THE DOME MODEL IN MANAGEMENT OF ADDICTION

Major Modalities in the Treatment of Drug Abuse (Brill Ed.)
New York: Behavioral Publications
(1973)

I INTRODUCTION

The presence of a stable addict population in a neighborhood represents a visible fraction of a complex and deeply rooted sociopath logical phenomenon saturating the entire area. In these terms, addiction correlates with numerous factors which can be identified with ease: Individual psychopathology, detrimental family climate, educational inadequacies, racial and economic class tensions, bureaucratic incompetence and corruption, war, unequal law enforcement, local tolerance for deviant behavior, scarce job opportunities. At a local community level the sum total of the impact of these factors account for the flourishing of drug abuse and addiction in endemic and sometimes epidemic proportions. This area of impact I call the psychopathic matrix.

Two major philosophies are followed at present for the management of addiction. One is the individual approach. The other I call the dome approach.

The individual approach strives to isolate, remove and otherwise protect the addict from his environment. Once isolated either by commitment, incarceration, deportation or maintenance, an attempt is made to capacitate him, mainly with vocational skills, so that he can become relatively self-sufficient in an environment which is preferably other than his place of origin. Most of the programs developed in this country fall in this category. The impact of these programs on the overall picture of addiction has been negligible, specially in the area of prevention.

During the last decade I have developed a new modality based on the applications of a systems approach to community mental health. I have chosen the term dome to designate this system.

As the word dome implies, this approach defines a psychopathic matrix as the catchments area for a tight network of prevention, treatment, and rehabilitation services. This network, which encompasses an area defined geographically, culturally and according to the prevailing modes of drug abuse, reduces the problem of addiction to human size. In other words, an endemic community takes care of its on problem within its own geographic and cultural confines.

The dome approach is the subject of this chapter. Its prototype was developed in San Juan, Puerto Rico between 1961 and 1966. In a modification form, several domes were started in New York City between 1966 and 1968 as part of the Addiction Services Agency program and as private programs, such as Odyssey House and Interfaith House. Preliminary planning for a dome has been completed for Middlesex County, New Jersey. Other New Jersey counties as well as Texas, England and Denmark are under study for dome developments.

As a result of the experience accumulated over these years, it is my conviction that the dome approach is the method of choice in the management of endemic and epidemic addiction and drug abuse.

What follows is a composite picture of the basic process of planning and implementing a dome. Due to limitations of space administrative details are omitted. The emphasis is on the clinical aspects. Once the tentative target area has been identified, it has to be more clearly delineated thru network dynamics. I use this term to describe a supervised process of individual and group interactions among volunteers within the target area to achieve several purposes!

a) Perform a survey of the catchments area in qualitative and quantitative terms, by tapping the knowledge of people directly or indirectly affected by the drug problem.

b) Integrate this knowledge into a basic area addiction profile which will serve as a guide for program planning.

c) Investigate the number of programs operating in the area that could conceivably become components of a dome.

d) Assess the level of mutual cooperation among these programs to determine the real real resources available.

e) By extrapolation, determine the new facilities, programs, or program coordination efforts needed to provide an adequate continuum of services.

f) Identify local financial resources or resources in kind available.

g) Determine the minimum outside help needed.

h) Secure this help from donations, grants and contracts with public or private funding sources.

i) Assign operational responsibility.

These functions, developed in a systematic way, provide rewarding task engagements to widely diverse categories of people who are usually available in target neighborhoods. To identify these individuals and to match them to their proper functions, experienced trainers and community developers are needed. As the functional network emerges, short-term enthusiasts are weeded out and more long-range responsible people take over. This core

group, sharing a high degree of awareness and commitment, become the Dome Advisory Council. Some members serve their functions in advising, supporting, sponsoring and launching programs. Others act thru their personal connections to bring people and resources together. Others seek and assume operational responsibilities in new programs. A few become the planners, the executives, the dome godfathers.

Out of this original group - with the help of the experienced trainers -specific subgroups emerge naturally.

Parents groups - clusters of parents and relatives of addicts or drug abusers who meet, not only to support the dome activities, but to get personal training and sometimes treatment for their own problems, which inevitably are related to the problem of their addicted kin.

Neighbors - meeting to learn more about the sociological aspects of addiction and receiving training to improve their own homes, social groups and work settings.

Employers - people with available job opportunities, trained to assess the risks in employing rehabilitated ex-addicts, working closely with the re-entry program and the ex-addict certification board.

Sponsors- individuals and agencies both private and public who are willing and able to help provide a stable financial setting for the dome operations.

Ex-addict Certification Board - a group of professional and non-professionals who, utilizing established criteria such as the ones developed by the Addiction Services Agency of New York, will evaluate the individual ex-addict in his rehabilitation process.

Juvenile evaluation and prevention teams - operating as a roving team or out of a youth center, providing early diagnosis of pre-addiction character disorders and preventive activities based on group confrontation.

Educational teams - providing up to date, non-sensational information about addictions not only in its pharmacological aspects but covering legal, moral and sociological considerations.

Training team - providing structural training in the skills of attitudinal confrontation within the encounter setting for members of the above teams, attitudinal confrontation skills training evolved from my efforts to expose non-addicts to the process of group-encounter used in rehabilitation. The intensity of the experience had to be toned down to the heightened sensitivity of the non-psychopathic individual, and the process itself had to be broken down in a number of discreet, sequential steps leading the trainee to a state of mind amenable to the encounter experience.

These groupings do not exhaust the possibilities - each target area will probably find variations to this scheme. In spite of local variations, the essential purpose of laying an effective community-wide foundation is served if the different subgroups are actually linked - either by interlocking memberships and/or an encompassing concept based on the principles of division of labor.

Once this dome foundation network is achieved, after weeks or months of organizational and training work, the readiness for programs reaches a high pitch which has to be responded to. Otherwise, enthusiasm falters and the project stagnates.

The most effective catalyst to advance the dome development to the stage of induction is the importation of a re-entry crew. Re-entry candidates, ex-addicts who have had an intensive personal experience in induction and treatment programs, are deployed either in a special re-entry residence or re-entry apartments within the dome area. Therapeutic, educational, and training activities are continued for them as a group. Simultaneously and according to their level of maturity and skills, they are employed in a variety of jobs that will provide the backbone of the dome system. Job assignment is reviewed by the dome certification board, for the purpose of standardizing job requirements and following the progress of individual candidates.

Level V candidates, functioning at the most advanced levels of the re-entry process, are capable of assuming executive responsibility in several dome programs: community orientation centers, day-treatment facilities, detoxification services, induction communities, therapeutic communities, prevention teams, d Level IV candidates - serve as assistants to Level V candidates, undergoing, at the same time, apprenticeship experience.

Level III - capable of line responsibilities in the different programs.

Levels II and I - operate as induction aides, working in day treatment centers and detoxification wards, stimulating the raw-addict to progress thru these stages.

In all cases, whether the re-entry candidate operates as an executive, or as a staff member, his maximum performance is achieved as a team component contributing invaluable skills and experience to the various professionals in the programs and at the same time benefiting from their technical supervision. This essential professional para-professional integration is enhanced when a staff encounter becomes standard program procedure.

The actual induction phase of the dome system provides a ladder of progressively more demanding training experiences for the average street addict. The goal of induction is to train a raw, basically unmotivated an addict into/motivated, voluntarily committed candidate for a therapeutic community. If this training process fails, the addict then has to be shunted to the other treatment modalities which do not require voluntary commitment to therapeutic community. Religious programs, individual and group out-patient follow up, sheltered work shops, chemical maintenance and even civil commitment and incarceration for desperate cases must be provided, but only after an adequate trial at drug-free psych-social rehabilitation has proven the patient to be refractory to it. About three-fourths of the street addicts will respond favorably to induction if given an adequate trial.

This trial starts actually as a result of the preliminary ground work described previously. Inevitably, the addict subculture grapevine spreads the word that "something is happening". This generates positive interest in at least a few of the neighborhood addicts, especially if they are acquainted with some of the re-entry candidates. If re-entry candidates from the neighborhood are employed, the ripple effect is dramatic.

The first visible component of the induction phase is a recruitment center manned by ex-addicts (Levels Iv and V, usually). This center, which could be an isolated storefront, a part of a multi- service community addiction orientation center, or a facility attached to a day-treatment center, a therapeutic community or a re-entry house, provides the door to the program. Addicts come, out of curiosity or necessity and are bluntly confronted about their addiction. In my experience over the past six years, one out of two addicts so confronted become engaged in the induction process immediately. This means that they keep coming and gradually accept a few basic principles:

a. that they have defective characters
b. that they want to be straight if they only knew how
c. that they need help but they have to earn it
d. that addiction is curable until they prove otherwise
e. that no one wants them to be a square, but rather the purpose of rehabilitation is to become creative, self-sufficient agent of social change.

The acceptance of these concepts as the basis for long-range rehabilitation is further reinforced in a day-treatment center where incidentally most addicts gradually cut down daily drug use until they can kick completely. This reinforcement is achieved thru several program features:

a. more prolong*treatment time - from early morning to late afternoon or evening.
b. integrated profession - non-professional staff.
c. larger dynamic - up to 50 patients versus 8 - 12 in a storefront
d. status achieved thru the privilege of being admitted, to a stage closer

to therapeutic community.

For those addicts who cannot kick the habit in the day-treatment center, admission is arranged at a regular detoxification ward. The standard detoxification regime (gradually diminishing oral methadone plus supportive medical services) is enriched by regular orientation and/"floor" encounters by Level I and II re-entry candidates.

Selected patients from day-treatment centers and detoxification wards, with an occasional outstanding storefront graduate, are admitted to the next facility, an induction community. This is usually a small program in a hospital annex, 14 - 40 beds and with separate facilities for each sex. This is a trial run in which the patient spends the first 60 to 90 post--detoxification days learning the mode of life that prevails in a therapeutic community. This induction community is run entirely by trained ex-addicts (Levels III, IV kk and V). The voluntary commitment is reinforced and reinstated. In my experience, preliminary stay in induction community increases the "take" into therapeutic community considerably.

As soon as a core of about 10 properly inducted individuals is ready, a therapeutic community can be started. Ideally, this should be housed in an independent building with capacity for at least 25 residents and with a maximum of about 80. The programs become co-ed for the first time. The house director is a level V or post re-entry former addict assisted by a deputy director for operations and a deputy director^ for female services. A complement of department heads, expediters and supervisors, ideally re-entry candidates level III but initially the most advanced residents, complete the full-time staff. Professionals are integrated into the operation at part-time level.

The placing of a treatment residence in a neighborhood with a high addiction rate will provide the untreated street addict a firsthand observation of the possibility of his own rehabilitation. The living example of the rehabilitated addict will help him overcome his own self-defeating attitude towards his future, Furthermore, the house residents also benefits from the assurance and confidence that comes from the awareness of the higher social status of his new life style.

Normally, the resident addict will not relapse although he knows that drugs are close at hand. His new-found control re-enforced by his fellow residents will prove a strong foundation in the long road to rehabilitation. At random times, throughout the program, a urine analysis is done to verify that the patient is in effect free from drugs.

The residential community lends itself to a functional integration of a staff made up by professionals and non-professionals. The staff should include a medical doctor, a psychiatrist, social workers and occupational therapists and rehabilitated former addicts. The latter serve as role models, direct supervisors and counselors for the new residents.

By definition, most addicts have been deprived of, or have given up the practice of social skills. Most of them function for the first time as members of a positive society in the residential community. Having the resident participate actively in house government is the best/way to practice these skills. The resident will first identify with the role model, whom he understands, having been like him, an addict. He respects the ex-addict/ because the status the role models enjoy have been their own achievement. In addition, the resident, who is a role model, will be skilled in reaching the addict through the techniques of attitudinal confrontation as practiced in an existential encounter.

The existential encounter techniques offer the resident effective ways of exploring his attitudes and behavior as well as constructive vents for his feelings of hostility and frustration. This procedure is not a psychoanalytical approach to the patient's emotions, but a form of the group experience which emphasizes character logical growth through attitudinal re-orientation, on a here-and-now setting.

In the commune, it becomes the responsibility of each member to see to the enforcement of democratically accepted house rules. Violations of the basic rules of no violence and no drugs will not be tolerated and total participation by the resident in assigned work and group encounters is mandatory. Penalties determined by the director may be severe I a resident may be ousted for repeated infractions. He may be demoted from his job; he may be placed on restricted privileges. A group consensus will be sough as to what sanctions correspond to the level of his faulty behavior.

The community life is so structured that all activities contribute to the common goal of character re-orientation. The day starts with a morning meeting after breakfast which may consist of a report of communal activities or the announcement of a coming visitor. These meetings, usually having humorous moments, contribute to the natural "high" from which the resident draws motivation to work thru his day.

The basic therapeutic activity of the community is the peer encounter, a group session which engages from 8 to 12HK members in an intense verbal confrontation. Emotional outbursts are not rare, and are in fact encouraged. Members of the group confront each other with the consequences of their individual behavior, attitudes, and emotions in an effort to make *it* each member accept responsibility for his own life. Emphasis is placed on the daily behavior of the addict in the community and through the observation of, and confrontation with his day-to—day functions. "Street" patterns of relating are gradually substituted by a' new attitudes of acceptance of responsibility, concern, awareness of community living, and tolerance of unavoidable reality.

Peer encounters are arranged according to the participant's particular degree of maturity and responsibility. The same group rarely meets twice, as members are changed regularly by the director to avoid protective "contracts". Interpersonal hostility between residents is deliberately worked out through groupings of those involved.

The resident is constantly confronted in groups on his total behavior. Antisocial, self-defeating and immature behavior is quickly pointed out by the group and while the encountered members may try to rationalize, he will find that honesty is his only way out, for the group will not accept anything else. As soon as the resident is free from his pretenses, he will start to develop a realistic picture of his own personality, will become uncomfortably aware of his limitations, and with the consistent help of his fellow residents, will start growing into a better integrated individual.

One way of achieving this is by the "acting as if" behavior. The addict is asked by the group to "act as if" he enjoys his chores, "as if" he were a neat person, for example. This conditioning process is guided by such values as are democratically accepted by the total population of the house, including professional staff and active participants of the neighboring society.

There are several variations of the encounter form floor encounters, tutorial encounters, staff encounters, special encounters, individual or small group confrontation, mixed staff-resident encounters, family network encounters, resident-square encounters.

Floor encounter - groups led by experienced residents to train newcomers in the skills of attitudinal confrontation within the encounter setting.

Tutorial encounter - therapeutic groups lead by people experienced in group psychotherapeutic processes.

Staff encounter - task-oriented encounters among staff members where personal problems are dealt with if they interfere with the smooth functioning of the staff as a team.

Special encounter - called by any member of the community to clarify issues and deal with special situations and emergencies.

Individual and small group confrontation - spontaneous encounters happening in the course of normal activities as a method to deal with behavior on the spot without having to "save it" for the regular encounter.

Mixed staff-resident encounter - sessions where residents have an opportunity to encounter staff with their own indictments and feelings.

Family network encounter - in which a resident usually accompanied by a staff member confronts a group of his relatives for the purpose of re-stablishing productive relationships.

Resident-square/ encounters for advanced residents prior to re—entry to start dealing with interaction problems with non-en-addicts.

After an encounter is over, the participants "decompress" by gathering socially and informally. People are "put together", accepted and supported. Attitudinal change is a painful process and healing is enhanced by community support. unavoidable reality.

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community.

Community spirit is further reinforced by the economic contributions of each member toward the operating expenses of the house. This may be done through the pooling of the residents' welfare stipends and other personal income. Each member then receives a small amount of pocket money every week, depending on his progress.

An education program involves the resident in seminars and lectures which may include topics such as personality structure or development, or basic psychology. The individual seminar is a talk given by the resident on a subject he himself chooses. The concept seminar is designed to stimulate conceptual thinking and expression. It is free discussion on a literary, religious, philosophical or psychological subject, and participants are asked to offer interpretations. In the impromptu-speaking seminar a participant is given a topic for a small talk after which the residents may offer constructive criticism. Another type of seminar is a debate where two teams are assigned the positive and negative sides of an argument.

House residents are periodically evaluated to ascertain their progress and records are kept. This record will accompany the member when he completes the community house program and advances to the re-entry house for the final stages of his rehabilitation. These records will be transferred to the Certification Board which will assume responsibility of evaluating the therapeutic community graduate in a long-range basis.

The majority of individuals rehabilitated through this system choose in to become engaged in some aspect of the people's business. As time goes by, and the value of the well-trained former addict as a lay therapist is firmly established, job opportunities in a wide variety of fields become available. There is increasing demand for planning consultants, trainers, counselors, lecturers, community workers, school prevention workers, therapeutic assistants for private practitioners, etc. Eventually, as criteria for experience requirements, training and supervised on-the-job performance become standardized, official recognition of semi-professional and professional status will be requested from the appropriate Government licensing authorities.

Other individuals, after the required re-entry experience, choose to go into careers not related to rehabilitation and prevention work. A variety of specially tailored, educational and vocational plans are required at this point. A movement to incorporate all rehabilitated ex-addicts into a member— ship corporation has already been started. This corporation will be run by ex-addicts for the express purpose of influencing legislation, raising funds for programs, establishing criteria for recovery, and more important, to keep

long-range contact with dome graduates. This contact will serve as the most reliable source of data for program evaluation and, at the same time, provide reliable criteria to allow the beneficiaries of the program to improve and perfect it.