent rewards and punishments are discontinued. Undoubtedly, undesirable patterns of behavior, including substance misuse, may recur when treatment stops, but this should be seen as yet another instance of relapse due to the severity of the substance dependence and not necessarily as a failure of intervention.

Contingency management, carried out in a systematic and comprehensive way, provides a firm and consistent structure for substance-dependent individuals’ lives, and it may be the first time in a long while that they have experienced such structure. It provides the recovering substance dependent with the opportunity to learn the boundaries of acceptable behavior, and, even if relapse occurs, the learning experience will not have been wasted. One way of improving the long-term efficacy of contingency management is to include the family because they may have in their control many social and material reinforcers that can be made contingent on desired behavior long after the individual has stopped attending hospitals and clinics.

**Motivational Interviewing**

Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping substance dependents explore
and resolve ambivalence. Compared to nondirective counseling, it is more focused and goal oriented. The examination and resolution of ambivalence is its central purpose, and the therapist is intentionally directive in pursuing this goal. Motivation to change is elicited from the client and not imposed from without. Other motivational approaches have emphasized coercion, persuasion, constructive confrontation, and the use of external contingencies (e.g., the threatened loss of job or family). Such strategies may have their place in evoking change, but they are quite different in spirit from motivational interviewing, which relies on identifying and mobilizing the client’s intrinsic values and goals to stimulate behavior change. It is the client’s task, not the therapist’s, to articulate and resolve his or her ambivalence. Ambivalence takes the form of a conflict between two courses of action (e.g., indulgence versus restraint), each of which has perceived benefits and costs associated with it. Many substance dependents have never had the opportunity to express the often confusing, contradictory, and uniquely personal elements of this conflict. The therapist’s task is to facilitate expression of both sides of the ambivalence impasse and guide the client toward an acceptable resolution that triggers change. Direct persuasion is not an effective method for resolving ambivalence. It is often tempting to try to be helpful by making the substance dependent aware of the urgency of the problem and benefits of change. It is fairly clear, however, that these tactics may increase the client’s resistance and diminish the probability of change.

The therapeutic style is generally a quiet and eliciting one. Direct persuasion, aggressive confrontation, and argumentation are the conceptual opposites of motivational interviewing and are explicitly proscribed in this approach. To a therapist accustomed to confronting and giving advice, motivational interviewing can present as a hopelessly slow and passive process; however, the proof is in the outcome. More aggressive strategies, sometimes guided by a desire to confront client denial, easily slip into pushing clients to make changes for which they are not ready. Readiness to change is not a client trait but a fluctuating product of interpersonal interaction. The therapist is therefore highly attentive and responsive to the client’s motivational signs. Resistance and denial are seen not as client traits but as feedback regarding therapist behavior. Client resistance is often a signal that the therapist is assuming greater readiness to change than is the case, and it is a cue that the therapist needs to modify motivational strategies. The therapeutic relationship is more like a partnership or companionship than expert and recipient roles. The therapist respects the client’s autonomy and freedom of choice (and consequences) regarding his or her own behavior.
A number of specific intervention methods have been derived from motivational interviewing. The Drinker’s Check-up\textsuperscript{65} is an assessment-based strategy developed as a brief contact intervention with problem drinking. It involves a comprehensive assessment of the alcohol dependent’s drinking and related behaviors, followed by systematic feedback to the client of the findings. The checkup strategy can be and has been adapted to other problem areas, such as substance dependence. The key is to provide meaningful personal feedback that can be compared to some normative reference. Motivational interviewing is the style with which this feedback is delivered. It is quite possible, however, to offer motivational interviewing without formal assessment of any kind. It is also possible to provide assessment feedback without any interpersonal interaction such as motivational interviewing (e.g., by mail), and evidence shows that even such feedback can itself trigger behavior change.\textsuperscript{66}

**Family Therapy**

Family therapy offers a way to view clinical problems within the context of a family’s transactional patterns; it is an umbrella term for a number of therapeutic approaches, all of which treat a whole family rather than singling out specific individuals for independent treatment. The term is neutral theoretically; family therapy can be practice within many different frameworks.\textsuperscript{67} Family therapy also represents a form of intervention in which members of a family are assisted to identify and change problematic, maladaptive, self-defeating, enabling, and repetitive relationship patterns. Unlike individual-focused therapies, in family therapy, the identified patient (the family member considered to be the problem in the family) is viewed as a symptom bearer, expressing the family’s disequilibrium or current dysfunction. The family system itself is the primary unit of treatment and not the identified patient. Helping families to change leads to improved functioning of individuals, as well as the families as a whole.\textsuperscript{56} Some form of family intervention is now standard for both residential and outpatient treatment of substance use disorders. Successful outcome to intervention is related to family stability and support.\textsuperscript{68-71}

In traditional African belief systems, illness is thought to be caused by disturbed social relationships that create imbalances in the form of mental and physical problems. Mental illnesses such as substance use disorders are regarded as a sign of a lack of harmony between the person and the environment.\textsuperscript{72,73} In most African communities, this harmony is controlled by the ancestors and thus affects traditional African belief systems; for example, the majority of Shona people in Zimbabwe believe that illnesses such as
substance dependence may come from the ancestor spirits, angry spirits, or even alien spirits. Indigenous healers usually work successfully with illness that has high emotional content, which is known as psychosomatic illness in allopathic medicine. They regard themselves to be successful because they receive their healing powers from the ancestors. To this end, family therapy can be used in a complementary manner within the African indigenous context to address ancestral, family, and social dynamics.

**Maturing Out Approaches**

In his 1962 seminal paper, “Maturing Out of Narcotic Addiction,” Charles Winick demonstrated that a substantial portion of heroin addicts mature out of their addiction as they age. Based on a study of 7234 arrestee records of opiate dependents in the United States, which showed that, as age increased, the number of people being arrested for drug-related offenses decreased, he concluded that two-thirds of opiate dependents mature out of their syndrome in their mid-30s.

The maturing out hypothesis consisted of more than a trend to cessation of opiate use within a specified age group. Winick proposed a psychodynamic explanation. He speculated that substance abusers begin taking opiates as a method of coping with the challenges and problems of early adulthood. Years later, as a result of some process of emotional homeostasis, the stresses and strains of life become sufficiently stabilized so that the individual can face them without the support provided by opiates. Apart from maturing out of opioid dependence, Waldorf argued that, apart from death, individuals can also drift out of use, become alcoholic or mentally ill, give up due to religious or political conversion, retire by giving up the substance while retaining certain aspects of the lifestyle, or change because their situation or environment has changed.

In summation, Winick’s study findings indicated that substance dependence is not a chronic, progressive disease in a substantial portion (up to two-thirds) of substance dependents, even when measured using a stringent criterion of five years’ remission. The maturing out of a substance dependence process begins in the mid-20s; peaks in the mid-30s; and, for the majority of substance dependents, is completed by the mid-40s. Winick posited that the proximal cause of the maturing out process occurs because “the addicts’ inner fires have become banked by their thirties.”

The results of Winick’s pioneering study have, for the most part, been replicated and extended since its publication 48 years ago. A substantial body of scientific evidence now exists in the literature that suggests the maturing out of addiction is a common property of all substances of abuse.
The only aspect of Winick’s 1962 data that has proved to be erroneous is an overly optimistic assessment of the portion of substance dependents who mature out. The more recent studies cited above suggest that the rate of sustained remission is closer to one-third than to two-thirds.

Young African males are turning to substances such as heroin at an alarming rate in Africa. In a sense, substances such as heroin are replacing the traditional manhood rituals and initiation rites of the indigenous African culture. Traditional initiation schools, for example, may be unfamiliar with drug dependence and withdrawal syndromes and the specialized care that such syndromes necessitate. This phenomenon may highlight the significant role that the re-instilling of traditional rites may have in averting such dependencies and in helping African substance dependents mature out of their syndromes.84

**Contextual Factors**

Changes in the socioemotional context of a substance abuser can lead to complete remission. For instance, Robins85 proposed that a change in environment for many servicemen returning from the Vietnam War resulted in remission, indicating the important role that social context may play in substance dependence and recovery. The second factor in remission is very severe dependence, which seems paradoxical, but evidence suggests that severity (i.e., getting tired, hitting rock bottom) may be favorable for recovery. The third factor in remission is the fortuitous occurrence of life experiences, which disrupt entrenched habits and minimize relapse. These experiences include acquiring a substitute behavior that competes with the dependence, encountering compulsory supervision, discovering new sources of hope and an improved self-esteem, and finding new people to love to whom the dependent is not “in debt.” Several studies have also shown that the influence of significant others, such as partners or children, can be important in the decision to quit.77,86-88 Another important factor reported to be influential in the decision to stop is deteriorating health or the fear of health problems,77,80,87 as well as the occurrence of more general negative events such as a period in prison or the overdose or death of drug-using friends or associates.89,90

**Phases of Recovery**

Frykholm88 proposed three phases of addiction recovery, referred to as experimental, adaptation, and compulsive, and three phases of de-addiction, where the process of becoming addicted is reversed. According to Frykholm, the first phase of de-addiction involves a period of ambivalence, in which the negative effects of substance use are increasingly felt, resulting in a gradual
desire to stop using substances. This is generally offset by a continuation of pleasurable effects of and a physical dependence on substances. In contrast, in the treatment phase, attempts at detoxification become more sustained, and substance-free periods grow longer. In this phase, substance dependents perceive a need for external control and support and so seek help; they may also undergo a radical reorientation in which they suddenly experience a desire to fulfill the role of ex-addict. The final stage is referred to as emancipation and involves the period following detoxification when the substance dependent effectively becomes an ex-addict and can remain clean without external assistance. Although Frykholm provided a useful model of substance dependence, his work has been criticized for not allowing for spontaneous recovery from dependence. As previously noted, spontaneous recovery from substance use is possible from personal and contextual influences.

Pharmacological Approaches
Pharmacological approaches have been updated to include the latest advances in the pharmacological treatment of substance use disorders. The use of medications specific to the treatment of substance use disorders, despite reasonably strong research evidence for their efficacy, has not yet become widespread in practice in Africa. Pharmacological interventions remain one of the most fervently researched and heavily funded of all approaches to substance dependence intervention.

CULTURAL, LEGAL, AND PROFESSIONAL ISSUES
Key cultural, legal, and professional considerations in understanding substance use counseling in African settings relate to affected African populations, regulation criteria, access to treatment, and professional skill development. Each one of these aspects is discussed in turn.

Affected African Populations
Most indigenous African communities continue to believe in and practice the use of certain substances, including alcohol and tobacco, for ritualistic purposes. The extent to which use of mind-altering drugs by indigenous African communities results in dependence is unknown. It is possible that social sanction in these communities restricts the use of psychoactive or mind-altering substances to “privileged” others believed to be leaders in spiritual health and mediation. In contemporary Africa, use of psychoactive substances is increasingly prevalent in the younger generations and mostly for recreational...
purposes. Recreational substance use refers to the use of psychoactive drugs for recreational purposes rather than for work and approved medical or spiritual purposes, although the distinction is not always clear (often spiritual use is considered to be recreational use). Sociocultural pressures associated with transition to modernization in predominantly traditional African communities may encourage the recreational use of substances. Traditional use of substances for therapeutic, ritualistic, or religious reasons has been replaced by socially detrimental substance abuse and dependence. The modern-day African suburbs are likely to be emotionally alienated jungles, just as any squatter camp, township, or slum in which the individual must fight to survive.

In the African context, the problems of illiteracy, high unemployment rates, AIDS, poverty, and crime exacerbate the substance abuse problem. Furthermore, some treatment procedures, such as detoxification and rehabilitation, can be especially expensive, and a large disparity exists between the services of the private health sector and those of the public health and welfare sectors. Warning signs indicate that Africa is under attack, targeted by cocaine traffickers from the west (Colombia) and heroin smugglers from the east (Afghanistan). This threat needs to be addressed rapidly to eradicate drug-related crime and money laundering and corruption and to prevent the spread of drug use that could cause havoc across a continent already plagued by other tragedies.

Regulation

In the not so distant past, almost anyone in South Africa could open a drug rehabilitation center, offer rehabilitation services, and ask a fee for these services regardless of his or her professional training or background. These facilities are able to fall outside the ambit of the Mental Health Act (Act 17 of 2002) and the Prevention and Treatment of Drug Dependency Act (Act 20 of 1992) by calling themselves “care centers.” Such facilities are not regulated by the National Departments of Health or Social Development. Numerous unregistered examples of such centers still prevail in South Africa, and various human rights violations have been reported. This situation has also arisen due to the state’s closure of several long-established drug rehabilitation centers and a reduction in subsidies for organizations such as the South African National Council on Alcoholism and Drug Dependence. Psychiatric facilities, registered by the National Department of Health, most often treat substance use disorders as secondary symptoms. However, there is a recent inclination in psychiatric facilities to open specialized substance use disorder units. Only recently, the Minimum Norms and Standards for Substance
Dependence Inpatient Centres has been issued by the National Department of Social Development. These norms and standards outline the criteria for the registration of residential rehabilitation facilities in South Africa. However, the workforce to monitor the standards set is likely to be deficient. The Minimum Norms and Standards for Outpatient Treatment are currently under review by the National Department of Social Development.

Access to Services

Research indicates that patients who receive residential care are more likely to succeed than those who do not and the probability of success rises with the length of stay in residential treatment. Substance dependents do not have equal access to residential care; probably the single most compelling reason for redundancy of adequate substance use disorder interventions in Africa is the lack of affordable treatment centers to which clients may actually be directed, though there is a trend to open up state subsidized beds in some African countries. It is also clear that an important interaction exists between the characteristics of the client and the type of intervention. Therapeutic success depends on matching client and therapy. Regrettably, the period between a young substance user’s first experience with the substance and his or her first treatment consultation is often several years, by which time successful treatment is likely to be more complicated.

Professional Skill Development Within the Health Workforce

A lack of general training on the part of program personnel makes assessment and rehabilitative intervention initiatives redundant. Counseling interventions are now also provided by a wide range of personnel with various training backgrounds and in a wider range of settings. The processes of recovery from a substance use disorder are not always gradual and incremental, but they often reflect sudden changes in beliefs and behaviors. Recovery may also be highly idiosyncratic. Counseling is not an impersonal process offered by neutral agents. For the client, it can be an important life event, and the relationship between patient and therapist can have great emotional and psychological significance. It is surprising that substance use disorder research has paid very little attention to the role of therapist’s characteristics and skills and therapist’s influence on treatment outcome.

At present, techniques and tools are available that provide individuals with useful assistance and knowledge on how to stop using and refrain from returning to substance use. It is no longer acceptable to simply do what feels right. Organizations and professionals who specialize in treating substance
use disorders from a primary health care level are an accepted part of the
health care delivery system. As in all other areas of health care, there is a
rapidly increasing dependence on the use of scientific information to shape
and improve the future of the field. Within the past decade, psychiatrists,
medical doctors, psychologists, social workers, family therapists, nurses, and
allied health professionals have all incorporated knowledge about the identi-
fication and treatment of substance use disorders into categories of licensure
and certification requirements. It is the ethical responsibility of the clinical
practitioner in the substance use disorder intervention field, as in other fields
(i.e., cancer and heart disease), to stay informed about new and more effective
clinical procedures. The field of substance use disorder treatment is becom-
ing increasingly professional, and those who are part of the system need to
continue to stay abreast of new developments. New techniques and tools can
be used to make a difference in promoting successful recovery for individuals
currently unsuccessful with existing treatments. As new approaches with
sound scientific support emerge, methods may be revised and new treatment
options added. Although some of the elements of effective treatment interven-
tion have been defined in this chapter, there is much to learn and much room
for improvement.

Policy

In the past decade, drug control has matured. Policy has become more respon-
sive to the needs of those most seriously affected along the whole chain of the
drug industry—from poor farmers who cultivate it to desperate addicts who
consume it, as well as those caught in the crossfire of the traffickers. Coun-
tries are learning from each others’ experiences and drawing on expertise
from the international community. Drug control is also increasingly taking a more balanced approach,
focused on development, security, justice, and health to reduce supply and
demand and disrupt illicit flows. In regions where illicit crops are grown, it
is vital to eradicate poverty, not just drugs. A realization exists that under-
development makes countries vulnerable to drug trafficking and other forms
of organized crime. Therefore, development is part of drug control and vice
versa. Most important, a concerted effort has been made to return to the
roots of drug control, placing health at the core of drug policy. By recogniz-
ing that substance dependence is a treatable health condition, pioneers in the
field of drug treatment are developing scientific, yet compassionate, new ways
to help those affected. Slowly, people are starting to realize that substance
dependents should be sent to treatment, not to jail, and substance dependence
treatment is becoming part of mainstream health care intervention.
ASPECTS FOR FURTHER RESEARCH AND SCHOLARSHIP

Most research indicates a need for some level of social support or therapeutic intervention for substance dependents, and a number of models and programs have been developed to help them. Unfortunately, many interventions remain input orientated, and little is done to measure their impact and effectiveness. However, just because a program has not been subjected to the scrutiny of research does not mean it does not work, but the sheer number of people receiving services of unknown value for substance use disorders is cause for concern.\(^{103}\)

Rocha-Silva\(^ {104}\) noted that matters are further complicated by the lack of integrated information needed for the effective intervention of substance dependents in Africa. She cites the lack of infrastructure in developing countries that generally facilitates long-term comprehensive and integrated information gathering. Unlike other sub-Saharan countries, South Africa is unique in that it now has a well-developed capacity for surveillance and research on drug-related problems. The primary resource of this information is the South African Community Epidemiology Network on Drug Use project, which currently monitors alcohol and other drug use trends in South Africa.\(^ {105}\)

Because the problem of substance dependence intervention and recovery spans multiple disciplines, substance dependence research reflects the preconceptions of the variety of researchers who have studied it. The clinical psychologist may view substance dependence as a character disorder that may be addressed by the facilitation of the identity restructuring of the personality. The economist may see substances as commodities and study their marketing systems in terms of supply and demand measured by cost and purity of the substance. In a similar way, the pharmacologist, the anthropologist, and other specialists bring their own skills and special points of view to substance dependence and recovery. Because the particular aspects regarding substance use disorder recovery are intrinsically complex and difficult, all these approaches are incomplete, and their narrow focus denies a wider perspective. There is no doubt that the increased interest in this area of research can significantly improve the understanding of some of the processes involved in counseling, rehabilitation, and recovery.\(^ {9}\)

THE WAY FORWARD

With the increase in our knowledge of the chemistry and psychodynamics of people has come specialization, and specialization has tended to dismember human beings. Observation and treatment in bits and pieces can mean that
the total person is fragmented and becomes no more than the sum of his or her symptoms. Substance use disorder recovery is more likely to be successful if it is multisystemic and multidisciplinary in approach and when it addresses the clients’ functioning in a number of contexts and from the viewpoint of people familiar with those contexts. An intervention team should comprise members with unique expertise and insight into the contexts in which the recovering substance dependent will ultimately function. Although professionals are encouraged to work with people with experiences and expertise outside their customary comfort zones (e.g., with indigenous healers) who may be significant to the client’s worldview, integrating such systems will not be easy. Not just the beliefs of the patient but also those of the doctor or therapist are important in a doctor–patient relationship.

Despite growing evidence of an association between African substance abusers’ use of indigenous and supplementary modern treatment services (such as psychosocial and pharmacological and medical care) and treatment outcomes, substance dependence treatment programs in Africa generally fail to meet research-based treatment standards; for example, detoxification services are provided by less than half of all facilities in Cape Town. Emerging standards for substance use disorder treatment have called on treatment providers to enhance traditional addiction services with services that address clients’ psychosocial and medical needs.

Collaboration with indigenous healers cannot be promoted as a matter of urgency because more knowledge needs to be gained about how indigenous healers can complement mental health intervention. Some of the scholarship relating to indigenous healing in community settings in central and southern Africa demonstrates that the field is not well defined; it is not clear where to begin. Current scholarship tends to break indigenous healing systems down into a distinction between religion and healing. The units of study and subsequent substance use disorder counseling interventions need to be clarified and variations between interventions explored. This can be undertaken ethnographically, contextually, culturally, historically, ethnologically, or analytically. Definitions of substance abuse have to be the same for all approaches. Criteria of efficacy in substance use disorder counseling need to be formulated, both in terms of specific therapies and interventions found in indigenous and in modern practice and in terms of the more general question of whether and how they may contribute to substance use disorder recovery. Both individual (psychological, symbolic, pharmacological) and social mechanisms (entering and extending a network, creating support groups and redistributive chains, social competence) need to be studied as therapeutic
mechanisms that may have generalizable qualities. Many of these measures enhance the ability of individuals and societies to contain trauma and to deal appropriately with difficulties, thereby contributing to social reproduction in the marginalized, alienated, or stressed sectors of African society.47

CONCLUSION

The field of substance use disorder intervention worldwide has been in transition for some time in terms of theory and practice; however, the field is less in transition now than it was a few years ago. Many interventions and procedures have begun to be integrated routinely into clinical practice within the African context. In particular, motivational and cognitive behavioral approaches, following the surge of interest in these approaches in research studies, have made great inroads into practice at a grassroots level.

It is easy to forget that the treatment of individuals with substance use disorders has been rendered in an organized service delivery system for only less than 50 years. The systematic application of science to the study of substance use disorders on a large scale has occurred for only just over 25 years. Outpatient treatment has been an organized form of care for only just over a decade. As progress is made in the 21st century, scientific information is now beginning to be used to guide the evolution and delivery of illicit drug dependence care. Making accreditation mandatory might also result in significant benefits for clients in treatment, especially those in residential care. It is an imperative that law enforcement action be followed by an integrated program of psychological, social, and pharmacological outreach. These programs will have to be expanded to address new demands and need to include specialized skills training. Many interventions and procedures have begun to be integrated routinely into clinical practice.

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