Application of the Minnesota/Medical Model : An Approach to Substance Abuse Treatment of Deaf and Hard of Hearing Individuals

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Abstract

This article discusses the principles of the Minnesota/Medical model as utilized in work with clients at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. A case study is used to demonstrate the application of an effective approach to providing chemical dependency treatment to deaf and hard of hearing individuals. Prior to the case presentation, background information about substance abuse and the medical model will be provided.

Introduction

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals opened in 1989. It was designed to provide a comprehensive treatment program that was accessible and able to meet the communication and cultural needs of deaf and hard of hearing people in treatment. The Minnesota Program has served over 700 clients from 48 states and 4 provinces in Canada. The Minnesota Program is based on the Minnesota/Medical model of treatment which is abstinence based and uses the principles of Alcoholics Anonymous. A case study will be presented demonstrating the application of this model when providing treatment to Deaf and hard of hearing individuals. Prior to the case presentation, background information about treatment models is provided.

Treatment Models

Chemical dependency treatment programs use a variety of models to determine how the problems of substance abuse will be addressed. Some of the more commonly used models view chemical dependency in the following ways. The moral model relies on the belief that chemical

dependency results from a moral weakness or lack of willpower. The learning model sees chemical dependency is the result of maladaptive habits. The self medication model considers chemical dependency as a symptom of another primary mental disorder. In the social model, chemical dependency results from environmental, cultural, social, peer or family influences. In the dual diagnosis model, a chemical dependency diagnosis is accompanied by an Axis I or psychiatric diagnosis. The disease model describes addiction as an illness which progresses in ever worsening stages to death unless there is a therapeutic intervention.

Deaf and hard of hearing individuals have participated in mainstreamed treatment programs around the country that use a variety of substance abuse models. Because there is a lack of research focusing on treatment for deaf and hard of hearing persons, it is unclear which model is most effective with this population. A study done by Guthmann (1996) discussing outcome data from clients who completed the Minnesota program, which utilizes the Disease Model of treatment, is the only research completed on the use of a particular model with Deaf and hard of hearing persons.

The disease model, also referred to as the Medical or Minnesota model**,** is abstinence based and uses the principles of Alcoholics Anonymous. The Program clients participate in individual and group counseling, therapeutic work assignments, family counseling, lectures, Twelve Step meetings and a variety of other activities. As previously mentioned, this model views alcoholism as a progressive, irreversible disease characterized primarily by denial of a problem and a loss of control over drinking. The disease is thought to be influenced by many factors including genetics, environment and social factors. Without intervention, the disease is progressive and fatal.

A basic belief of the disease concept is that the alcoholic is biologically different from the non-alcoholic person. The alcoholic, it is felt, can never safely drink any alcohol. In the disease concept, the person is viewed as unable to control drinking as opposed to unwilling or weak.. Although the individual is not blamed for his/her disease, he/she is thought to be responsible for behavior. We do not blame diabetics for their diabetes but we expect them to control their diet and take medication. The alcoholic is seen to have responsibility for managing the disease on a day to day basis. Alcoholics Anonymous is very closely linked with this model of alcoholism.

In this model, a diagnosis is made by the alcoholic or chemically dependent person with the help of an interdisciplinary team of physicians, nurses, counselors, and psychologists. Once diagnosed, this disease is regarded as always present; there is no cure. Without abstinence the disease is regarded as progressive and eventually fatal. Standard treatment includes medically supervised detoxification, education, group therapy and a drug/alcohol free living environment. Typical programs have traditionally been 28 days in length although the Minnesota Program utilizes a 40 day length of stay when funding is available. The Program has found that the Deaf and hard of hearing clients who enter treatment have limited knowledge of alcohol and other drugs, little support and minimal intervention, and need a longer treatment stay. The substance abuser or alcoholic is guided in developing a positive identification as a recovering addict or alcoholic who is powerless over alcohol and other drugs. In recovery, the addict is asked to adopt new behaviors and to access support by to Alcoholics Anonymous or other Twelve Step

meetings. Family education and therapy are designed to address issues of enabling by family and significant others.

The Minnesota/Medical model has a number of advantages. It is neither punitive nor blaming in its approach and stresses the importance of seeking treatment and help. Blame is directed toward the disease rather than toward the person. Guilt is alleviated because people are not held responsible for developing the disease any more than they would be for developing diabetes. The emphasis is on self-care. Another advantage is the clear focus on chemical dependency as a problem to be treated in its own right.

One disadvantage of this model is its inability to account for alcoholics who return to non-abusive drinking. These people tend to be less impacted by alcohol use in terms of intensity of associated problems and duration of use. These people tend to be younger and do not regard themselves as having a disease. Another disadvantage is that some practitioners may fail to recognize or appreciate coexisting psychopathology. For example, many if not most alcoholics experience symptoms of depression during the first year of abstinence. It may in fact be a part of recovery. Normalizing symptoms of depression and attributing them to the alcoholism may cause a coexisting major depression to go undiagnosed and untreated.

Many treatment program who subscribe to this model do not follow it strictly and incorporate aspects of other models when to do so is helpful to the clients recovery. The Minnesota Program is one of those programs. It is based on a medical model, but also uses approaches from other models to meet the needs of individual clients. For example, many clients are provided education and skills training in relapse prevention, an offering not typically part of this model. The model also talks almost exclusively about alcohol and alcohol use but is typically broadened in practice to include the use of other drugs as well. Consideration for dual diagnoses(co-existing psychopatholgy) is also incorporated into the treatment process at the Program. In some other settings, the ability to diagnose co-existing psychopathology may be impaired by communication barriers**.**

Utilizing the information about the Minnesota/Disease Model and the Minnesota Program, a case study will be presented through which some key treatment concepts and principles will be illustrated.

Case Presentation

Mary was referred to treatment by a social worker with whom she had been working. Marys family was also concerned about her use and the associated problems. She is single, never married, and twenty-seven years of age. She comes from a hearing family where she is the middle child of three, with one brother and one sister. Mary attended a public school program during the elementary grades and transferred to the School for the Deaf in 7th grade. She graduated from high school and attended college for a while but eventually withdrew. Mary has had numerous jobs but was unable to keep a job for an extended period of time. Mary was living in an apartment after leaving college but has recently moved back in with her parents.

When Mary was admitted to the program, she stated that she had used marijuana, cocaine, LSD and alcohol. Mary identifies alcohol as her drug of choice and states that she uses alcohol nearly everyday. She states that she smoke marijuana occasionally, most often on weekends. She experimented with LSD while she was in college but no longer uses it. She admits to periodic cocaine use at parties. Mary was monitored for medical concerns including any symptoms of withdrawal. She was given Ativan to assist with the withdrawal from alcohol.

Phase I - Evaluation

The admission process also involves collecting information including a physical examination, a social history, a drug use history and any history of previous mental health or chemical dependency treatment. Mary is asked to complete a Drug Chart assignment in which she identifies all the drugs she has used, describes her last use prior to entering treatment and explains consequences of her use in major life areas. Mary is asked to do this work in drawing and is asked to draw 5 to 7 pictures in each of the consequence areas (physical, financial, legal, family, social, job/school and monetary. Once Mary completes this assignment, she presents the work in a group consisting of peers and staff. This information is used to diagnose the extent of Marys alcohol/other drug problem and to make recommendations for ongoing services. This activity also helps Mary begin recognizing the extent of her use and how her use of chemicals has negatively impacted her life. Mary begins to form relationships with other deaf people in her treatment group and starts to see that others have similar kinds of problems**.**

In her drug chart presentation, Mary disclosed the following information. Mary stated she had used marijuana, alcohol, LSD and cocaine. She reported that her last use was the day prior to her admission to treatment. Mary's physical consequences included hangovers, blackouts, poor self care/hygiene, acquiring a sexually transmitted disease and losing weight. In family consequences, Mary reports fighting with family members, not being allowed at her brothers home, missed family activities, not being allowed to babysit for her sister and a lack of trust from her parents. Under financial consequences, Mary disclosed that she did not pay her rent, that she owed money for other bills, borrowing money from family and friends and not paying it back and a depleted savings account. Mary reports legal consequences that include the police breaking up a party, speeding, being stopped while she was drunk, unpaid tickets and nearly being caught for dealing. With regard to job/school consequences, Mary reports having withdrawn from college, being suspended from high school, quitting jobs and having her vocational rehabilitation case closed. Mary's social consequences include losing friends, experiencing problems at the Deaf Club, friends who take advantage of her and embarrassing friends by her behavior.

Phase II - Primary Treatment

Upon completion of this evaluation phase, Mary is referred to the treatment phase based on the following criteria: need for increase amounts of the substance to achieve desired effects; substance is taken to relieve or avoid withdrawal symptoms; substance is taken in larger amounts or over a longer period of time than intended; persistent desire/unsuccessful efforts to cut down or control substance use; time spent in activities necessary to obtain the substance or recover from its effects; important occupational, social or recreational activities given up or reduced because of substance use; and continued use despite the knowledge of negative consequences.

Upon referral to treatment, a master treatment plan was developed with Mary and based on input from the multi-disciplinary team that included problems of chemical dependency, ineffective coping skills and grief/loss issues. These three problem areas represent the focus of treatment efforts and patient assignments.

Mary would begin her treatment work with Step One of the Twelve Step program of Alcoholics Anonymous. This Step says, *We admitted we were powerless over alcohol and drugs and that our lives had become unmanageable*. Mary would be asked to focus her work around two key concepts of the first step; powerlessness and unmanageability. Because written English may pose a barrier in completing a Step One assignment, Mary is asked to complete her assignment through the use of drawing. She is asked to draw pictures of how her life was unmanageable due to her use of chemicals. Her examples of unmanageability might include stealing from her parents, and dropping out of college. She is also asked to draw pictures of how she was powerless over alcohol and other drugs. Some of her examples of powerlessness might be previous attempts to quit without success or having given up friends in order to continue to use. In addition, Mary is asked to describe how her use has hurt her and others. By presenting her work in group to staff and peers, Mary is accomplishing the part of Step One that refers to admitting a problem. During Mary's presentation of her Step One assignment, her peers will be attending to the information she presents and feelings she exhibits. Peers may ask questions during her presentation to clarify the information she provides. After Mary has completed her presentation, her peers will be invited to give feedback in which they can related by talking about similar experience they have had or similar feelings they have experienced. During Mary's presentation, treatment staff will be looking for indications that Mary is being honest, that she sees the connection between her use and the circumstances of her life and that she recognizes a need for help. If Mary's presentation indicates that she is not ready to admit her problems and a need for help, she may be asked to do more work on whatever aspect of Step One is not clear. If Mary has made progress toward admitting a problem and accepting help, she will be given a Step Two assignment.

During her time in treatment, Mary will be encouraged to seek help from peers and staff. She will be given opportunities to get feedback from her peers. In the treatment process, Mary will be challenged about indications of denial of her problem. In addition to individual therapy and chemical dependency groups, Mary will be referred to groups for other special purposes. She will likely be referred to weekly grief group where she will be given the opportunity to begin identifying and dealing with her experiences of loss. (Grief issues may include the death of family members or friends, loss of the use of chemicals, the loss of relationships and her hearing loss as well as many other losses.) Other possible specialty groups could include womens group, spirituality group and relapse group.

Step Two says *Came to believe that a power greater than ourselves could restore us to sanity*. While the Drug Chart assignment and Step One look back and focus on the problem, Step Two shifts the focus to solutions. Step Two is typically very individualized with regard to what the patients circumstances are and what his/her needs are. Mary will be given a Step Two assignment that is designed to help her develop knowledge and skills that will help her to stay sober. Mary may be offered the opportunity to make some comparisons such as listing people/places to avoid and people/places she can go to for support. She may be asked to identify

goals she has as a sober person, reasons to stay sober, skills she can use in sobriety and/or times she has received help. She may be given the opportunity to journal about feelings on a daily basis and to work on her self esteem by listing positive attributes, accomplishments or skills. A combination of these tasks will likely comprise Mary=s Step Two assignment which she will work on after receiving some education about Step Two.

During Mary's work on Step Two, the treatment team will be observing her behavior as well as her work and Mary will be encouraged to do the same. Staff will be looking to see if Mary is demonstrating a willingness to change and if she is seeking help. She would be expecting to be asking and other patients for one to ones and asking for time in group. Mary would be expected to become more open and share additional information or feelings. She should be more open to feedback and show signs of beginning to trust the program and other people. She would be expected to show an investment in treatment by being on time for activities, completing her work on time and focusing on herself. These indicators, in addition to the assignment work, can help Mary and the staff to measure her progress. Staff members, and possibly her peers, would be giving Mary feedback that helps her to see progress she is making.

Step Three says, *Made a decision to turn our will and our lives over to the care of God as we understood him.* (This Step is written here as it is presented by Alcoholics Anonymous. However, it is presented in treatment in a broader context allowing each person to identify his/her own Higher Power whether that is God or some other entity.) This step is an action step. Mary may be asked to identify a Higher Power and to develop a way of communicating with her Higher Power. Mary might be asked to differentiate between her wants and her needs. She may be asked to look at how her will and Gods(or Higher Powers) will may be different. She may be asked to look back at situations where she has already been cared for by God or her Higher Power. Mary may also be asked to describe what she is willing to do for her sobriety, to gather information from recovering people about Higher Power issues and/or to explore various aspects of spirituality. During Step Three, Mary may also be given the opportunity to explore how aspects of the Serenity Prayer (used in many Twelve Step meetings) apply to her life. For example, she may be asked to identify things she can change and things she cannot change. Frequently, patients will identify high risk situations which they have survived and will attribute that to the care of their Higher Power. Behaviors that Mary would be expected to demonstrate including continuing to seek and accept help, establishing and utilizing good boundaries, continuing to share feelings and experiences and remaining open to feedback.

Step Four says, *Made a searching and fearless moral inventory of ourselves. Step Five says Admitted to God, to ourselves and to another human being the exact nature of our wrongs*. In Steps Four and Five, Mary would be expected to show some leadership and to begin giving back to new peers. Along with making the transition to leaving treatment, she will likely express some fears including fears about relapse and fears about re-entering her life. Mary would be expected to have more insight with and better able to confront threats to her sobriety. She would be dealing with the issue of living as a sober person and continuing to work the Twelve Step Program.

When working on 4th and 5th Step work, Mary would make an extensive list of feelings and experiences from throughout her life. Preparation for these two steps would also be done with the

chaplain. Once she has completed her inventory, Mary would meet with a chaplain to complete Step 5. Following this, she can be offered the opportunity to select some kind of ceremony such as burning the paperwork from her inventory as a way of letting go of the past.

Phase III - Aftercare

Mary would typically be discharged after the completion of her 5th Step. Each patient, however, progresses at his or her own speed. The goal is to complete the first five steps prior to discharge but this is not always possible. Very likely, Mary would be involved in making her aftercare plans with the help and support of staff members. Aftercare recommendations for Mary would consist of getting a sponsor or temporary sponsor, attendance at AA/NA meetings, at least three times a week if possible. She will need to have an interpreter or attend deaf meetings so her attendance will depend on the availability of such meetings. Mary would probably also be recommended to seek counseling to deal with her relationships problems. A relapse prevention group would also be a wonderful resource for Mary.

Conclusion

As previously discussed, the Minnesota/Medical model is one approach that is used when working with chemically dependent individuals. The Minnesota Program uses this philosophy as the foundation for the program. Approaches and assignments are individualized based on client need. In Mary's case example, her chemical use history did include a variety of drugs and alcohol. It is clear that Mary's use is out of control and that it is chronic and progressive. She identified a number of consequences in various life areas including family, financial, legal, job/school and social consequences. Mary was able to work through Steps 1-5 and complete assignments that pertained to each of the steps. Some of the determining factors in Mary's ability to maintain sobriety include her focus on self-care, her participation in aftercare counseling and her involvement in ongoing support such as Alcoholics Anonymous. The road to recovery for Mary and other Deaf and hard of hearing individuals is not easy. There are numerous barriers that may interfere in her desire and ability to stay sober. However, the treatment experience at the Minnesota Program provides Deaf and hard of hearing clients with a foundation for recovery. The use of an established model in combination with modified approaches and an accessible environment provide clients with the opportunity to learn about their disease. They are also given information and skills that can help them change their behavior and practice recovery.

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