

Many people who are experiencing drug and alcohol problems prefer to tackle their problems themselves, using treatment services as a last resort. Why don't we acknowledge this and use health promotion and treatment planning to actively support self-change and empowerment?, asks Anthony Hewitt.

Tier Zero

➤ If a DAAT has managed to establish that there are 5,000 problem drug or alcohol users in their area, does that mean they need 5,000 treatment places? No, it does not, and it never will.

Our beliefs as drug and alcohol workers about addiction and dependency are heavily influenced by our work experience: it takes years of struggle; considerable resources are required; abstinence is the only safe end-option, etc. But as we often forget, the reality is that we only see the tip of the iceberg, and it would be a mistake to think that we can develop an understanding of substance misuse problems based only on what we see presenting to services.

The fact is, most people (research shows as many as 50 to 80 per cent) who experience significant problems with drugs or alcohol (or for that matter eating, gambling, smoking) manage to get on top of these problems without professional help from either drug or alcohol services or self-help groups.

Natural recovery, spontaneous remission, self-change: there are many terms used in relation to this phenomenon – but what are its implications? What can we learn from the studies of those who managed to overcome their problem without specialist help?

Much of the research in this area asks why people

didn't seek specialist help, and there is clearly much we can learn from this to improve take-up of services, particularly for groups such as stimulant users and ethnic minority users who could benefit from services but do not appear to be taking them up.

Reasons for people not seeking help include: the stigma associated with being labelled; belief that the need the person has does not match the services on offer; and the conclusion that they would rather handle their problems on their own.

Self-recovery offers a number of immediate benefits. There is less cost, less disruption to the person's life, and less addict identity and stigma.



They can gain an increased sense of self-efficacy and a feeling of individual empowerment.

Interestingly, self-change may be more common among women than men, and there may also be differences between cultures. Natural recovery from alcohol problems also seems to be more difficult than that from illicit drugs, probably due to the ready availability of alcohol.

In general, the more severe and complex the addiction, the more professional help may be needed. But self-change is possible and can and does occur with any kind or level of addiction.

Much self-change does not result in abstinence,

but can result in sustained, long-term, controlled usage without apparent problems – a different scenario to that offered by many treatment settings and self-help groups. This finding has caused a great deal of controversy in some countries (particularly North America), where it challenges prevailing ideologies on the nature of addiction.

Related to this point, research also indicates that there are broadly two groups (among dependent users) who cease problem use. The first – who we tend to see more in treatment – tend to have had worse problems for longer, regain control at a later age and tend towards ultimate abstinence. The second generally had less severe problems over a smaller length of time, managed without specialist help, overcame their problems at a younger age, and tend not to be abstinent. This reinforces the view that interventions aimed at controlled usage are less likely to succeed for those with a severe dependence, who may need to be supported more towards abstinence.

Research broadly suggests the more severe the problem, the more intensive the intervention that may be needed, supporting the concept of Stepped Care. When considering incorporating self-directed change at the strategic planning stage in relation to drug or alcohol problems, there are several principles to bear in mind: interventions should be the minimum necessary to accomplish the aim; they should be evidence-based, individualised, and acceptable to the consumer.

This perspective supports a range of processes used for managing drug and alcohol problems, from self-change, to assisted self-change (such as bibliotherapy or internet-based interventions), to guided self-change with brief interventions, to more intensive out-patient and inpatient treatment and care. An alternative view is that all recovery is essentially ‘natural recovery’ and that the role of treatment is to support this process – and indeed, that this is all treatment can hope to do.

This would imply that in the first instance people should try and manage their problem themselves, without recourse to professionals or specialists, which is what happens in practice for many people. But is there a role for professionals that can encourage and support this process of self-change without undermining it?

The Motivational Interviewing Cycle of Change grew from research with both the treatment and non-treatment population, which aimed to understand the process of change for all people. The beginning of this process is the moving of the person from pre-contemplation to contemplation; research with both treatment and non-treatment populations consistently points to a process of cognitive appraisal of the pros and cons of continuing a behaviour as being at the heart of most people’s change attempts.

The drug and alcohol fields have done much to make use of this knowledge in developing the role and ability of non-specialists (such as GPs) in encouraging people to become more aware of the impact of their use of drugs and alcohol. But is

there more that can be done?

One important intervention that supports self-change, is to develop the social climate that sustains it. Societal beliefs about addiction are powerful, but these can be changed. These beliefs influence individual attitudes about what is possible,

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both within treatment and without. Crucially, the biggest factor associated with maintaining recovery is social support, particularly from friends and family, and expectations will also affect this support.

There have been health promotion campaigns in Switzerland and Canada that have been successful, both in increasing awareness of the potential for self-change, and in directly supporting that change by promoting contemplation. They have provided avenues to access relevant materials either on the internet or in book form, and have been shown to be highly cost-effective.

For example in Switzerland there has been a 1997 drugs campaign based on self-efficacy, a 1999 alcohol campaign based on stages of change, and an internet-based 1999/2000 tobacco campaign on significant life events triggering the decision to change smoking habits. An example from the 1999 campaign was a series of TV adverts with minor mishaps related to drinking (eg a woman about to accidentally go in to the men’s toilet), asking the question ‘everything under control?’

The scale of problems with drugs and alcohol means that even at the problematic end, most people manage without specialist services. But there is much that can be done with health promotion campaigns to support and trigger change earlier and more effectively than otherwise may happen.

There are considerable benefits in including the potential for self-change in our planning around drug and alcohol problems at both the local and national level – which ultimately may lead to better focusing of the resources and efforts of drug treatment providers.

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