ARTICLES

Heroin use disorder intervention within the South African context

Monika M. L. dos Santos
Independent Practice
Vista Psychiatric Clinic
Centurion, South Africa
and the Foundation for Professional Development
monika.wilde@gmail.com

Solomon T. Rataemane
Department of Psychiatry
University of Limpopo (Medical University of South Africa campus)
South Africa

Russell E. Matthews
Independent Practice
Vista Psychiatric Clinic
Centurion
South Africa

Andreas Plüddemann
Alcohol and Drug Abuse Research Unit
Medical Research Council
South Africa

Vincenzo Sinisi
Independent Practice
South Africa

Michael Benn
Independent Practice
South Africa

Abstract
It is a sad reflection upon the field of heroin use disorder intervention that practices and procedures for the treatment of such disorders can be introduced and applied without (or even contrary to) evidence. In South
Africa, the field of heroin use disorder intervention has been ‘in transition’ since the outbreak of the heroin epidemic. Yet, despite growing evidence of an association between heroin dependents’ use of supplementary intervention services and intervention outcomes, heroin use disorder intervention programmes in South Africa generally fail to meet international research-based intervention standards. This study delved into the insights of 10 heroin use disorder specialists and synthesised the findings with the results of a previous study (Dos Santos and Van Staden, 2008; Dos Santos, 2009) relating to 40 long-term voluntarily abstinent heroin dependents. In terms of theory and practice, the findings of the study suggest that the field is less in transition now than it was in 1995. It is imperative that law-enforcement action be followed by an integrated programme of psychological, social, and pharmacological outreach. These programmes will have to be expanded to address new demands and will need to include specialised skills training. Many interventions and procedures have begun to be integrated routinely into clinical practice.

Key words: heroin; heroin dependence; heroin use disorder; intervention; recovery; South African context

It is a sad reflection upon the field of heroin use disorder intervention that practices and procedures for the treatment of heroin 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. Several of these treatments have been more dangerous than the untreated withdrawal syndrome (Kleber, 1981). This should be judged in the context that, although the heroin withdrawal syndrome causes considerable discomfort, it is of relatively short duration and is not medically serious, much less life-threatening. Prior to the 1970’s, there was virtually no formal understanding of heroin dependence and little was known about how heroin use disorders could be managed or treated effectively. During the late 1960’s and early 1970’s, many countries established systems of substance use disorder intervention services. Prior to that, intervention was provided by very small numbers of ‘specialist’ doctors, or in other types of services (e.g., mental hospitals, prisons). Differences in the governing ideas behind British and American substance use disorder policies were articulated in the 1916 Harrison Act in the United States (US) and the 1926 Rolleston Report in the United Kingdom (UK). The US tended to pursue a policy that relied solely on control measures, whereas the UK took a more medicalised view of the disorder and its management. These differences are still reflected in the contrast between the British acceptance of harm-reduction measures that can be utilised to limit the damage to the continuing heroin user, and the American goals of ‘zero tolerance’, ‘users’ accountability’, and a ‘drug-free America’ (Gosten, L., 2007, p. 385).
SOUTH AFRICAN CONTEXT

In the not too distant past, almost anyone in South Africa could open a drug rehabilitation centre, offer rehabilitation services and charge a fee for these services – regardless of his or her professional training or background. These facilities were 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 centres’. Such facilities were thus not regulated by the Department of Health (DoH) or the Department of Social Development (DoSD, 2005). Numerous unregistered examples of such centres still exist in South Africa, and various human rights violations have been reported (Bateman, 2006). This situation has also arisen due to the state closing down several long-established centres and reducing subsidies for organisations, such as the South African National Council on Alcoholism and Drug Dependence (SANCA).

However, there has been a recent trend in psychiatric facilities to open specialised substance use disorder units. Recently, in 2007, the Minimum Norms and Standards for Inpatient Treatment Centres, which explicate the criteria for the registration of residential substance dependence rehabilitation centres in South Africa, have been issued by the DoSD. However, the manpower to monitor the standards set is likely to be deficient (Bateman, 2006; Leggett, 2001). According to Weich, Perkel, Van Zyl, Rataemane and Naidoo (2008), medical practitioners in South Africa are increasingly confronted with requests to treat patients with heroin use disorders, but many do not possess the required knowledge and skills to deal with these patients effectively. Furthermore, some treatment procedures, such as detoxification and rehabilitation, can be especially expensive, and a large disparity between the services of the private and public health and welfare sector prevails.

Co-morbidity

Epidemiological study findings have indicated a high prevalence rate of concurrent mental health diagnosis in heroin dependents (Karam, Yabroudi & Melham, 2002; Rodrigues-Llera et al., 2006; Vasile, Gheorghe, Civrea & Paraschiv, 2002). 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 that lead to their relapse. The misuse of opiates alone has been associated with a 14-fold increase in the risk of suicide, the same order of increase that is found in severe mental illness (Appleby, 2000; Neale, 2000). Another significant challenge to the study of depression in heroin dependents is that heroin and opiate use may induce transient symptoms that are difficult to distinguish from organic mood disorders (Brienza et al., 2000). Heroin dependents with mental illness co-morbidity are more likely to engage in behaviours that increase their risk of contracting HIV and AIDS, for example, injecting heroin dependents who have an
antisocial personality disorder more frequently share needles (Leshner, 1999). Since the misuse of heroin alone has been associated with a 14-fold increase in the risk of suicide, its assessment and management by all professional staff with whom heroin dependents have contact should be regarded as central to general mental health care (Appleby, 2000; Neale, 2000).

**GOALS OF THE STUDY**

The present study explored heroin use disorder intervention strategies as imparted by a group of heroin use disorder specialists. The results were then synthesised with an earlier study undertaken by Dos Santos and Van Staden (2008) and Dos Santos (2009) regarding heroin dependence recovery. The objectives of the study were as follows:

1. To obtain expert opinion from heroin use disorder specialists with regard to intervention strategies that best facilitate heroin use disorder recovery.
2. To furnish a description of the effective and ineffective aspects of heroin use disorder intervention from the perspective of heroin use disorder specialists.
3. To compare and integrate the views of long-term voluntarily abstinent heroin dependents with those of heroin use disorder specialists.
4. To formulate tentative suggestions for the advancement of heroin use disorder intervention programmes.

**METHOD**

**Research design**

A qualitative descriptive research approach was used for the in-depth specialist participant interviews. Although the analysis of the material is potentially subject to researcher bias, the aim of the study was to provide an explorative and descriptive account of the intervention strategies from heroin use disorder specialists that best facilitate the recovery process. To this end, because the participants interviewed are regarded to be specialists in their field, the information collected seems likely to offer a high level of corroboration. The study findings were compared and integrated with the results of a previous study by Dos Santos and Van Staden (2008) and Dos Santos (2009), which adopted a mixed research design, making use of qualitative analyses of in-depth case study interviews, as well as quantitative analyses of data from the cross-sectional survey regarding the sample profiles.
Sampling procedure and data collection

Interviews were conducted with 10 specialist participants who were recruited on the basis of their reputation/specialisation within the South African heroin use disorder intervention field. This relatively small sample size was deemed adequate because of the in-depth nature of the study. While large samples increase the labour of analysis, they rarely add incrementally to the findings of the study (Potter & Wetherell, 1987). Information was collected from 40 participants in the study by Dos Santos and Van Staden (2008) and Dos Santos (2009), 31 of whom had voluntarily abstained from heroin for over a year, meeting the DSM-IV-TR criteria for Opioid Dependence Sustained Full Remission (American Psychiatric Association [APA], 2000). The remaining nine participants fulfilled the DSM-IV-TR criteria for Opioid Dependence Early Partial Remission (APA, 2000).

Participants in the present study

Specialist 1 is a director and founder of an established rehabilitation centre, and is also registered as a National Association of Alcoholism and Drug Abuse Councillors (NAADAC) counsellor. The specialist is also a long-term abstinent heroin dependent, who was dependent on heroin for 12 years, but has been abstinent for 14 years. The specialist has been involved within the substance use disorder rehabilitation field for the last 12 years.

Specialist 2 is head of a university psychiatry department and was formerly involved on a prominent level with the Central Drug Authority, South Africa. The specialist has extensive international experience within the substance use disorder field, specifically with regard to heroin use disorder assessment and intervention. The specialist has worked in Singapore, Hong Kong, Canada, Australia, the SADC region, Western and Central Africa, Thailand, the UK and the US.

Specialist 3 is an executive director of an organisation that specialises in substance use disorder research, advocacy and policy formulation for state departments. The specialist holds a diploma in drug and alcohol policy and intervention from the University of London, and has over 18 years of experience within this specialised field. The specialist is also a recovering heroin dependent who was dependent on heroin for six years, but has abstained for 30 years.

Specialist 4 is a social worker from the Gauteng DoSD who has worked for over 16 years within the substance use disorder field, specifically with heroin dependent committals for rehabilitation. The specialist is also an honouree member of Narcotics Anonymous and renders a facilitator role within Nar-Anon.

Specialist 5 is a social worker who formerly worked for a state hospital in South Africa, managing an out-patient programme for heroin dependents for five years. The
specialist has also worked in the UK with heroin dependents undergoing methadone maintenance out-patient intervention.

**Specialist 6** is involved on a national level in Tough Love South Africa. The specialist has dealt with the many families of heroin dependents for the last 16 years.

**Specialist 7** is a medical nurse who was employed within the SANCA network for 17 years. She specialised in psychiatry and has attended medically to many withdrawing heroin dependents since the onset of the epidemic in 1995.

**Specialist 8** is also a medical nurse who has been employed within the SANCA network for 12 years. She has been involved in the assessment and medical intervention of heroin dependents since 1995.

**Specialist 9** is a general practitioner who has for the last six years practised within the field of heroin use disorder intervention within a private practice capacity, as well as at a private psychiatric institution. The specialist has also undergone international training in buprenorphine maintenance regimes.

**Specialist 10** is a clinical psychologist, who is also qualified and has experience as an anthropologist. The specialist has worked in private practice for 24 years. The specialist, who runs offices at a private psychiatric hospital, has dealt clinically with clients presenting with heroin use disorders since the onset of the syndrome in South Africa.

**Procedure**

The interviews were conducted from April 2007 to March 2008. The interview recordings, which ranged from 24 to 42 minutes, were subsequently transcribed. No incentive was offered to the specialist participants during recruitment. Before the interview commenced, a standardised plan of the interview was read out to each specialist participant, and they were assured of confidentiality and anonymity. The specialist participants were also informed that they were under no obligation to answer any questions that they were uncomfortable with, and that they were free to pause for a break or terminate the interview at any time. The biographic particulars of the specialist participants were documented, after which an interview with each specialist participant was tape recorded. Ethical approval for this study was granted by the Ethics Committee of the Psychology Department, Unisa, in December 2006. In the study by Dos Santos and Van Staden (2008) and Dos Santos (2009), interviews were conducted from April 2004 to June 2005.

**Semi-structured interviews**

Semi-structured individual interviews were conducted with 10 heroin use disorder specialists in order to gain a detailed description of their perspective with regard to
heroine dependence intervention and recovery (Babbie & Mouton, 2001). The semi-structured interviews with the heroine use disorder specialists were tape-recorded. A general plan of enquiry was conducted with the specialist participants, and an interview schedule with relevant ‘probes’ was utilised. The specialists were asked the following initiating question: What interventions, both psychosocial and pharmacological/medical, are in your opinion the most effective in treating heroine use disorders?

Semi-structured interviews were also carried out in the study by Dos Santos and Van Staden (2008) and Dos Santos (2009), which sampled 40 long-term voluntarily abstinent heroine dependents and explored their heroine dependence recovery processes.

**Interview analysis**

Content analysis was employed to analyse the interview information. This technique of analysis was considered to be especially relevant considering the scarcity of research within the heroine use disorder intervention field in South Africa. Content analysis is different from other methods in the sense that it allows the generation of theory that closely approximates the reality/views it represents, rather than the testing of theory (Babbie & Mouton, 2001). Transcribed interviews were read, subjected to content analysis, and discussed by the authors in order to determine the usability of the material and the categorising of themes within the interviews; this increased the inter-rater reliability of the study. To authenticate interpretations, interview conclusions were taken back to all the specialist participants for possible enrichment and verification of interpretations/significance (Breakwell, Hammond & Fife-Shaw, 1995).

In the study by Dos Santos and Van Staden (2008) and Dos Santos (2009) statistical analyses, relating to the participants’ biographic, socio-demographic, and drug use history, were performed on the cross-sectional data. Non-parametric statistics was utilised as it could not be assumed that the long-term voluntarily abstinent heroine dependent population adheres to parametric distributions, and these measured their parametric alternatives. Content analysis was conducted on the semi-structured interview data.

**RESULTS**

**The impact of the heroine use disorder epidemic in South Africa**

All the specialist participants regarded the availability of heroin, and consequent heroine dependence syndrome, to be a relatively new and disturbing phenomenon in South Africa. The need to intervene on a national level with regard to heroin/drug dealers was highlighted as an imperative, especially taking into account the relatively early onset of heroine dependent individuals in South Africa. The lack of manpower due to the dismantling of specialised police units, such as the South African Narcotics
Bureau (SANAB), was cited as a severe constraint in dealing with the heroin/illicit drug problem in South Africa. Corruption within law enforcement departments and amongst mental health/health professionals was also mentioned by the specialist participants. Due to the relatively new emergence of heroin use disorders in South Africa, there has been a lack of specialised knowledge amongst professional people working within the heroin use disorder field; however, the specialist participants conceded that this backlog of knowledge has improved markedly in recent years. Problems with regard to the monitoring of drug rehabilitation programmes were also cited as a barrier in the effective implementation of the National Drug Master Plan:

‘South Africa has not kept up to speed with the rest of the world ... it was seen as a non-white issue, and because of the Calvinistic culture of this country, it was seen as a moral issue.’ (Participant 3)

**Intervention**

Intervention was regarded by all the specialist participants to be a central aspect in recovery and deemed of high importance. The themes of intervention and recovery were regarded to be interchangeable. The need to initiate intervention as early as possible (at the onset of heroin use disorder) was cited as vital, supporting the concept of high-level early intervention in the study by Dos Santos and Van Staden (2008) and Dos Santos (2009). The need to thoroughly assess patients was thought to be pivotal in terms of planning the most appropriate treatment intervention, such as psychotherapeutic, outpatient/residential, pharmacological and legal/statutory input. All the specialist participants were of the opinion that the length of residential intervention was reliant on the chronicity of the individuals’ dependence on heroin.

**Components of intervention**

The necessity for information and education within intervention, both in terms of facilitating cognitive restructuring and in terms of enhancing professional staff’s therapeutic skills, was thought to be of significance both in the present study and in Dos Santos and Van Staden’s (2008) and Dos Santos’ (2009) study. The obligation to enhance and improve therapeutic skills, professional qualifications, maintain professional boundaries, incorporating indigenous healers within the therapeutic intervention, seeing heroin dependence as a primary health condition (as opposed to solely a social/moral problem), education and accreditation within the substance use disorder treatment field within South Africa, was viewed as an imperative. Similarly, participants in the study by Dos Santos and Van Staden (2008) and Dos Santos (2009) described the need for specialist treatment rather than general help, for example, several participants referred to the need for both an individualistic, non-judgemental and realistic style of treatment intervention, which should be easily accessible when required. Therapeutic competencies, such as Motivational Interviewing, as opposed
to confrontation, were deemed as an effective means of intervention. The particular structure of treatment intervention was also crucial to some participants, in the sense that it provided an abstinence-based, structured/intensive residential programme (as opposed to out-patient intervention), sometimes over a relatively long period of time. High-level early intervention and long-term care were highlighted as important strategies in treating chronic heroin dependence syndromes.

These findings were consistent with the findings of Dos Santos and Van Staden (2008) and Dos Santos (2009). It was clear that for this sample of long-term voluntarily abstinent heroin dependents at least, that type of treatment intervention was considered to be what they needed for recovery. The need for adequate resources, such as skilled medical staff and equipment/medication, in residential facilities was cited as key in treating clients holistically. The monitoring of heroin dependents on an after-care/outpatient basis was deemed important in securing long-term abstinence and eventual recovery, supporting the findings of Dos Santos and Van Staden (2008) and Dos Santos (2009). Lack of accommodation and facilities, such as halfway houses, was cited as a major obstacle relating to the long-term treatment and care of heroin dependents. Similarly, in Dos Santos and Van Staden’s (2008) and Dos Santos’ (2009) study, some participants verbalised a lack of accessibility to residential care as a barrier to their recovery. A number of the specialist participants in the current study felt that few resources could be found to assist extremely progressed cases of persons presenting with heroin dependence syndromes. The need for an adequate time period to detoxify from heroin was regarded as vital especially prior to continuing on an out-patient basis with therapeutic intervention. The use of alternative therapies in treatment intervention, such as relaxation and exercise, was supported within the scope of this study, as well as that of Dos Santos and Van Staden (2008). A further treatment intervention component that was reported to be influential in producing positive effects was the adoption of a holistic approach, supporting the findings of Dos Santos and Van Staden (2008), in addressing the heroin dependence syndrome, underlying problems, and problems caused by the using of heroin. The range of vulnerability targets include coping methods, physical and mental health problems, practical problems, interpersonal difficulties, self-awareness, problematic behaviours, lifestyle, circles, and so on, rather than just the heroin use disorder syndrome. In the present study, the specialist participants emphasised the need for protected specialised drug units away from temptations, especially for youth, during early recovery.

**Psychological intervention**

Diagnosing psychological/psychiatric problems, such as depression, anxiety/panic attacks, paranoia, psychosis, and eating disorders, was regarded to be an essential aspect within the holistic approach to the assessment and treatment of heroin use disorders.
‘You have to assess as to whether or not they are depressed or not anxious. Do they have any pre-existing psychological or psychiatric problem? Because if there’s co-morbidity, then you don’t just deal with the addiction on its own, but you attend to the underlying problems, maybe if it’s depression and so on.’ (Participant 2)

Psychological intervention was deemed necessary in order to deal with the underlying causes of the heroin dependence syndrome (e.g., self-esteem). Psychological therapeutic interventions, specifically Cognitive Behavioural Therapy, were regarded by several of the specialist participants as an effective means of facilitating cognitive change in heroin dependents.

**Relationship intervention**

Another clear consequence of heroin dependence in the study by Dos Santos and Van Staden (2008) and Dos Santos (2009) occurred in terms of the effect of using heroin on relationships, which resulted in various negative effects, such as increased arguments, a bad family atmosphere, or the break-up of many relationships. Family and relationship intervention was also regarded to be of importance; parents, for example, need to deal with their own underlying emotional problems as well. The need to build on trust and self-esteem/respect between family members was also expressed. Consistent and congruent boundaries and discipline from both parents, as well as family involvement during the course of therapeutic intervention was mentioned as useful strategies in facilitating changes within the heroin dependent’s life worlds. An additional component that was considered integral to successful treatment intervention was good support networks and working with the entire support system, as opposed to a heroin dependent in isolation.

... that support group, either peer group, family or employer is very important in the whole treatment process. Because after 10 days when you’re sort of out of the withdrawal period, then people should start working on your way of seeing life, your whole perception of being, and your place in the world, your place ... you know where do you fit in, and where did things go wrong. (Participant 10)

The role of co-dependents and significant others during therapeutic interventions was also highlighted as important within the process of psychosocial intervention. The need to address co-dependence issues was also mentioned by the participants in the study by Dos Santos and Van Staden (2008) and Dos Santos (2009).

**Social intervention**

The need to stay away from using communities, at times making a geographic move, was emphasised, supporting the findings of Dos Santos and van Staden (2008) and Dos Santos (2009). The extreme isolation and stigmatisation experienced by heroin dependents is something that needs addressing, and engaging in intervention can
act as one means of rebuilding (non-using) social networks. The inability of heroin dependents to work during heavy heroin use further exacerbates their isolation, due to a lack of contact with family/friends/work colleagues (Dos Santos & Van Staden, 2008; Dos Santos, 2009). The use of groups, such as Narcotics Anonymous, and after-care can provide sources of contact for recovering heroin dependents. However, it was emphasised that Narcotics Anonymous and other self-help groups should not be regarded as therapeutic treatment per se, but rather as an active maintenance system for recovering heroin dependents.

**Practical intervention**

The study emphasised the importance of helping recovering heroin dependents find employment, which can provide a particularly useful substitution for the rewards previously found only in using heroin. Other core requirements of recovery, apart from employment, included acquiring friends, recreational activities, exercise, and structuring time. The view was held by the specialist participants that persons in recovery need to fully occupy their life in a beneficial manner in order to avert high risk situations/temptations for relapse.

**Therapeutic intervention**

Some of the specialist participants held the sentiment that most rehabilitation centres in South Africa are not successful in the treatment of heroin use disorders, and that the need for more therapeutic specialisation is necessary. The need for a holistic therapeutic intervention (as discussed above) was again highlighted, as well as the need for therapeutic intervention together with medical treatment. Also, as mentioned earlier, the inclusion of the recovering heroin dependent’s significant others were deemed an important component of the therapeutic process. The need for resources was a theme that arose from the analyses, and resources alluded to included financial, materialistic, human capacity, and skills. One of the factors considered to be of most value was the continued use of post-treatment aftercare/counselling, and the importance of having a safe environment to return to if required. Long-term care as opposed to brief interventions with no form of follow-up was regarded as crucial to the recovery process; this finding supports those of the study by Dos Santos and Van Staden (2008) and Dos Santos (2009), with most of the long-term voluntarily abstinent heroin dependents citing long-term care and resources as having played a crucial factor in their recovery process. Residential detoxifications were also regarded to be medically safer compared to detoxifying on an out-patient basis. The need for counselling alongside pharmacological/medical intervention was regarded as an important component to intervention. Problems with regard to residential treatment accessibility were mentioned, especially for people with average or low incomes – this factor remains a barrier to services delivery.
Relapse prevention

The necessity of preparing recovering heroin dependents to deal with cravings and any potential relapse was thought to be of importance in terms of planning and implementing therapeutic and medical intervention initiatives. A particularly important strategy in recovery mentioned by the specialist participants was the acceptance and expectancy of cravings and other problems associated with heroin dependence. The specialist participants were of the opinion that relapses should be regarded as a fairly normal part of the recovery process for most recovering heroin dependents.

Community-based/out-patient intervention

The cost benefits of out-patient programmes were highlighted by several of the specialist participants. The financial viability and accessibility of such programmes, especially for advanced heroin dependents that have little recourse to financial resources, was regarded as a major advantage of such intervention. The opinion was held that out-patient treatment, as opposed to in-patient care, is more realistic in that it facilitates recovering heroin dependents to deal with demands and triggers within their environment without succumbing to heroin.

‘In-patient treatment is expensive, and doesn’t test if the person can be out in the community without suddenly using the stuff; that is, can you control the craving within a community where there are a lot of triggers, knowing that there is support available.’

(Participant 2)

The use of out-patient facilities that supply supervised pharmaco-therapeutic interventions, such as the outpatient methadone maintenance programmes in the UK, despite the association with accidental death, was cited as being very beneficial in assisting recovering heroin dependents to adapt to their new life-styles while still being supported and monitored. One of the drawbacks of residential treatment, especially long-term residential treatment, is the possibility of inadvertently institutionalising recovering heroin dependents and not facilitating their ability to cope in the outside world. The need to offer regular structured out-patient programmes, which enhance self-efficacy skills, was regarded to be of fundamental importance in the rendering of efficient services. Formulating a contract with clients, such as regular random urine testing, and the stipulation of possible consequences, was also highlighted as key in the rendering of such services. Compliance with such programmes was found to be better with heroin dependents who had an active support system and employment as opposed to those with minimal resources.

Tough love, in conjunction with other rehabilitative initiatives, was also regarded to be an important asset in assisting heroin dependents’ significant others to facilitate change. As previously mentioned, involving parents, extended family, and significant others within the intervention process was regarded to be of key importance in
the holistic intervention for heroin dependents, not only in setting boundaries for the dependent, but also in facilitating insight for family members and significant others. The use of behaviour modification techniques, support, and addressing co-dependence issues were examined and regarded as an effective means of parental/significant other support and intervention.

**Medical/physical intervention**

The disease concept of heroin dependence and the physiological dependence that heroin induces was discussed by some of the specialist participants, and neurological differentiations between heroin users and non-heroin users were alluded to, signifying the physiological changes that heroin may bring about. The highly physiological dependence potential of heroin was cited as the main reason for the necessity of physiological intervention. In the study by Dos Santos and Van Staden (2008) and Dos Santos (2009), heroin dependence was regarded as harder to recover from than most other forms of substance abuse. This powerful addiction seemed to lead to a preoccupation with heroin as the problem progressively took over participants’ lives and they also seemed to lack any sense of choice over their heroin dependence. Similarly, in the present study, the specialist participants felt that as heroin misuse problems develop, increasing tolerance and physical dependence may play a major part in influencing this preoccupation. The specialist participants generally felt that heroin was more dependency producing than the majority of other substances of abuse, supporting the findings of Dos Santos and Van Staden (2008) and Dos Santos (2009).

**Pharmacological intervention**

Substitute pharmacological intervention was generally supported by the specialist participants, especially those with a medical background. The need for some kind of substitute pharmacological intervention was also reported to be necessary for many participants in the study by Dos Santos and Van Staden (2008) and Dos Santos (2009). However, some of the specialist participants in this study reflected that a significant number of recovering heroin dependents maintain their abstinence with supportive therapeutic input only; this view was also supported in the study by Dos Santos and Van Staden (2008) and Dos Santos (2009). Two alternative modes of intervention were discussed by the specialist participants, namely, no use of substitute pharmacology, implying the use of only symptomatic pharmacotherapy, the alternative being substitute pharmaco-therapy, such as methadone and buprenorphine. A number of the specialist participants felt that the pharmacotherapy intervention should not be of a long duration. The problem of sleep difficulties was noted as another key facet that needed to be addressed pharmacologically in recovery as sleep deprivation is often regarded as a high risk factor for relapse.
Criticism against the use of pharmaco-therapy were voiced mainly from those specialist participants without medical training, some of whom shared the sentiments that long-term voluntary abstinent heroin dependents who were not on any form of substitute maintenance programme were more likely to remain completely abstinent from all forms of psychoactive substances. The use of opiate maintenance programmes was generally seen as a form of substitution, without addressing the underlying psychological and physiological factors. The negativity of prolonging the dependence syndrome was cited as a prominent criticism against pharmacological maintenance programmes; however, based on the outcome of this study and the previous study of Dos Santos and Van Staden (2008) and Van Staden (2009), pharmacological intervention appears to continue to play an important role in heroin use disorder recovery, as the phenomenon involves some degree of physical dependence.

**Incarceration**

The lack of sufficient medical and rehabilitative initiative within prisons, especially those awaiting trial, was highlighted as a serious problem within the correctional services structure within South Africa. Heroin dependents who struggle with withdrawal symptoms seldom obtain the necessary medical intervention. Furthermore, heroin dependents serving long-term sentences rarely obtain any form of specialised care for their syndrome. The incarceration of heroin dependents displaying no co-morbidity or anti-social type personality traits was generally held in disdain by the specialist participants. There was consensus with regard to the establishment of community programmes, diversion programmes, and rehabilitation instead of incarceration. Lobbying government to be more proactive in it’s stance toward heroin dependence rehabilitative initiatives was seen as a necessity.

**Harm reduction intervention**

Initially, most of the heroin use in South Africa was by means of smoking, but this tendency has been changing in recent years, with evidence indicating that more heroin users are using or experimenting with intravenous use (Dewing, Plüddemann, Myers & Parry, 2006). Although contentious, harm reduction interventions, such as needle exchange programmes, were discussed at length by all the specialist participants. Two of the specialist participants with a medical background, who are both internationally renowned drug intervention experts, noted that since the implementation of needle exchange programmes overseas (such as in Holland), a significant decrease in health-related consequences has failed to actualise. The fact that under international law (regulated by the International Narcotics Control Board), heroin remains an illicit substance, which also adversely impacts on the implementation of needle exchange programmes in terms of inadvertently condoning the use of heroin, was also discussed by one of the specialist participants.
‘Harm reduction is a debatable issue. Unfortunately I have to quote the existing international law within the legislation, which is clearly regulated by the International Narcotics Control Board, and implemented by the United Nations Office for Drugs and Crime (UNODC). Heroin is an illicit substance, and it is listed as such.’ (Participant 2)

All the specialist participants were in agreement that needle exchange programmes are generally implemented with the intention of reducing harm associated with intravenous heroin use, such as the contraction of AIDS and hepatitis B, C, and G, although such programmes at present still contravene the United Nations Convention. Needle exchange programmes might also maintain heroin dependents at a user level, extenuating their syndrome. The sentiment was held by some that as mental health and health professionals, the goal of intervention should be to heal – not to maintain heroin users’ at the level of dependence. Another concern voiced by some of the specialist participants was that needle exchange programmes may further discourage heroin dependents from seeking rehabilitation intervention; such programmes may also be promoting the use of heroin by sending mixed messages to impressionable individuals. A number of the specialist participants also held the view that programmes, such as needle exchange, are too extremist, and a few others were of the opinion that it is immoral to condone and implement such programmes. Another problematic aspect with regard to needle exchange programmes, and so-called ‘careful’ or ‘responsible use’, arises with regard to progressively increasing tolerance levels and that inability to maintain dosages of methadone/buprenorphine/heroin use. The opinion of some of the specialist participants was that abstinence is not encouraged in such programmes, and that the heroin dependence syndrome is therefore perpetuated.

You’re actually encouraging the addiction and you’re not going to stop it like that because I don’t think that one guy who’s really severely addicted ... you will not be able to maintain a dosage of that, that’s my experience with addiction. I mean he will always want more. (Participant 7)

An intravenous user’s family, and in particular children, might also be drawn into the heroin use subculture due to exposure and by experiencing contradictory messages from their parents and other family members. Comparisons were made between intravenous heroin use and STDs in terms of advocating abstinence or implementing ‘harm reduction’ approaches, such as condom use. One specialist participant made the comment that once an individual is sexually active or dependent on heroin, for example, the likelihood of abstinence and behaviour change is small. In such instances, harm reduction approaches may be the only way to reduce risk, be it through needle exchange programmes (regarding intravenous drug use) or condom use (regarding sexual risky behaviour). One specialist participant argued that South Africa (as well as the SADC and African Union) is not at present in a position to support needle exchange programmes due to a lack of monitoring infrastructure and
resources. The specialist participants were of the opinion that stipulations of the United Narcotics Convention should still be adhered to within the South African context.

For substances that are as destructive as what heroin is, I think needle exchange provision of clean syringes and so on, is not something you can recommend in a country such as South Africa, in the SADC region, in the African Union countries, because we don’t have the infrastructure to monitor, and we don’t have the resources to provide these things. (Participant 2)

Another factor that should be taken into consideration is that at present intravenous use is still fairly low compared to that of other countries where needle exchange programmes have been implemented. However, some of the specialist participants commented that should the intravenous drug use level rise in South Africa (which it is likely to), then needle exchange programmes will become crucial in terms of harm reduction.

Maturing out hypothesis

A change in life circumstances, such as getting married and having children, was also believed to contribute to recovery. Most of the specialist participants were familiar with the maturing out hypothesis of heroin dependence, and generally felt that interventions could help facilitate such change – this finding mirrors the significant inferential findings in the study by Dos Santos and Van Staden (2008), which supported the maturing out hypothesis of heroin dependence.

DISCUSSION

The findings of this study suggest that interventions should include a ‘mix’ of approaches, both modern and indigenous, including assessment and diagnosis, pharmacological intervention, self-help intervention, out-patient, diversion and restorative justice approaches, residential care, and harm reduction tactics.

There has been a significantly increased emphasis on matching heroin dependents to intervention. For many heroin dependents, especially those with long and complex histories, the assessment procedure itself may be a therapeutic process. Assessment may identify the nature and severity of the heroin-related problem, to understand why it arose, to assess its consequences, and to establish the strengths and weakness of the client and his or her situation. Armed with this information it is possible to formulate and develop an intervention programme to help the individual to live a full life, integrated into society without the need for a substance. Accurate diagnosis of the state of dependence is also very important (Dos Santos & Van Staden, 2008; Dos Santos, 2009; McIntosh & McKeeganey, 2002; Terry, 2003).
Once assessment is completed, the crucial question of how to help heroin dependents with their problem has to be answered. The findings of this study suggest that the immediate response is often pharmacological, although this is usually only a short-term measure and can only be regarded as one component of the total intervention response. A variety of counselling therapeutic intervention options are available: some are directed at the underlying causes which may have initiated drug taking or are contributing to its continued use, while others help to resolve the problems associated with or the consequences of heroin taking. Others deal more with the heroin-taking behaviour itself; these are aimed at reducing or stopping heroin taking regardless of other problems or circumstances. These finding are also supported in the studies of Coombs (2004) and Rotgers, Morgenstern, and Walters (2003). Not all interventions are suitable for every heroin dependent, nor are they mutually exclusive. Intervention plans must be drawn up thoughtfully, according to the needs of the individual. Single interventions or a ‘mix’ of interventions, or components of different interventions, including indigenous healing practice, can be effective. Agrawal (1995) affirmed that it makes sense to talk about multiple domains and types of knowledge and intervention. The general measures of intervention that are described in this article are mostly long-term measures, aimed at bringing about long-term and fundamental changes. They are often collectively described as ‘rehabilitation’.

The following intervention principles emerged from the study:

- **Clarity of purpose:** Are the goals of the treatment clear and are both provider and recipient in tune regarding these goals? Are specific outcomes (whether proximal or ultimate) being sought?

- **Appropriateness to the presenting condition:** Is there a fit between the person’s current condition and what is proposed by him or her?

- **Assessment and care planning:** Has there been a thorough assessment to inform the care plan? Is this assessment based upon sound practice and knowledge and conducted skilfully? Is the care plan clear and well thought out?

- **Motivation for change:** Can the intervention cope with and respond intelligently to ambivalence, fluctuating motivation, and varying degrees of realism? Does it meet the client where he or she is? Is the client’s choice understood and taken into account?

- **Preparation:** Is the client thoroughly prepared for the intervention to which he or she is referred? This applies to initial treatment or aftercare.

- **Supportive evidence and best practice:** Is evidence available to justify using the intervention and to indicate that it offers a better chance of success for the
presenting condition than others? Has it been properly applied in practice? If there is a shortage of evidence, what is the rationale for employing the intervention? Does this make sense and is it testable? Qualitative and quantitative research may be able to make an important contribution here.

- **The whole person:** Are physical, psychological, social, cultural, and spiritual factors taken fully into account?

- **Families:** Where appropriate and depending on circumstances, engage with families and significant others at the earliest opportunity.

- **Responsiveness:** Is there an ability to adapt to changing circumstances?

- **Workforce:** Do its members possess the right knowledge and skill to be of real help and can they apply them effectively? Do they have adequate self-knowledge? Can they combine professionalism and vocationalism? Are they expertly led, supervised and managed? Is there a commitment to continuing professional development by both the employee and employer?

- **Environment and culture:** Is it conducive to helping people to effect change? Is it attractive and does it encourage engagement? Does it signal care and invite confidence and trust? Is it structured, containing and safe? Is it positive and optimistic? Does it situate the client’s welfare at the centre of its business? Does it help promote a recovery culture as opposed to a using one?

- **Scaffolding and recovery resources:** Individual interventions function better and last longer if the client is ‘scaffolded’ by a support system to sustain motivation and is helped to develop personal resources so as to sustain treatment gains.

- **Organisation:** Is the organisation or service well run? Is it able to cope with the powerful projections associated with a distressed client group and to avoid the associated pitfalls? Does it state a very clear ethical code which ensures that professional boundaries are maintained?

- **Quality control:** Are there active systems for auditing and monitoring processes and gaining client feedback?

- **The system:** Is the system for arranging and funding treatment, and in which the treatment operates, coherent and therefore one that promotes effectiveness or undermines it? Are the pathways clearly defined and free from obstacles?

Different treatment settings may be appropriate for different recovering heroin dependents. Residential hospital care may be appropriate for those with coexisting acute medical or severe psychiatric problems. Long-term residential care in a non-medical setting (such as halfway houses) may be most appropriate for recovering heroin dependents who are socially unstable, but who do not suffer from co-existing acute medical or severe psychiatric problems. Out-patient care, apart from its cost
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efficiency, may be indicated for socially stable individuals without coexisting acute medical or severe psychiatric problems. The differences in problems and in the individuals with these problems must be taken into account before an informed decision can be made about what type of treatment intervention is likely to be most appropriate, which finding is supported by Dos Santos and Van Staden (2008), Dos Santos (2009); Gossop (2003), and Gruber, Chutuape and Stitzer (2000). In South Africa, the collaboration between mental health practitioners and indigenous healers should perhaps also be promoted, as healers are clearly providing a significant mental health service to certain sectors of the substance use disorder population. It is 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 (2006). The motivation for corroboration is put forward as 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 (Dos Santos, Rataemane, Plüddemann & Matthews, 2009). 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 (Janzen, 1992; Mpofu, 2003). More knowledge needs to be gained, widely shared, and debated, specifically about how indigenous healers practise, and what form of collaboration would be most appropriate (Robertson, 2006).

When illicit substance use can be prevented, every effort should be made to stop the problem before it starts. Where it cannot, creative means of dealing with the risks may have to be sought. The problem is that heroin dependence is a kind of mental illness that does not manifest itself until it is too late. Most people would recognise that those who are not responsible enough to make rational choices, such as children and the mentally ill, can be morally constrained in terms of the kinds of options that society allows them. It sometimes makes sense to intervene at a political level. This is particularly true in cases where demand is not yet widespread – it may be in the best interests of society to make a collective decision not to allow certain substances to become popularised. The question of any given society must be: is this strategy workable in the present circumstances (Lee & Humphreys, 2006; Leggett, 2001)?

Those specialist participants in favour of more ‘regulated’ drug markets advocate a variety of harm-reduction techniques, such as allowing dependents to obtain their heroin or methadone from a government clinic or sponsoring needle-exchange programmes. The state participates in the market by providing the drug or the equipment under controlled conditions, thereby undercutting the illicit market (Gossop, 2003). As the findings of this study, as well as those of Laurence (2007) suggest, programmes that have been piloted in Europe have led to mixed results even there. While it is unlikely that the South African government will be offering
any free drugs in the near future, condom distribution, for example, represents a very real concession to the view that endorsing ‘abstinence’ may have its limitations.

**Practice, policy, and future research implications**

The results of this study indicate that facilities may be best served by implementing feasible treatment plans which raise the likelihood of treatment completion and which retain clients for longer periods. However, efforts to lengthen the treatment episode may need to take into account the constraints on a facility’s autonomy, exerted by external agencies as well as the nature of a facility’s treatment technology. More is not necessarily better in the case of facilities which need to adhere to managed care and parent organisational rules and those which are relatively understaffed. Decision-making processes in facilities need to factor in organisational effects on heroin use disorder treatment outcomes. The identification of correlates of post-treatment risk for heroin use can inform treatment and policies that seek to lower the chronicity of heroin use disorders and possibly lengthen the time between treatment admissions. Making accreditation mandatory might also result in significant benefits for clients in treatment, especially those in residential care. Although representative shortcomings may be evident in this study as different professional disciplines were interviewed across the spectrum of health, mental health, self-help and policy makers, the most easily identifiable persons were approached based on the authors’ judgement and professional experiences within the heroin use disorder intervention field, as well as on the objectives of the study (Babbie & Mouton, 2001). The results of this study highlight the importance of collecting data on the individual and programme levels, as well as of employing representative multilevel methods in future studies to examine the effects of heroin use disorder intervention. The results of this study and those of Dos Santos and Van Staden (2008) and Dos Santos (2009) indicate that future studies on treatment intervention need to factor in the variance between interventions, even when examining individual-level correlates of outcomes of intervention, being administered across facilities.

**CONCLUSION**

The diagnosis, assessment, and management of interventions for those presenting with heroin use disorders can be complicated. Such disorders involve biological, psychological (including behavioural, cognitive, and emotional), and environmental factors that influence their onset, course, and treatment. Because of the interactions of these three types of factors, variations between presentations of heroin use disorders in different users are evident. Despite growing evidence of an association between heroin dependents’ use of supplementary intervention services (such as psychosocial and medical care) and intervention outcomes, and the fact that
international emerging standards for substance use disorder intervention have called upon treatment intervention providers to enhance traditional substance use disorder services with services that address clients’ psychological and social needs, heroin use disorder intervention programmes in South Africa generally fail to meet these research-based intervention standards (Myers, 2005; Myers & Parry, 2002). Much of what is currently delivered as intervention in South Africa is based upon current best guesses of how to combine some science-based (for example, Cognitive-Behavioural therapy and pharmaco-therapies) and self-help (12-step programmes) approaches into optimal intervention protocols. As progression is made in the twenty-first century, scientific information is beginning to be used to guide the evolution and delivery of illicit substance use disorder care internationally. In terms of theory and practice, the findings of this study suggest that in South Africa, the field is currently less in transition than it was in 1995.

Within the South African context, it is no longer acceptable to simply do what feels right. Organisations and professionals who specialise in treating heroin use disorders 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 development of scientific information to shape and improve the future of the field. During the past decade, psychiatrists, medical doctors, psychologists, social workers, family therapists, nurses and allied health professionals have all incorporated knowledge regarding the identification and treatment of heroin use disorders into categories of licensure and certification requirements. It is the ethical responsibility of the clinical practitioner in the heroin use disorder intervention field, as in other fields (such as cancer and heart disease), to stay informed with regards to new and more effective clinical procedures. The field of heroin use disorder treatment is becoming increasingly professional and those who form part of the system need to continue to stay abreast of new developments so that techniques and tools can be used to make the difference in promoting a successful recovery experience for the individuals for whom existing treatments are currently unsuccessful (Coombs, 2004). As new approaches with sound scientific support emerge, methods may be revised and new treatment options added. 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 programme of psychological, social, and pharmacological outreach. These programmes will have to be expanded to address new demands and need to include specialised skills training. Many interventions and procedures in South Africa have begun to be integrated routinely into clinical practice.
M. M. L. DOS SANTOS, S. T. RATAEMANE, R. E. MATTHEWS, A. PLÜDDEMANN, V. SINISI AND M. BENN

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BIOGRAPHICAL NOTES

Monika dos Santos has worked professionally with illicit substance dependents since 1998. She served as Clinical Head of Lapalame Youth Drug Unit: Castle Carey Clinic (SANCA Pretoria Society) and also worked with incarcerated illicit substance dependents at Emthonjeni Juvenile Prison. It was during this time that she developed a special clinical, research and policy interest in heroin use disorder recovery and intervention. She obtained her PhD in psychology at Unisa in 2008, her thesis titled ‘Healing the dragon: Heroin use disorder intervention’. She currently works as an academic/researcher at the Foundation for Professional Development, and counsels in private practice at Vista Clinic.

Solomon T Rataemane is the Head of the Department of Psychiatry at the University of Limpopo (MEDUNSA campus) and Vice-Chairperson of the Medical Research Council. He has served as deputy chairperson and chairperson of the Central Drug Authority of South Africa from 1995 to 2005. He has a special interest in child psychiatry, mood disorders and addiction medicine. He is currently involved with UCLA Substance Abuse Program in collaborative research to improve Cognitive Behavior Therapy for counsellors at SANCA Clinics in South Africa. He is a Board member of ICAA (International Council on Alcohol and Addictions) and serves on the Health Committee of the Health Professions of South Africa. Prof Rataemane is currently appointed as interim assistant deputy vice chancellor for student and corporate affairs at MEDUNSA. His current engagements include an effort to develop policy and protocols for management of substance abuse, particularly addiction to opioids.
Russell Matthews first lectured and conducted research in anthropology at the University of Pretoria. He qualified as a clinical psychologist in 1986, having first worked at Weskoppies Hospital and in the South African National Defence Force. Matthews has worked in private practice for many years, and holds offices in Pretoria and Vista Clinic, he holds extensive clinical experience across the spectrum of mental health disorders, having specialised in the field of Post-Traumatic Stress Disorder. He recently collaborated on various research undertakings within the field of substance-related disorders, having co-authored a psychology academic book chapter regarding substance-related disorder counselling for a Cambridge University Press Publication titled Counselling People of African Ancestry.

Andreas Plüddemann is a Senior Scientist in the Medical Research Council’s Alcohol and Drug Abuse Research Unit. He holds an MA in psychology from the University of Stellenbosch and is currently working towards a PhD in the Department of Psychiatry and Mental Health of the University of Cape Town. His doctoral study investigates methamphetamine use among adolescents in Cape Town and its association with mental health problems and sexual risk behaviour.

Vincenzo Sinisi is a clinical psychologist in private practice. He has a special interest in psychoanalytic and group analytic theory and their clinical application in understanding and treating mood disorders, addictions and personality disorders, in adults, adolescents and children. His research interests include understanding the discursive and cognitive strategies employed by those suffering from addictions and how these either promote or hinder recovery.
Michael Benn is a clinical psychologist presently working in private practice in Johannesburg. He works mainly psycho-dynamically with people struggling with: addictions, traumas, relationship difficulties, life crises and character pathology. He also runs a support groups for families of people with psychiatric illnesses, as well as an organisation called BRO, that offers support for people affected by cancer. Benn has an interest in qualitative research, particularly concerning the psychological affects of trauma, violent crime and racism in the South African context. He also supervises new training psychologists.

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HEROIN USE DISORDER INTERVENTION WITHIN THE SOUTH AFRICAN CONTEXT


