ADDICTION RECOVERY AND THE ROLE OF TREATMENT: AN OVERESTIMATED CORRELATION?

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Dept. of Special Needs Education
Addiction and Recovery cluster

OVERVIEW

1. Addiction recovery?!
2. Facts & figures about addiction recovery
3. The role of treatment
4. Natural recovery
5. Some conclusions

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1. ADDICTION RECOVERY?!

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BETTY FORD INSTITUTE CONSENSUS PANEL, 2007

"Recovery from substance dependence is a voluntarily maintained lifestyle, characterized by sobriety, personal health, and citizenship."

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UK DRUG POLICY COMMISSION RECOVERY CONSENSUS GROUP, 2008

"The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use, which maximises health and wellbeing and participation in the rights, roles and responsibilities of society."

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MENTAL HEALTH RECOVERY

Anthony (1993) defined recovery as "*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness*."

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SOME COMMON ELEMENTS

- Not only about stopping or reducing
- Individual process of change/growth
- Personal choice
- Importance of wellbeing/quality of life
- Meaningful activities
- Social participation
- Social support and the community
- Supportive role of treatment

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AT LEAST TWO DIMENSIONS OF RECOVERY

(SLADE ET AL., 2010)

- The first involves clinical recovery – when someone 'recovers' from the illness and no longer experiences its symptoms

- The second involves personal recovery – recovering a life worth living (without necessarily achieving clinical recovery). It is about building a life that is satisfying, fulfilling and enjoyable.

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SOME EVEN SUGGEST FOUR DIMENSIONS
(VAN DER STEL, 2013)

- Clinical recovery
- Personal recovery
- Functional recovery
- Social recovery

- Personal recovery as driving force

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DO PEOPLE PROCEED SIMILARLY REGARDING THESE RECOVERY DIMENSIONS (CASTELEIN ET AL., 2017)?

METHODS

- Data of the annual Pharmacotherapy Monitoring and Outcome Survey (PHAMOUS): 2012-2015

- Selection of data: PANSS-R, Functional Remission-Tool (FR-T) and Single-Item Happiness Question (as a proxy for personal recovery).

Psychotic disorder (99% within schizophrenia spectrum)
Mean age: 43 year
Male/female: 67/33%
Duration of illness: 18 year

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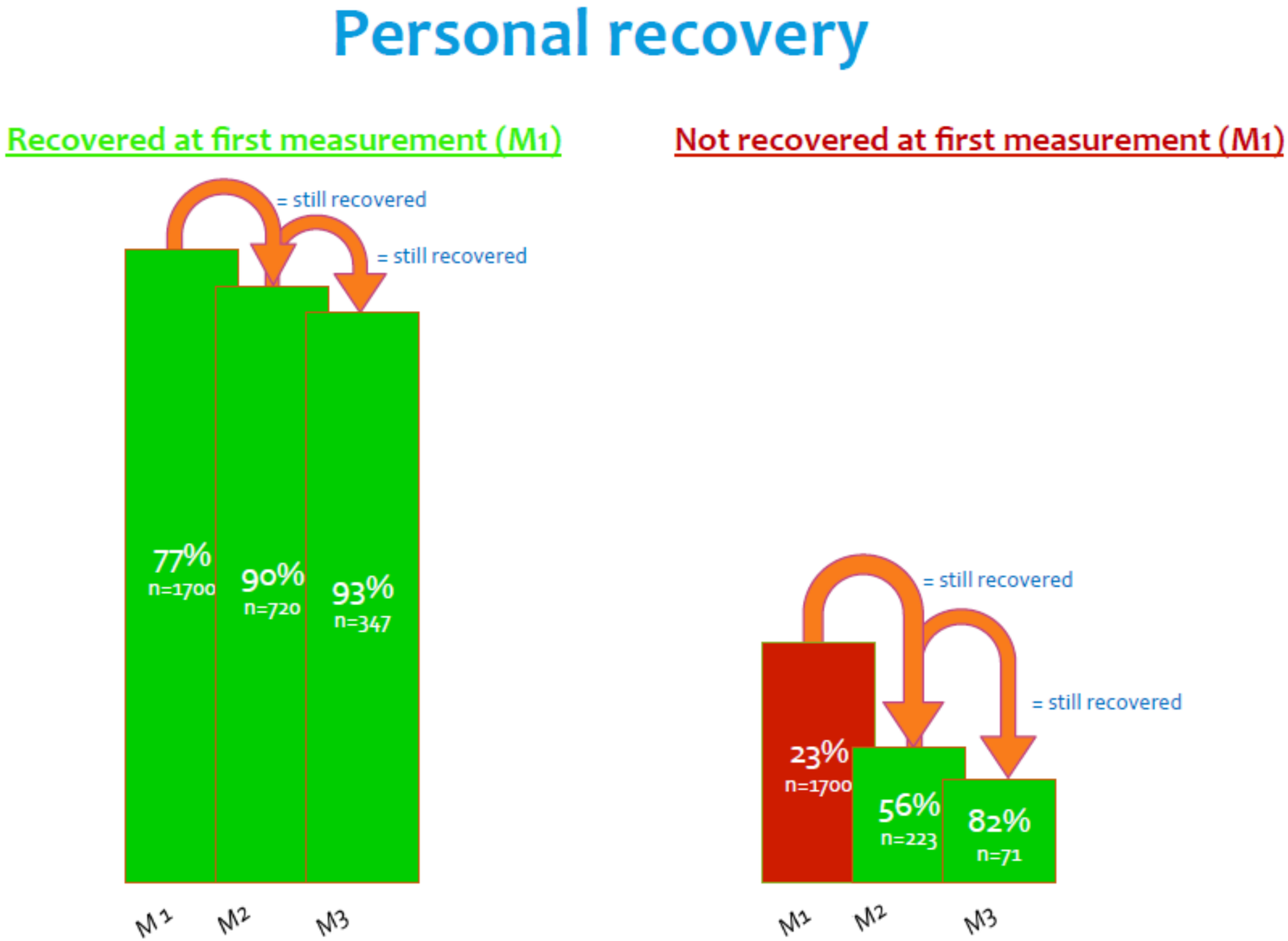
PERSONAL RECOVERY: 77%



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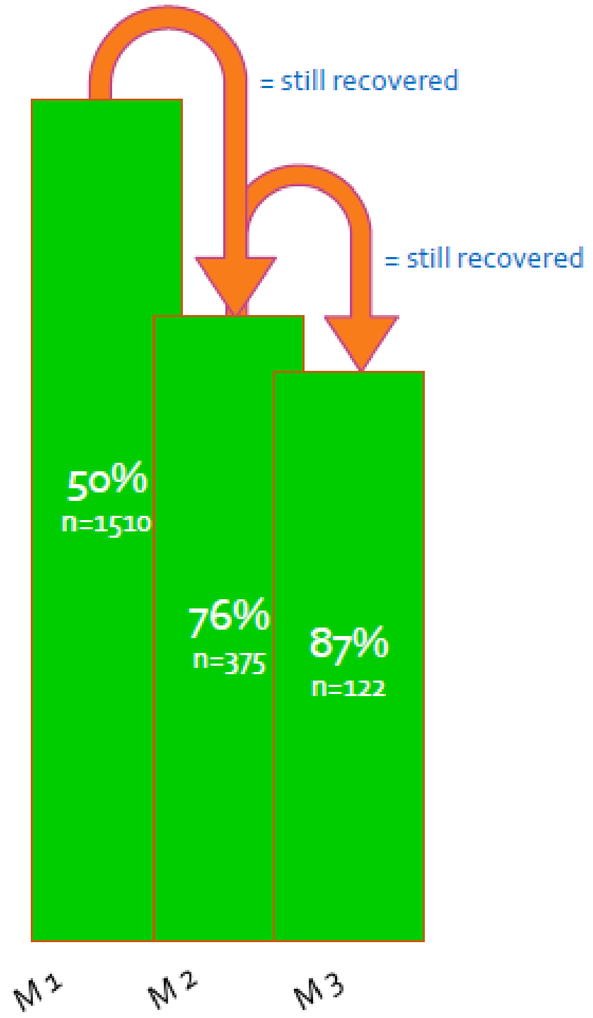
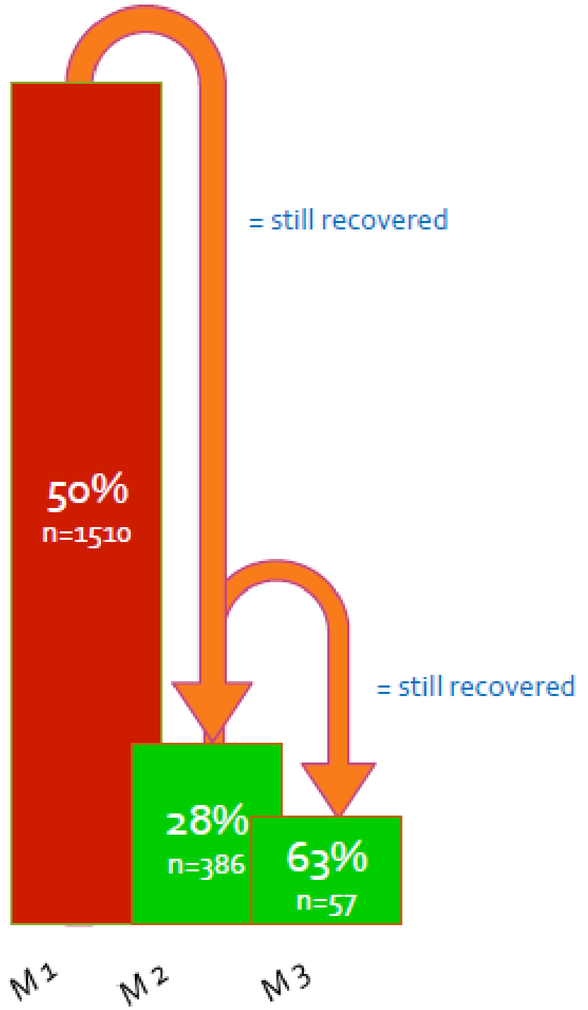
CLINICAL RECOVERY : 50%

Symptomatic recovery

Recovered at the first measurement (=M1)



Not recovered at the first measurment



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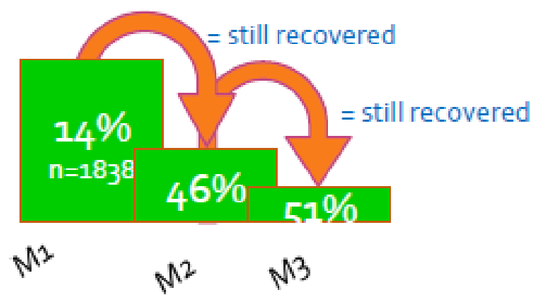
FUNCTIONAL RECOVERY: 14%

Functional remission

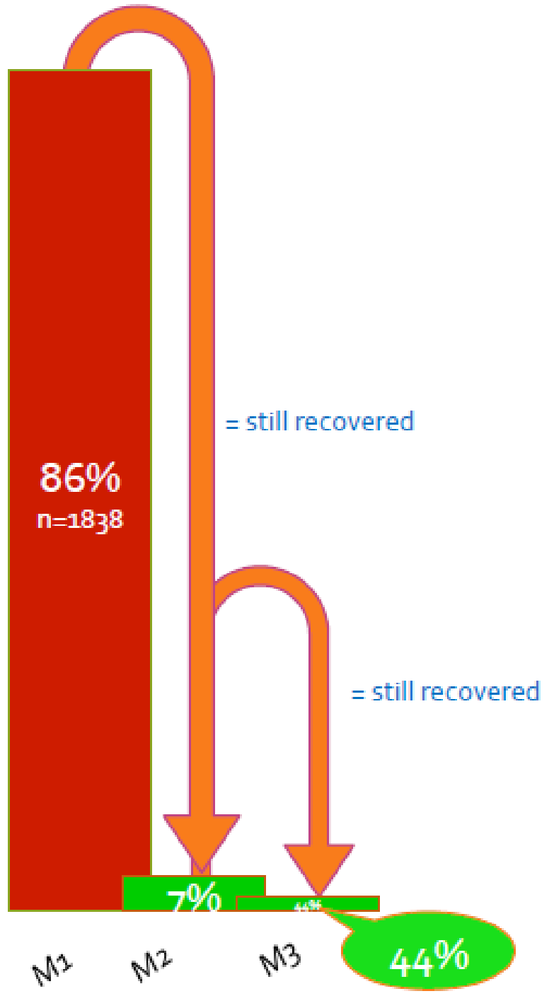
Recovered at first measurement

Reported problems:

Social contacts	55%
Daily living & self-care	61%
Work/study/ housekeeping	83%



Not recovered at first measurement



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2. FACTS AND FIGURES ABOUT RECOVERY

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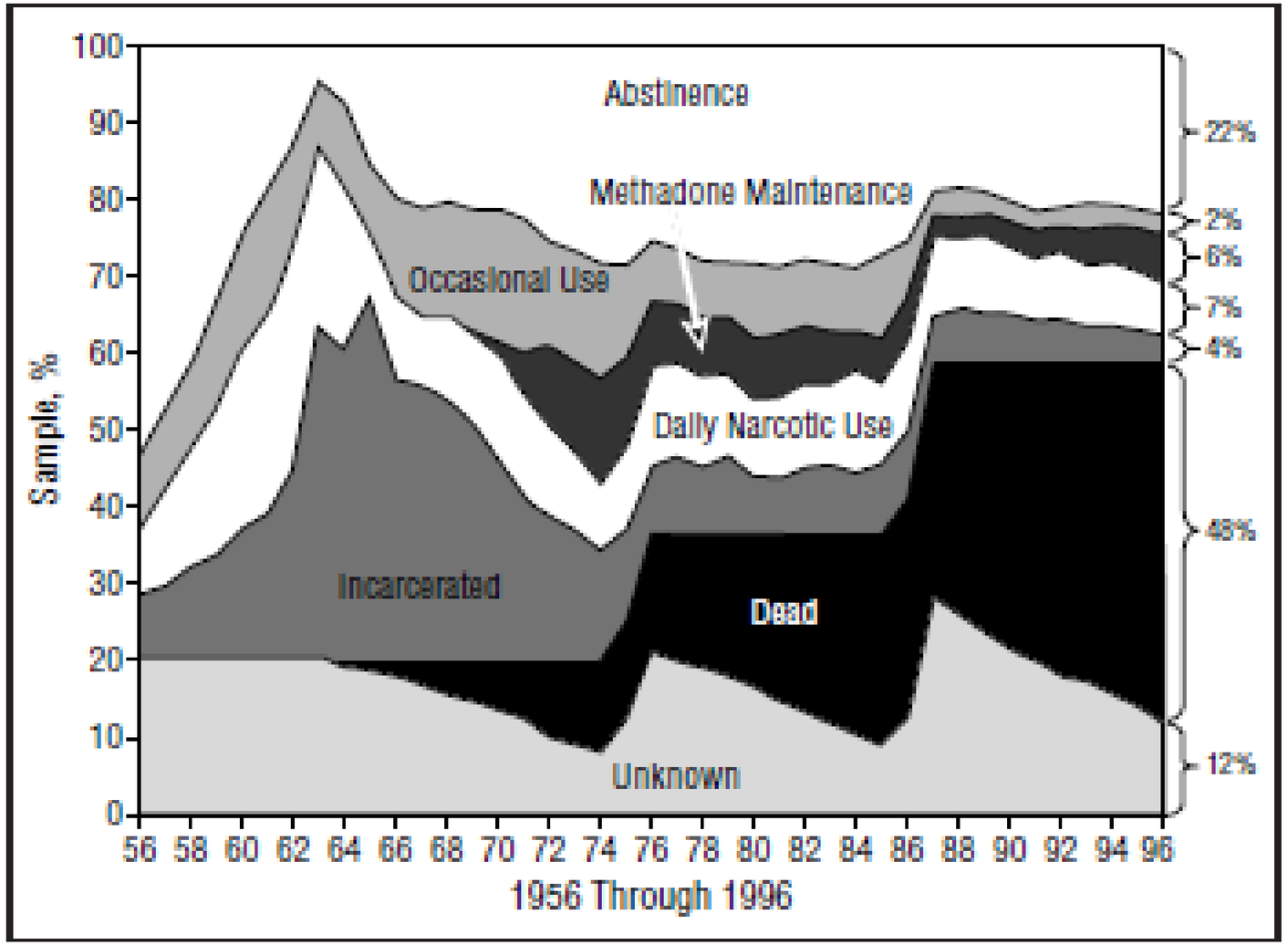
THE NATURAL COURSE OF DRUG ADDICTION (HSER ET AL. 2000)



The natural history of narcotics addiction among a male sample (N=581).

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40 YEARS OF ADDICTION RESEARCH: WHAT DO WE KNOW ABOUT TREATMENT & RECOVERY?

(SCOTT & DENNIS, 2003)

- MOST ADDICTS relapse unless treated early and effectively.
- MOST ADDICTS cycle more than 3 times through periods of untreated addiction, treatment, sobriety, and incarceration
- MOST ADDICTS experience a trajectory for recovery based on genotype *(severity of biological addiction)*
- MOST ADDICTS improve the odds ratio for remaining sober after one year of sobriety
- MOST ADDICTS achieve self-sustainable recovery (low odds ration for relapse) after 5 years of sobriety
- MOST ADDICTS take over 30 years to achieve 5 years of sobriety.

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RECOVERY CLEARLY NOT ONLY ABOUT ABSTINENCE (UKATT, 2005)

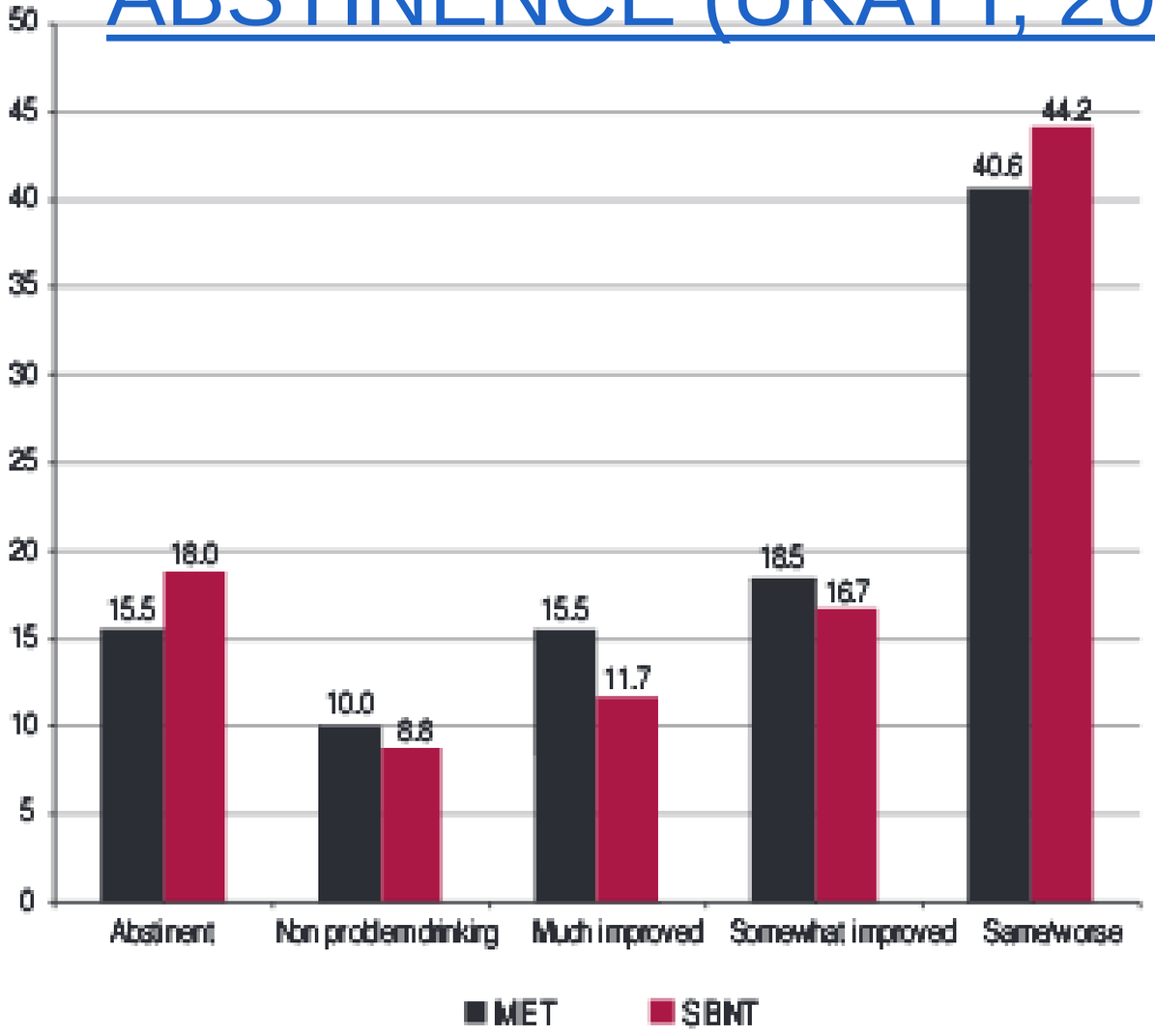

Figure 3c: Categorical treatment outcomes from the UK Alcohol Treatment Trial

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RECOVERY PREVALENCE (BEST ET AL., 2019)

- Sheedy and Whitter (2009): 58% but marked variability (30% - 72%)
- “Clinical fallacy” and worker attitudes

White (2012) reviewed remission rates in a review 415 scientific reports between 1868 and 2011:

- 49.9% of those with a lifetime substance use disorder will eventually achieve stable recovery (increased to 53.9% in studies published since 2000)
- White also argues that between 5.3–15.3% of the adult population of the US are in recovery from a substance use disorder (> 25 million people)

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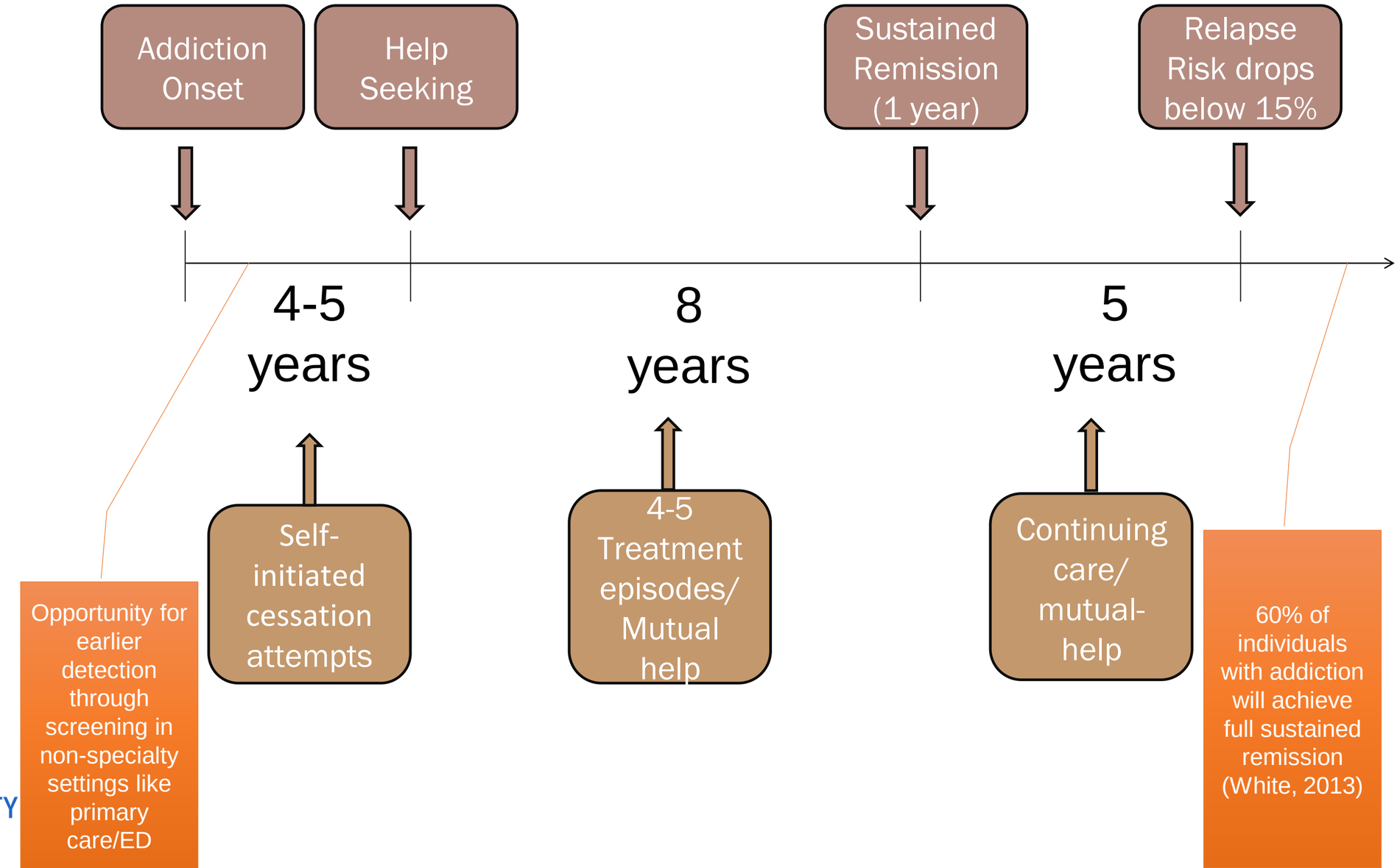
For severely dependent individuals … course of dependence and achievement of stable recovery can take a long time ... (White, 2013)



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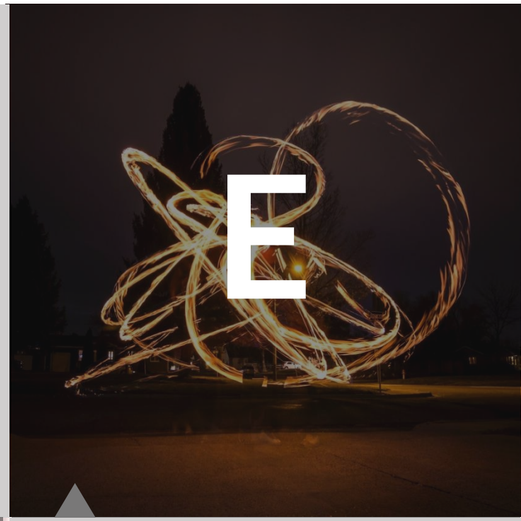
CHIME FRAMEWORK: SUPPORTIVE ELEMENTS FOR PERSONAL RECOVERY

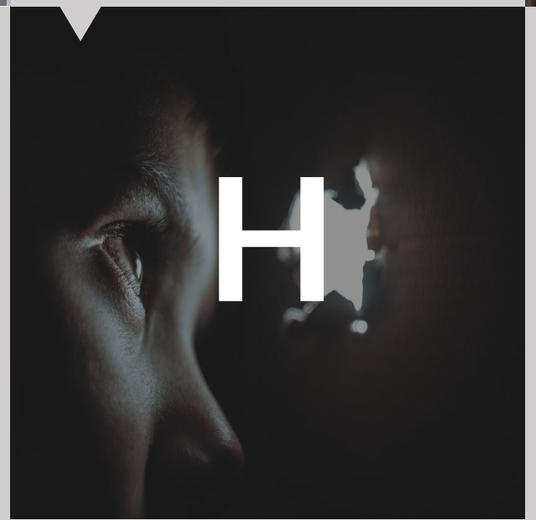
(LEAMY, BIRD, LE BOUTILLIER, WILLIAMS & SLADE, 2011)

HOPE

MEANING



CONNECTEDNESS



IDENTITY

EMPOWERMENT

RECOVERY CAPITAL (BEST AND LAUDET, 2010)

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THE ROLE OF RECOVERY CAPITAL

- Recovery capital is crucial at different stages of the recovery continuum (Best e.a., 2010; Laudet & White, 2008; Best & Laudet, 2010).
  - **Personal recovery capital**: personal characteristics and skills which can be supportive for recovery, such as specific competences, severity of dependence and style of attribution.
  - **Social recovery capital**: includes the social network of the individual and the extent to which the individual experiences support and acceptance from this network.
  - **Community recovery capital**: concerns the extent of support that is available within the wider community, such as housing, employment, training, treatment and self-help groups.

3. THE ROLE OF TREATMENT

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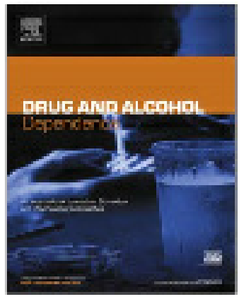
Drug and Alcohol Dependence 181 (2017) 162–169

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep



Full length article

Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy

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ARTICLE INFO

Keywords:
Recovery
Problem resolution
Treatment
Assisted

ABSTRACT

Background: Alcohol and other drug (AOD) problems confer a global, prodigious burden of disease, disability, and premature mortality. Even so, little is known regarding how, and by what means, individuals successfully resolve AOD problems. Greater knowledge would inform policy and guide service provision.
Method: Probability-based survey of US adult population estimating: 1) AOD problem resolution prevalence; 2)

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Table 2
Recovery pathway choices of U.S. adults who endorsed "used to have a problem with drugs or alcohol, but no longer do" (9.1% (SE = 0.28)).

Pathway	weighted%	SE
Used support	**53.9**	**1.69**
Professionally assisted recovery support (aka formal treatment) (any)	**27.6**	**1.43**
Outpatient addiction treatment	16.8	1.21
Inpatient or residential treatment	15.0	1.08
Alcohol/drug detoxification services	9.1	0.91
Anti-relapse/craving medication use (any)	**8.6**	**0.93**
Alcohol	4.8	0.70
Antabuse (Disulfiram)	2.4	0.45
Selincro (Nalmefene)	0.8	0.29
Revia (Naltrexone)	0.8	0.29
Campral (Acamprosate)	0.5	0.23
Topamax (Topiramate)	0.5	0.28
Lioresal (Baclofen)	0.2	0.23
Other	0.5	0.17
Opioid	4.4	0.73
Methadone	1.4	0.35
Orlaam (Levomethadyl acetate)	0.5	0.31
Suboxone (Buprenorphine-naloxone)	2.3	0.54
Subutex (Buprenorphine)	1.0	0.36
Revia (Oral naltrexone)	0.2	0.17
Vivitrol (Long-acting injectable naltrexone)	0.4	0.26
Other	0.2	0.09
Recovery support services	**21.8**	**1.40**
Faith-based recovery services	9.2	0.94
Sober living environment	8.5	0.95
Recovery community centers	6.2	0.85
State or local recovery community organization	3.0	0.61
College recovery programs/communities	1.7	0.52
Recovery high schools	0.8	0.37
Mutual-help groups	**45.1**	**1.60**
Alcoholics Anonymous (AA)	34.6	1.49
Narcotics Anonymous (NA)	17.5	1.23
Cocaine Anonymous (CA)	2.3	0.43
Celebrate Recovery	2.2	0.44
SMART Recovery	1.3	0.35
Women for Sobriety	1.2	0.37

9.1% in recovery of a SUD !

- Only 53.9% reported ‘assisted pathways’

International Journal of Drug Policy 53 (2018) 55–64

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research Paper

Is recovery from cannabis use problems different from alcohol and other drugs? Results from a national probability-based sample of the United States adult population

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ARTICLE INFO

Article history:
Received 2 August 2017
Received in revised form 1 December 2017
Accepted 8 December 2017

Keywords:
Cannabis

ABSTRACT

Background: The policy landscape regarding the legal status of cannabis (CAN) in the US and globally is changing rapidly. Research on CAN has lagged behind in many areas, none more so than in understanding how individuals suffering from the broad range of cannabis-related problems resolve those problems, and how their characteristics and problem resolution pathways are similar to or different from alcohol [ALC] or other drugs [OTH]. Greater knowledge could inform national policy debates as well as the nature and scope of any additional needed services as CAN population exposure increases.

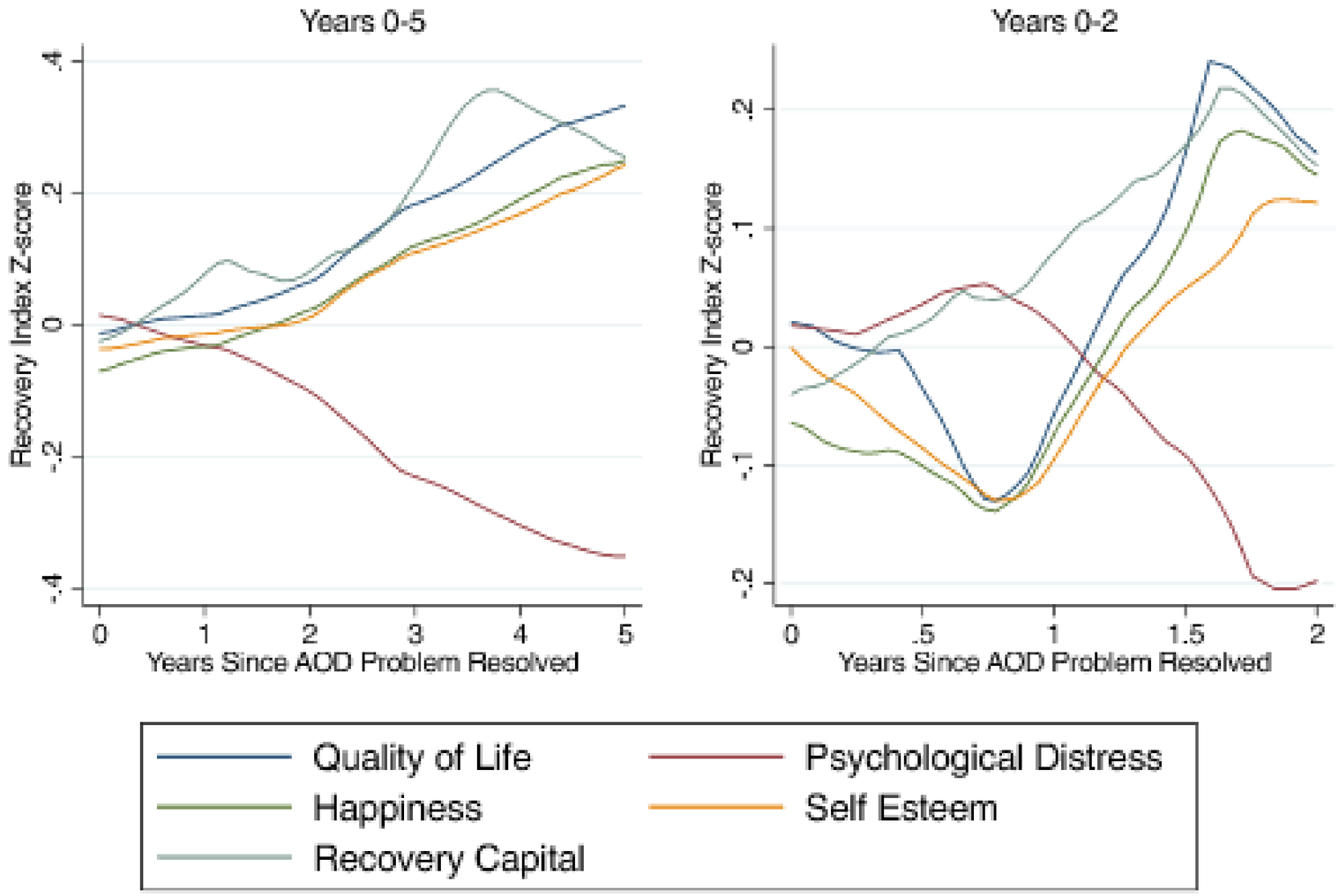
Method: National, probability-based, cross-sectional sample of the US non-institutionalized adult

Table 2
Recovery indices.

	Primary Problem Substance			OR/*d* CAN vs. ALC	OR/*d* CAN vs. OTH
	Cannabis (12.6%, n = 217)	Alcohol (58.5%, n = 1013)	Other Drugs (28.9%, n = 500)		
Definition of Recovery, %					
Abstinence from all drugs/alcohol	43.69	58.46	52.39	0.82	1.05
Abstinence from problem drugs/alcohol	32.39	18.35	38.09	2.13*	0.78
Non-problematic/moderate use of drugs/alcohol	13.92	23.19	9.52	0.54	1.54
Currently self-defined as "in recovery", %	37.95	47.27	50.18	0.68	0.61
Psychiatric Symptoms, M(SE)	5.53 (0.62)	4.58 (0.23)	5.69 (0.37)	0.18	−0.03
Happiness, M(SE)	3.74 (0.10)	3.74 (0.04)	3.66 (0.06)	0.00	−0.04
Self-Esteem, M(SE)	3.35 (0.14)	3.52 (0.05)	3.39 (0.08)	−0.15	−0.04
Quality of Life (Item mean), M(SE)	3.65 (0.10)	3.67 (0.04)	3.56 (0.05)	−0.03	0.12
Recovery Capital, M(SE)	47.70 (1.04)	46.43 (0.43)	46.92 (0.61)	0.14	0.09

* $p < 0.05$.

Recovery Indices by Years Since Problem Resolution



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INFORMAL SUPPORT AND HELP

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- Importance of ‘connectedness’/belonging + support by social network (family, peers, …)
- The network’s involvment and availability is crucial, but not self-evident
  - *Recovery is a social proces*
- Importance + role of experts by experience
- Empowerment + promoting self-care, eg. WRAP
- The relational and interactionist dimension of recovery:

  - *“I am surrounded by people and they really listen to what I say. Sometimes we sit together and laugh with things I like, funny things.” (man, 40 years)*

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RECOVERY THROUGH THE EYES OF FAMILY MEMBERS (DEKKERS ET AL., 2019)

- Focus groups (n=9) with family members
- Recovery?
  - “Hit rock bottom”
  - Process, but not endless opportunities
  - Identity and/or behaviour change
  - Finding a place to be (me)

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ON THE NECESSITY OF RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC) (DAVIDSON & WHITE, 2007)

Basic assumptions:

1. Recovery looks different for different individuals
2. ROSC matches with where an individual is in their recovery process, with appropriate interventions and resources
3. Recovery is a process along a continuum
4. Peer support, family support and involvement, and spirituality as core components

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RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC)

1. Early identification and engagement;
2. Use of role modeling;
3. Increase motivation for change;
4. Offer education;
5. Provide effective treatments and interventions;
6. Provide opportunities for individuals to occupy valued roles;
7. Connection between individuals and the larger recovery community;
8. Provide post-treatment monitoring and recovery coaching;
9. Offer meaningful recovery support services (e.g. supported housing, supported employment, supported education)
10. Offer legal advocacy

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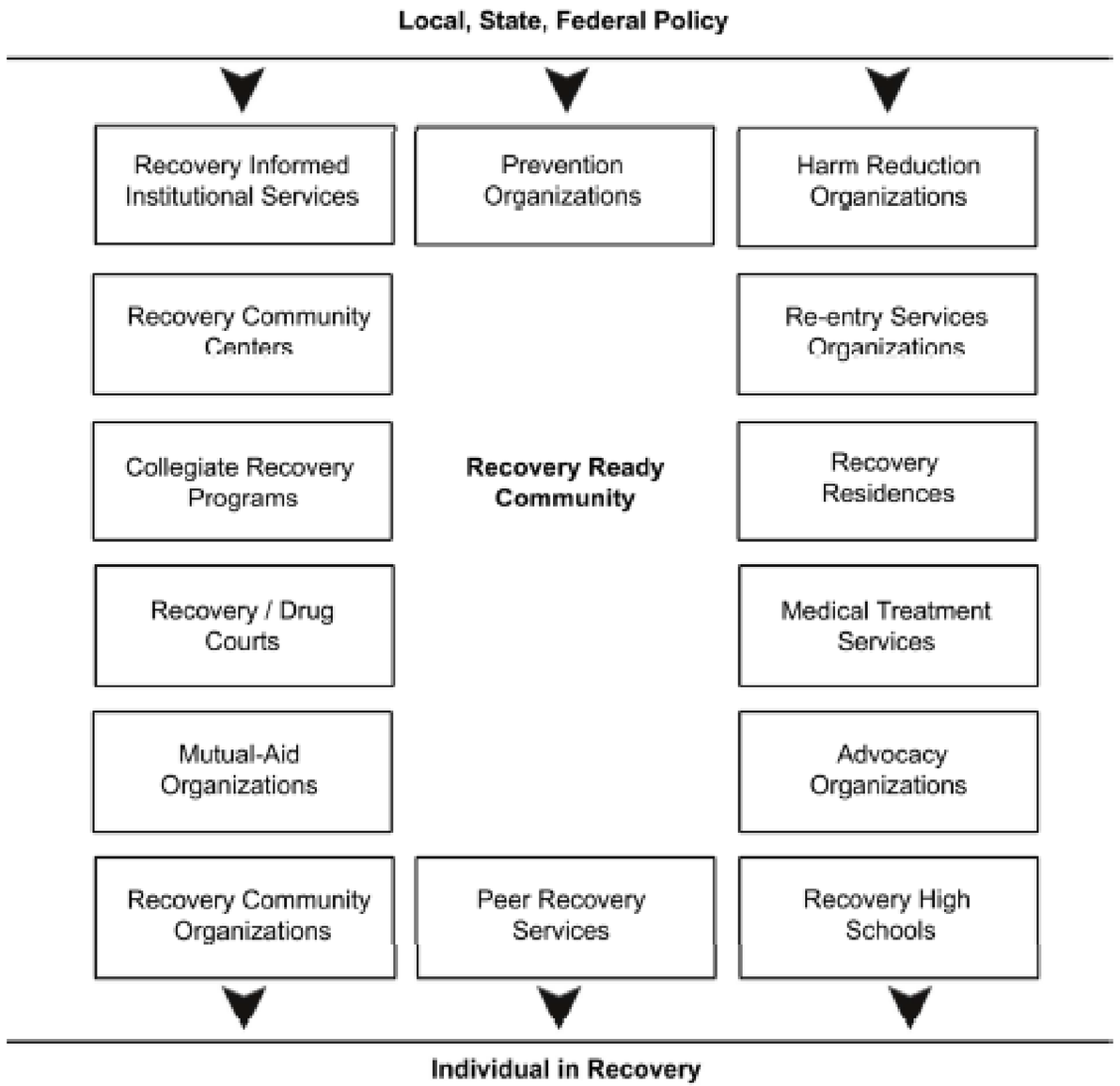
ONE STEP BEYOND: BUILDING RECOVERY READY COMMUNITIES (ASHFORD ET AL., 2019)



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4. RECOVERY PATHWAYS (REC-PATH)

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RECOVERY PATHWAYS IN THE UK, THE NETHERLANDS AND BELGIUM

REC-PATH

RECOVERY PATHWAYS

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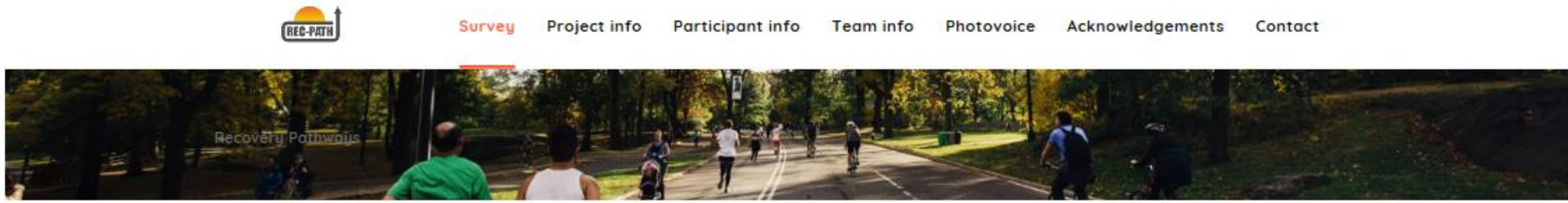
ERANID

European Research Area Network on Illicit Drugs

WWW.REC-PATH.CO.UK



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Life in Recovery Survey N=722

	United Kingdom n=311	Netherlands n=230	Belgium n=181
Gender			
Male	61%	59%	74%
Female	39%	41%	27%
Education			
None/primary	2%	4%	23%
Secondary	28%	55%	52%
Higher	70%	41%	25%
Recovery stages			
Early (<1 year)	10%	17%	32%
Sustained (1-5 years)	34%	46%	44%
Stable (>5 years)	56%	38%	24%
Age mean (SD)	45.5 (9.3)	40.1 (11.2)	35.5 (9.1)
18-29 years	4%	20%	25%
30-49 years	63%	58%	66%
50 +	34%	22%	8%

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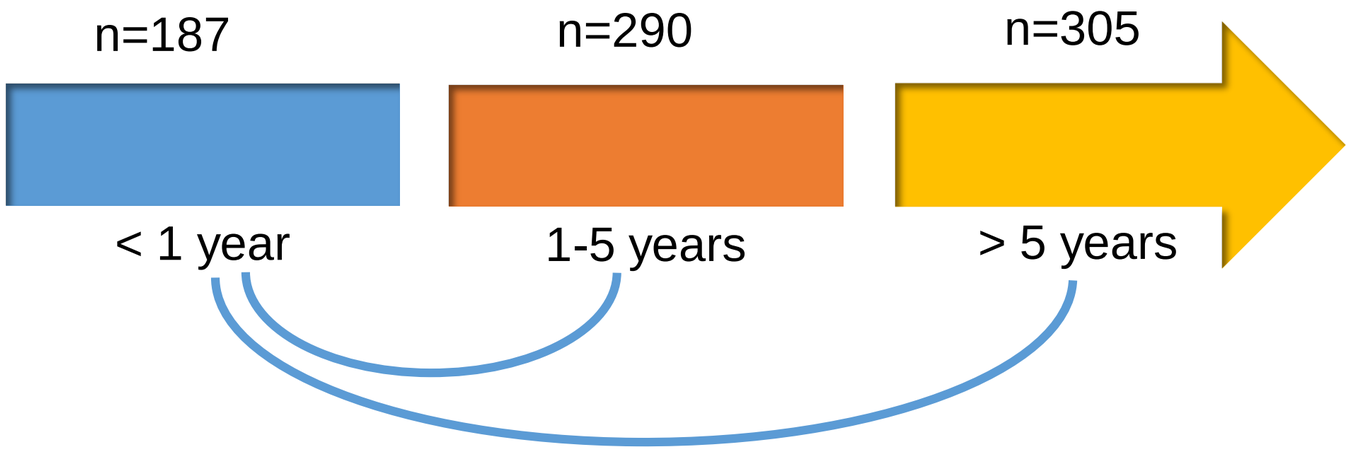
STAGES OF RECOVERY (LIFE IN RECOVERY SURVEY, 2018)



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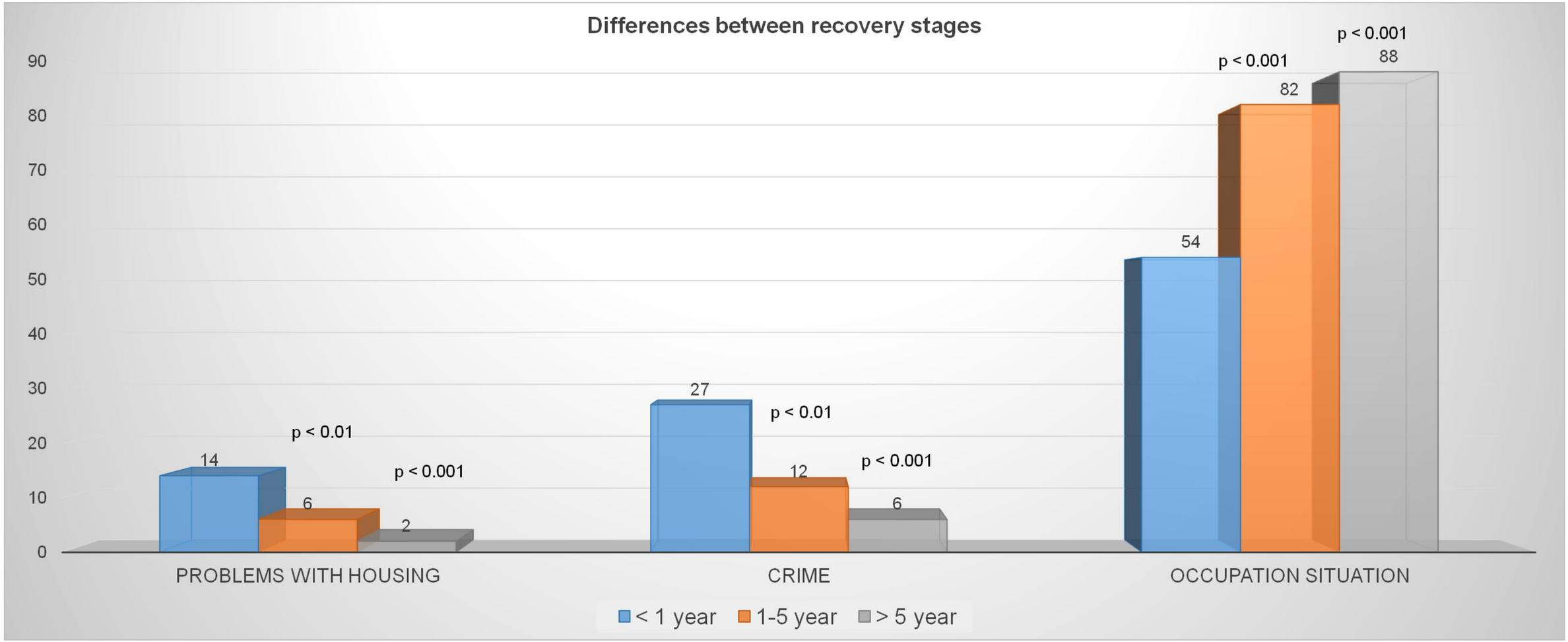
HOUSING, CRIME & OCCUPATIONAL SITUATION BY RECOVERY STAGE



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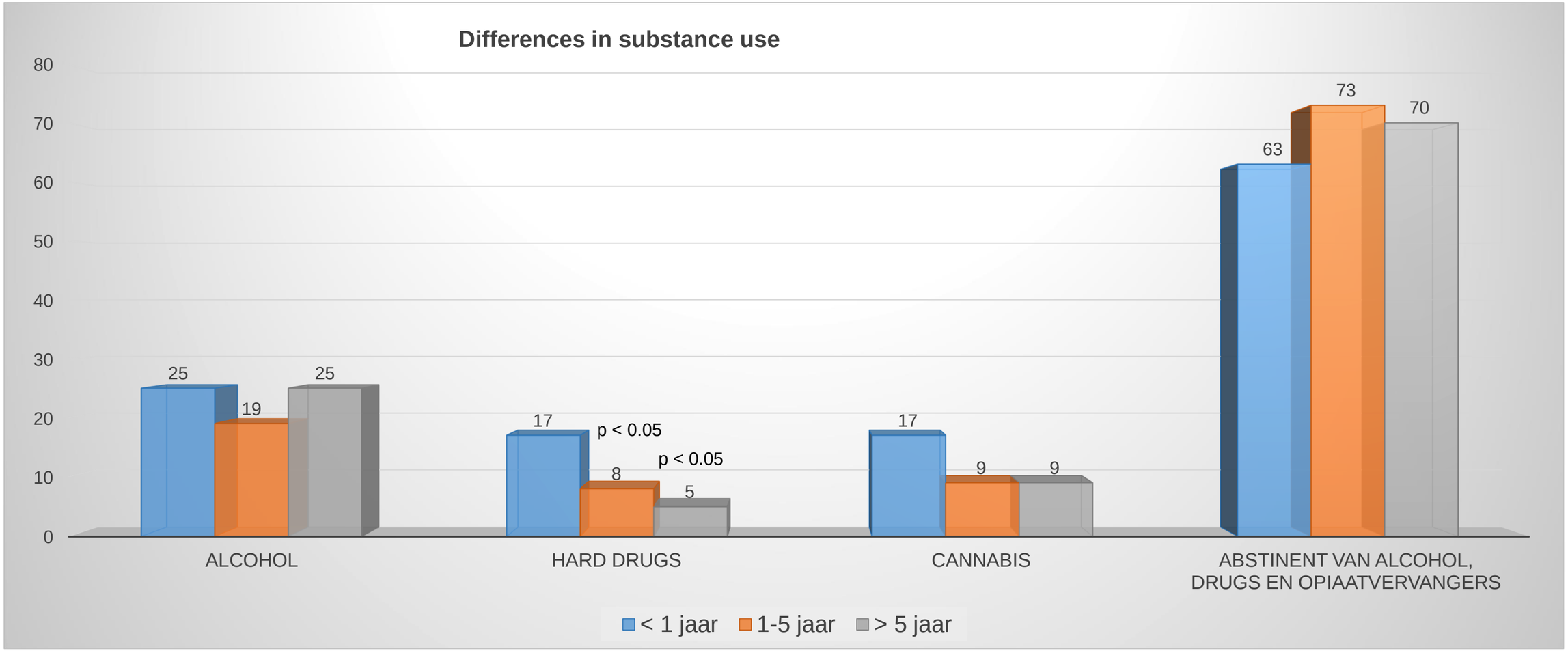
SUBSTANCE USE BY RECOVERY STAGE



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LIFE IN ACTIVE ADDICTION VS IN RECOVERY

Figure 1:Untreated emotional and mental health difficulties in addiction and recovery

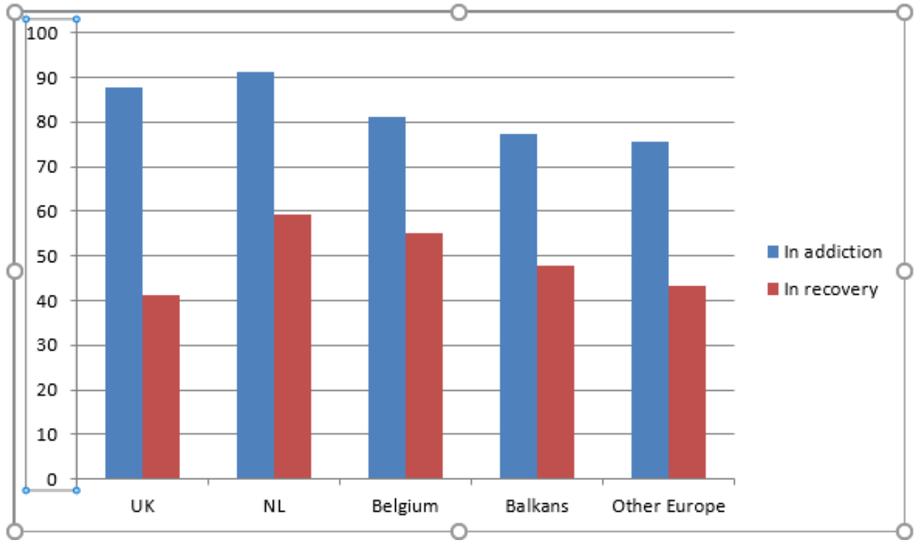


Figure 4: Driving under the influence in active addiction and in recovery

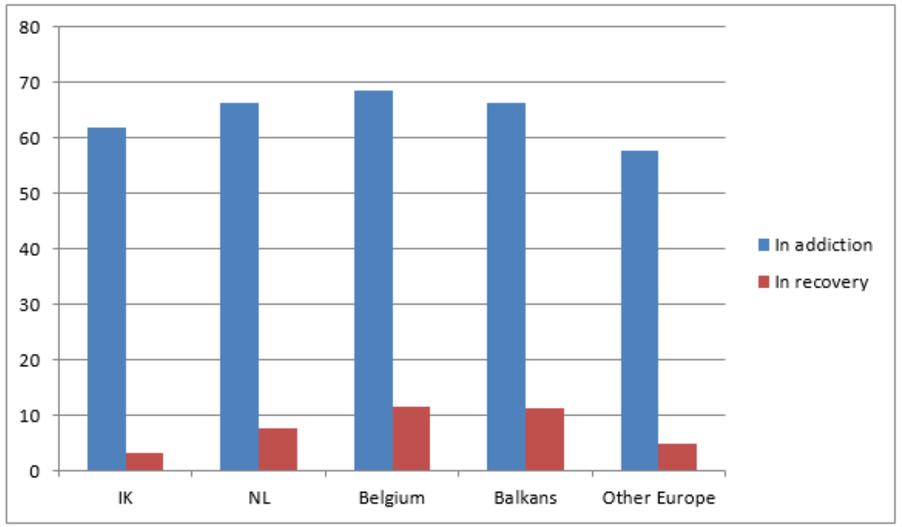


Figure 7: Stable housing in active addiction and in recovery

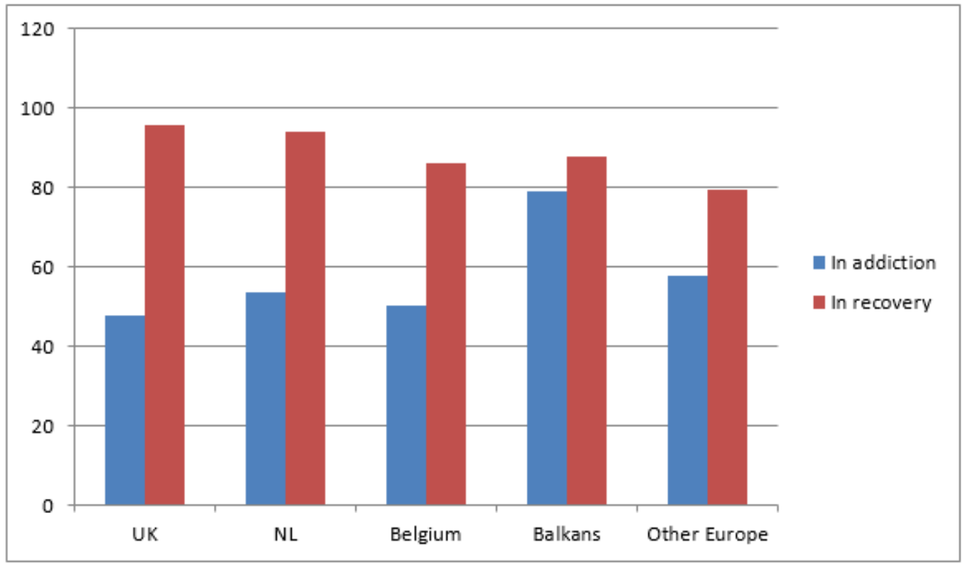
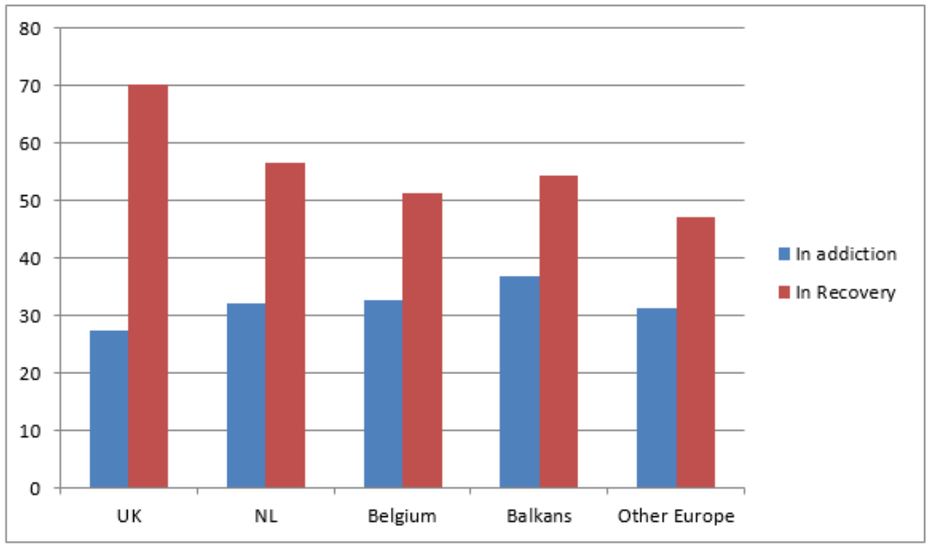
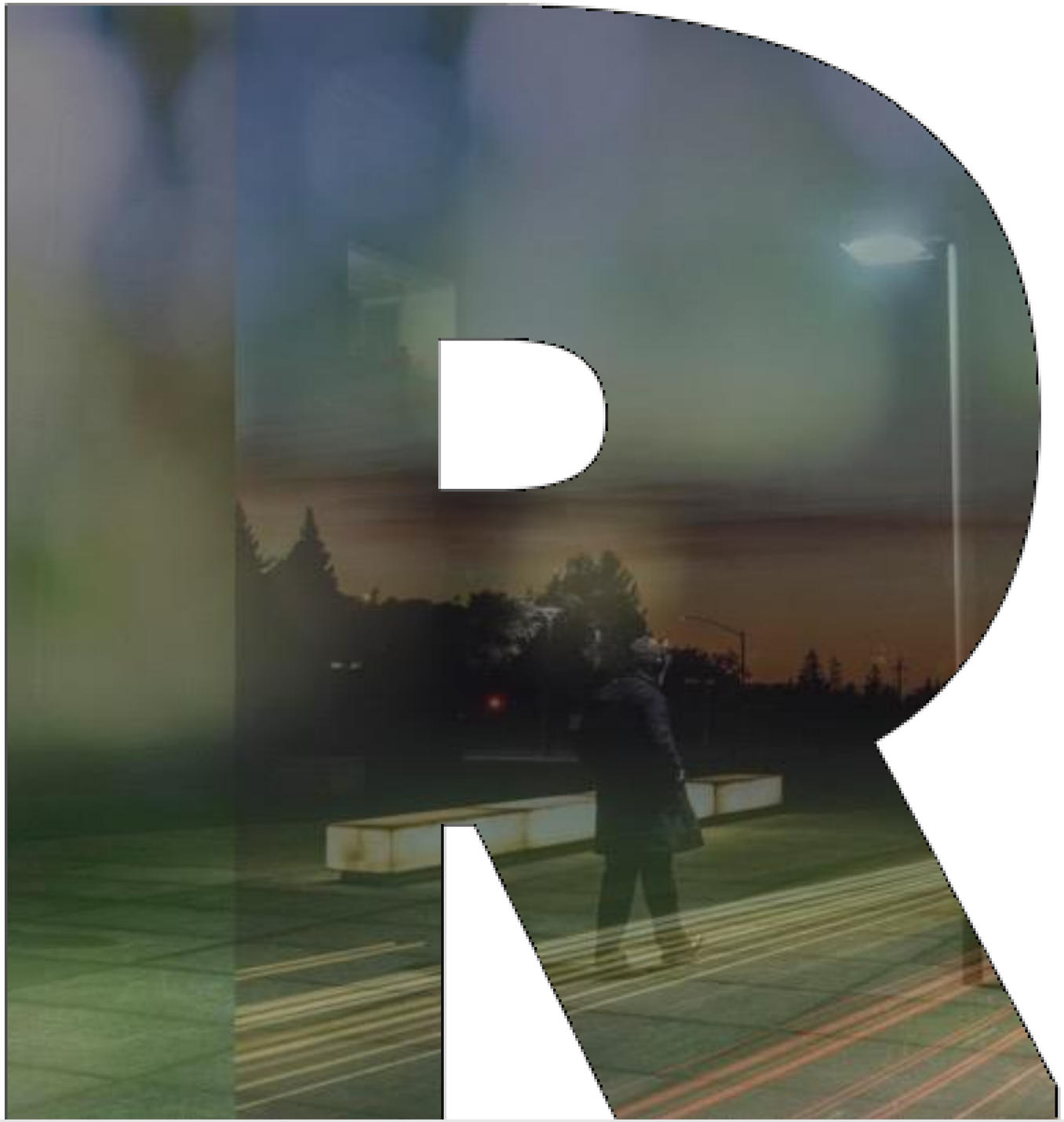


Figure 8: Steady employment in active addiction and recovery



OSB: Baseline assessment (n=367)

COMBINATIONS OF TREATMENT & SUPPORT (EVER)		
Treatment / Mechanisms of behaviour change	**N**	**% of total**
Natural / none	17	4.6
Mutual aid only	20	5.4
Outpatient only	19	5.2
Residential only	21	5.7
Outpatient + Residential only	58	15.8
Mutual aid + Outpatient only	33	9.0
Mutual aid + Residential only	49	13.4
Mutual aid + Outpatient + Residential	150	40.9



PHOTOVOICE & RECOVERY PATHWAYS

5. NATURAL RECOVERY

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NATURAL RECOVERY

“I was extremely embarrassed during that period. I still am. I didn’t want anyone to find out about it. I wanted to overcome my addiction on my own and I succeeded. Although I imagine that for many people this is incredibly difficult and almost impossible.”

- Emma, 26, had problems with speed and cocaine (LiR survey) -

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NATURAL RECOVERY

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Recovery pathway choices of U.S. adults who endorsed "used to have a problem with drugs or alcohol, but no longer do" (9.1% (SE =0.28)).

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Alcohol/drug detoxification services	9.1	0.91
Anti-relapse/craving medication use (any)	**8.6**	**0.93**
Recovery support services	**21.8**	**1.40**
Mutual-help groups	**45.1**	**1.60**

46.1% in unassisted / natural recovery

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Kelly et al. (2017). Prevalence and pathways of recovery from drug and alcohol problems in the U. S. population. *Drug and Alcohol Dependence*, *181*, 162-169.

NATURAL RECOVERY

- Also referred to as:
  - “spontaneous recovery”
  - “maturing out”
  - “self-change”

- Research mainly focused on:
  - smoking cessation
  - Prevalence

- Need for in-depth understanding of the phenomenon

- Complement to treatment-focused studies

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6. SOME CONCLUSIONS

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- Emerging recovery research in Europe, emphasizing:
  - Individuals' unique recovery journeys
  - clear country/regional differences
  - role of ≠ treatment mechanisms
  - importance of informal network and ongoing support

- Natural recovery may not be underestimated, but appears to be rather uncommon in Europe
  - Area of further interest

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Funding acknowledgement:

REC-PATH is a collaborative project supported by the European Research Area Network on Illicit Drugs (ERANID). This presentation is based on independent research commissioned and funded in England by the National Institute for Health Research (NIHR) Policy Research Programme (project ref. PR-ST-0217-10001), in the Netherlands by The Netherlands Organisation for Health Research and Development (ZonMW), and in Belgium by the Research Foundation Flanders (FWO, Belgium) and the Belgian Science Policy Office (BELSPO). The views expressed in this presentation are those of the authors and not necessarily those of the national funding agencies or ERANID.

CONTACT & ADDITIONAL INFORMATION

- https://www.rec-path.co.uk/project-overview/
- https://ivo.nl/recovery-pathways/
- https://vimeo.com/357297505

https://twitter.com/Recovery_Paths
https://twitter.com/RecPathsNL_BE

https://www.facebook.com/Recovery-Pathways-765058233667971/
https://www.facebook.com/Recovery-Pathways-NLBE-397830927307102/

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DRUG-FREE THERAPEUTIC COMMUNITIES AND RESIDENTIAL TREATMENT IN AN ERA OF COMMUNITY-BASED CARE: EVIDENCE AND PATHWAYS FOR RECOVERY

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OVERVIEW

- History and development of TCs
- TCs and the evidence-base
- TCs in an era of community-based care: supporting addiction recovery
  - Recovery an quality of life
- Conclusion

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HISTORY AND DEVELOPMENT OF TCS

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HISTORY AND DEVELOPMENT OF TCS

- Long history, dating back to 1958 (Synanon)
- Starting in the US, the model quickly spread as main answer to the drug problem in the 1960s and 1970s
  - Behaviorist American model adapted to European culture and treatment traditions (e.g. milieu therapy, psycho-analysis) + spread to other continents
- Based on self-help/mutual help principles + structured therapeutic environment
- Model for many residential programs worldwide
  - Many variations, not necessarily residential
  - Modified TCs for specific populations, shorter-term programs and smaller scale units

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HISTORY AND DEVELOPMENT OF TCS (CONT'D)

- TCs predominant treatment modality in many countries until:
  - Spread of the HIV/AIDS epidemic (1985)
  - Expansion of MMT and harm reduction programs

- But also:
  - Decreased popularity due to 'closed' communities
  - Assumed lack of effectiveness led to closure of TCs and reduced program length in some countries

- However, renewed interest in TCs due to emerging recovery movement, international expansion of TCs and the evidence that the cycle of addiction can be broken

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THERAPEUTIC COMMUNITIES (TCS) FOR ADDICTIONS: A DEFINITION

- *“A drug-free environment in which people with addictive problems live together in an organized and structured way to promote change toward a drug-free life in the outside society”*

  (Broekaert, Kooyman, & Ottenberg, 1998, p. 595)

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Table 1: Overview of the number of TCs per country, their capacity and (estimated) number of clients per year (2011), as well as an estimation of the average number of clients per TC/country and the estimated number of treated clients per available bed/year

Country	Number of TCs	Total capacity	Number of clients per year	Average number of clients per TC	Number of treated clients/bed per year	Number of TCs/ 100 000
Austria	9	269	599	30	2,23	0,107
Belgium	8	204	357	25	1,75	0,073
Bulgaria	3	60	140	20	2,33	0,040
Croatia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Cyprus	1	50	86	50	1,72	0,125
Czech Republic [b]	10	160	394	16	2,46	0,095
Denmark	1	15	41	15	2,73	0,018
Estonia	1	26	82	26	3,15	0,074
Finland	4	58	264	14	4,55	0,074
France	11	380	n.a.	34	n.a.	0,017
Germany	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Greece [a]	11	417	980	38	2,35	0,097
Hungary [c]	14	374	738	27	1,97	0,140
Ireland	2	45	75	22	1,67	0,044
Italy	798	n.a.	n.a.	n.a.	n.a.	1,317
Latvia	2	6,5	14	3	2,15	0,089
Lithuania	19	330	620	17	1,88	0,585
Luxembourg [a]	1	25	44	25	1,76	0,200
Malta	7	129	360	18	2,79	1,750
Netherlands	8	n.a.	n.a.	n.a.	n.a.	0,048
Norway	5	123	323	25	2,63	0,101
Poland	85	2 852	10 000	34	7,01	0,223
Portugal	57	1 977	3 584	35	1,81	0,535
Romania	3	25	n.a.	8	n.a.	0,014
Slovakia [b]	19	347	857	18	2,47	0,349
Slovenia	4	112	n.a.	28	n.a.	0,195
Spain [b]	129	n.a.	8 134	n.a.	n.a.	0,273
Sweden	1	11	27	11	2,45	0,011
Turkey	0	0	0	0	0	0,000
United Kingdom	10	454	851	45	1,87	0,016
Total	1 223	8 449.5				

Note :

[a] = 2010 data ; [b] = 2009 data ; [c] = 2008 data ; n.a. = not available

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TC MODEL UNDER PRESSURE IN SEVERAL EU-COUNTRIES

- TCs are challenged for:
  - High costs of lengthy treatment
  - High drop-out and relapse rates
  - Relatively low coverage rate of drug addicts
  - Changing views on addiction and its treatment
  - Altered client expectations, social norms and theoretical insights regarding lengthy stays in closed communities
  - Lack of evidence resulting from some systematic reviews (Smith et al., 2006; Malivert et al., 2012)

- Situation varies substantially across Europe:
  - eg. North vs. South and East Europe
  - Modified TCs for specific populations, shorter term programs, smaller scale units + prison TCs

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TCS AND THE EVIDENCE-BASE

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By: Limberger, Jessica; Andretta, Ilana
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3. **Women's Experience of Drug Ab der Therapeutic Community**

By: Possick, Chaya; Itzick, Michal
AFFILIA-JOURNAL OF WOMEN A sue: 4 Pages: 493-508 Published: NOV 2018

Times Cited: 0
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EVIDENCE FOR EFFECTIVENESS?

- TCs have been widely evaluated
  - Early (and later) studies underscored the strong relationship between TIP and success
    - Abstinence rates: 85-90% among graduates vs. 25-40% among early drop-outs (Holland, 1983)
  - Relatively few controlled studies regarding TC effectiveness
    - Poor applicability of controlled study designs in TC environments
      - Lack of adequate control conditions
      - High attrition rates
      - Reciprocal influence of resident and TC environment
    - Controlled studies mainly from US
  - Numerous (uncontrolled) field effectiveness studies from Europe and Australia/NZ and recently from Brazil, Iran, China, Korea, Philippines, Kyrgyzstan, …

AVAILABLE REVIEWS

- At least 9 comprehensive, independent reviews of TCs published in English language literature since 2000:
  - Lees, Manning & Rawlings (2004) (++)
  - Smith, Gates & Foxcroft (2007) (±)
  - De Leon (2010) (++)
  - Sacks et al. (2010) (++)
  - Malivert, Fatseas, Denis, Langlois & Auriacombe (2012) (±)
  - Vanderplasschen et al. (2013) (++)
  - Magor-Blatch, Bronwyn & Thorsteinsson (2014) (++)
  - Galassi, Mpofu & Athanasou (2015) (+)
  - Aslan (2018) (++)

- Leading to rather divergent conclusions:
  - ≠ scope, objectives, selection criteria, analytic methods
  - Few studies retained in all reviews

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- 29 controlled studies on TC treatment (8 RCTs)
- Democratic TCs, as well as concept TCs (1/4)
- Strong positive effect of TCs compared with control interventions
- Substantial study heterogeneity
- Addiction TC outcomes significantly more effective than democratic TCs (! More severely disturbed population, personality disorders)

Psychiatric Quarterly, Vol. 75, No. 3, Fall 2004 (© 2004)

A CULTURE OF ENQUIRY: RESEARCH EVIDENCE AND THE THERAPEUTIC COMMUNITY

Jan Lees, Nick Manning, Ph.D., and Barbara Rawlings, Ph.D.

This paper presents data from a systematic review and meta-analysis of 29 published studies of therapeutic community effectiveness using controls, including 8 randomised control trials. Meta-regressions suggest that the two types of therapeutic community, democratic and concept-based, and the age of the study, are the key sources of heterogeneity in the collection of studies analysed. Otherwise, heterogeneity is low and the meta-analysis confirms the effectiveness of therapeutic community treatment with overall summary log odds ratio for the 29 studies of −0.512 (95% ci −0.598 to −0.426).

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The Cochrane Library
Published Online: 16 JUL 2008
Abstract | Full Article (HTML) | Figures | Tables | References | Other Versions
Wiley Online Library

Therapeutic communities for substance related disorder (Review)

Smith LA, Gates S, Foxcroft D

OUTDATED !!!

- 7 RCTs of drug-free TCs, compared with varying control conditions (day TC, community residence, short TC program, …)
- Focus on substance use and retention
- Few evidence that TCs offer significant benefits compared with other types of residential Tx or other types of TCs
- Poor evidence due to lack of studies + its methodological limitations (high attrition rates, drop-out from Tx)

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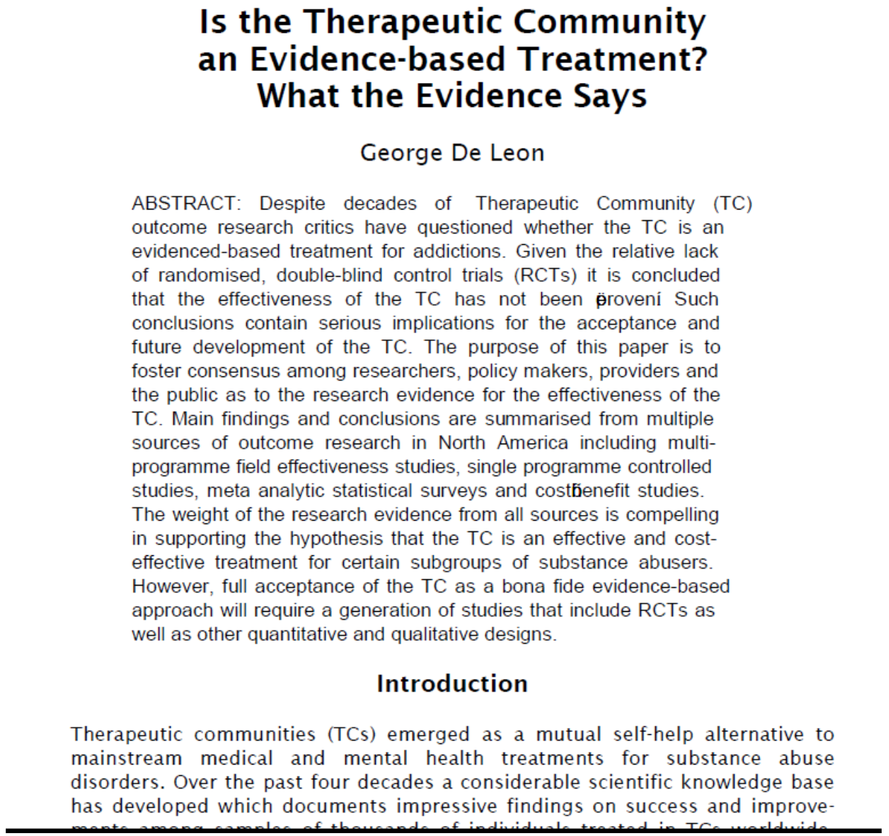
- Critical evaluation of the assertion that TC effectiveness is not proven (Smith et al., 2006)
- Non-exhaustive review of North American literature on addiction TCs
- Consistent evidence of TC effectiveness
  - numerous field effectiveness studies
  - controlled studies: better outcomes
  - meta-analyses: 4 found small to moderate effect sizes, 2 found insufficient evidence
  - cost-benefit analyses: in favor of TC treatment, in particular reduced costs associated with criminality and gains in employment
  - most TCs routinely use evidence-based interventions like MI, CBT, …



Is the Therapeutic Community an Evidence-based Treatment? What the Evidence Says

George De Leon

ABSTRACT: Despite decades of Therapeutic Community (TC) outcome research critics have questioned whether the TC is an evidenced-based treatment for addictions. Given the relative lack of randomised, double-blind control trials (RCTs) it is concluded that the effectiveness of the TC has not been proven. Such conclusions contain serious implications for the acceptance and future development of the TC. The purpose of this paper is to foster consensus among researchers, policy makers, providers and the public as to the research evidence for the effectiveness of the TC. Main findings and conclusions are summarised from multiple sources of outcome research in North America including multi-programme field effectiveness studies, single programme controlled studies, meta analytic statistical surveys and cost-benefit studies. The weight of the research evidence from all sources is compelling in supporting the hypothesis that the TC is an effective and cost-effective treatment for certain subgroups of substance abusers. However, full acceptance of the TC as a bona fide evidence-based approach will require a generation of studies that include RCTs as well as other quantitative and qualitative designs.

Introduction

Therapeutic communities (TCs) emerged as a mutual self-help alternative to mainstream medical and mental health treatments for substance abuse disorders. Over the past four decades a considerable scientific knowledge base has developed which documents impressive findings on success and improve-

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European Addiction Research

Research Report

Eur Addict Res 2012;18:1–11
DOI: 10.1159/000331007

Received: March 28, 2011
Accepted: July 19, 2011
Published online: October 13, 2011

Effectiveness of Therapeutic Communities: A Systematic Review

Marion Malivert[a, b] Mélina Fatséas[a, b] Cécile Denis[a, b] Emmanuel Langlois[c] Marc Auriacombe[a, b]

[a]Addiction Psychiatry, Laboratoire de psychiatrie et CNRS-USR-3413-Sanpsy, Université Bordeaux Segalen, [b]Département d'Addictologie, CH Charles Perrens et CHU de Bordeaux, and [c]Centre Émile Durkheim – Science politique et sociologie comparatives (UMR 5116), Université Bordeaux Segalen, Bordeaux, France

- Systematic review of 12 follow-up studies of TC effectiveness during and after Tx (studies on prison TCs excluded)
- Tx completion: 9-56%, program cessation most often after 15-30 days
- Decrease in substance use during follow-up, still 21-100% used or relapsed
- 20-33% re-entered Tx
- Large differences between studies in Tx duration + length of follow-up period
- Tx completion and retention identified as robust predictors of abstinence

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Review Article

Therapeutic Communities for Addictions: A Review of Their Effectiveness from a Recovery-Oriented Perspective

Wouter Vanderplasschen,[1] Kathy Colpaert,[1] Mieke Autrique,[1] Richard Charles Rapp,[2] Steve Pearce,[3] Eric Broekaert,[1] and Stijn Vandevelde[4]

- Systematic review of 16 controlled studies
- Traditional + modified TCs, in prison and community settings
- Retention + participation in aftercare robust predictors of TC outcomes, although drop-out higher than in most comparison conditions
- In majority of studies, TC group had better substance use and legal outcomes than comparison condition
- TCs can promote change regarding various outcome indicators, but continuing care approach needed

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Table 3.6: Overview of the review results

Reference number of the study/studies	Type of TC	Comparison condition	Follow-up lenghth	Outcome measures					
				Retention	Substance use	Criminal activity	Employ-ment	Health	Family & Social Relations
1.	Prison	TAU	1 year			+			
2.	Prison	TAU	1 year			=			
			5 years			=			
3.	Prison	Other TC	1 year	+	=	=		=	=
4.	Prison	TAU	2 years		=	+	+		
5.	Prison	TAU	1 year		+	+			
6.	Prison	TAU	1 year	=	+	=		+	
7.	Prison	TAU	6 months		+	+		+	
			1 year		+	+			
			3 years		+	=			
			3 years 6 months		+	+			
			5 years		+	+			
8.	Prison	TAU	1 year		+	+			
			2 years			+			
			5 years	=	=	+	=	=	
9.	Community-based	Other TC	6 months	=	+			+	+
			1 year	=	=			+	
			1 year 6 months		=			+	+
10.	Community-based	Other TC	1 year 6 months	=	+	+	+		
11.	Community-based	TAU	1 year		+	=	+	=	
			2 years		+ =	+	+ =	+	
12.	Community-based	TAU	1 year	-	+			+	
13.	Community-based	Other TC	6 months	=	=				
			1 year	-	=	=	+		
14.	Prison	TAU	6 months		=	+			
15.	Community-based	TAU	1 year	-	+	+	+	+	
			2 years	+	+ (illicit) - (alcohol)	+	+		
16.	Community-based	Other TC	1 year	=	+				

Abbreviations: TC=Therapeutic Community, Other TC=Other TC modality, TAU=Treatment As Usual

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SUBSTANCE USE AND LEGAL OUTCOMES

- Varying follow-up period (mostly 6-12 months, exc. >36 months)
- Between group differences diminished over time
- ‘Substance use’ and ‘legal involvement’ most frequently assessed
  - 10/14 studies: ++ substance use outcomes
  - 9/13 studies: ++ legal outcomes
  - Multiple outcome indicators used:
    - seldom ≥ 2 significant outcomes in one category (cf. Prendergast, 2003)
    - Improvement in one category not necessarily associated with improvement on other domains

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WHAT TO CONCLUDE FROM ‘THE EVIDENCE’?

- Inconsistent findings, but clear improvements regarding substance use, recidvism and social functioning 12 to 24 months after treatment
  - Studies on prison TCs: superior outcomes compared to other types of drug treatment (Aslan, 2018; Galassi et al., 2015; Mitchell et al., 2007; Perry et al., 2015)

- Focus on strategies to improve retention and maintain change:
  - Welcome houses (Tompkins et al., 2017)
  - Role of older peers (Broekaert, 2006)
  - Family and social network involvement (Soyez et al., 2006)
  - Attention for quality of life (Broekaert et al., 2017)
  - Impulsivity and psychopathology as predictors of drop-out (Stevens et al., 2015)

- Lack of convincing evidence ≠ evidence of ineffectiveness

- Need for comprehensive a review/meta-analysis of TC studies, taking into account setting, population, program/follow-up length, …

TCS IN AN ERA OF COMMUNITY-BASED CARE: SUPPORTING ADDICTION RECOVERY

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TCS CLEARLY CONTRIBUTE TO RECOVERY

"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship." (Betty Ford Institute, 2007)

"A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (Anthony, 1993, p. 527)

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DIFFERENT TYPES OF RECOVERY (SLADE ET AL., 2010)

- The first involves clinical recovery – when someone 'recovers' from the illness and no longer experiences its symptoms.
- The second involves personal recovery – recovering a life worth living (without necessarily having a clinical recovery). It is about building a life that is satisfying, fulfilling and enjoyable.

- Clinical vs. personal recovery
- Abstinence vs. Quality of Life !

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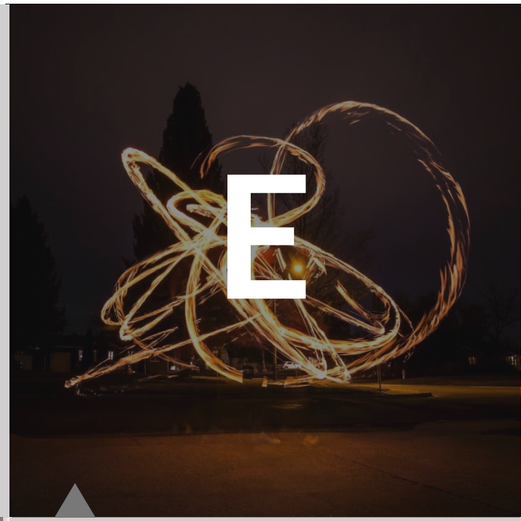
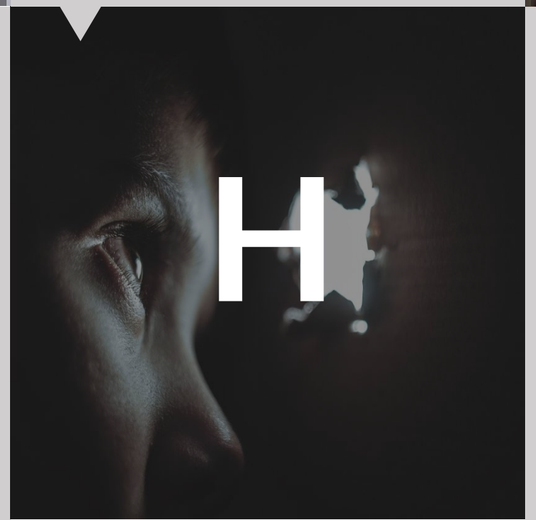
CHIME FRAMEWORK FOR PERSONAL RECOVERY (LEAMY, BIRD, LE BOUTILLIER, WILLIAMS & SLADE, 2011)

HOPE

MEANING



CONNECTEDNESS



IDENTITY

EMPOWERMENT

IMPORTANCE OF AFTERCARE AND CONTINUING CARE FOR PROMOTING RECOVERY

- Once individuals leave the TC, success rates drop quickly, especially during first month(s) after treatment
- Relapse: failure, learning moment, symptom of a chronic relapsing disorder
- Not Tx completion, but longer length of stay in TC (retention) and participation in subsequent aftercare predict better outcomes
- Provision of aftercare alone as or even more effective than initial TC treatment (Martin et al., 1999; Vanderplasschen, Bloor & McKeganey, 2010); combination of TC treatment and subsequent aftercare generates the best results (McCollister et al., 2004; Prendergast et al., 2004).
- Link wit employment, new social networks and community-based support

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QUALITY OF LIFE AND RECOVERY:

“Individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.”(The WHOQOL Group, 1998, p. 551)

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NOT A FOCUS IN MOST TC-STUDIES

- Despite numerous TC-studies, few have focused on QoL or well-being
- Focus on ‘hard’/socially desirable outcomes
- Often regarded as an ‘umbrella term’
- Scoping review of longitudinal studies of TC treatment and QoL:
  - N<15
  - Large heterogeneity
  - Mental health, wellbeing and QoL seldom reported
  - QoL recently used as outcome measure in TC studies on differential effectiveness

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PATHWAYS THROUGH TREATMENT: A MIXED-METHODS LONGITUDINAL OUTCOMES STUDY OF COOLMINE THERAPEUTIC COMMUNITY

Figure 3: Health and Well-Being Scores at Entry, on a scale of 0-20

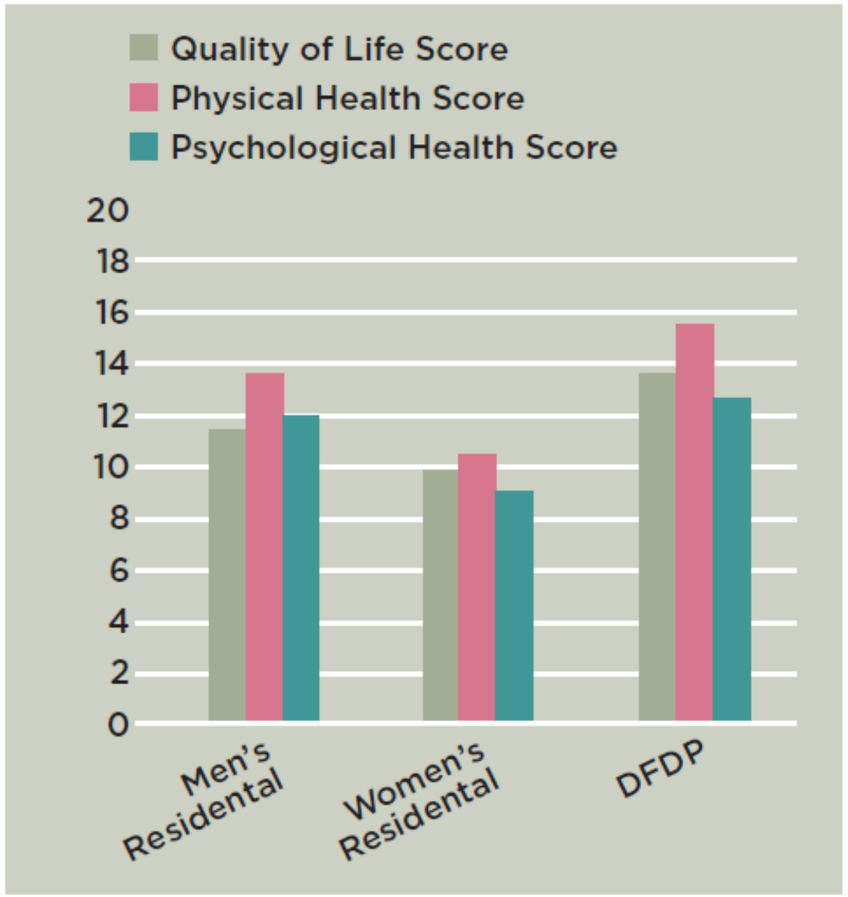
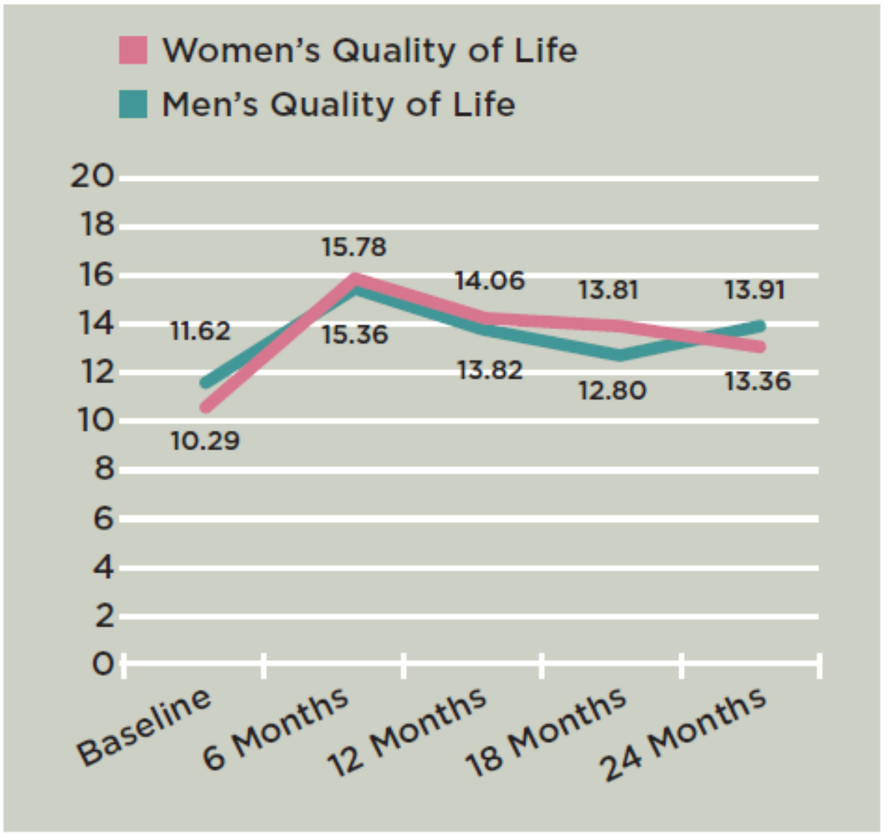


Figure 7: Self-perceived quality of life over 24 months: Mean scores



COOLMINE PATHWAYS THROUGH TREATMENT (2015)

- “*Post-treatment improvements in quality of life were reported by all participants. Establishing a routine, maintaining a household, moving away from full-time recovery-focused activities, (re)connecting with family, (re)building relationships with their children were all cited as sources of fulfilment, joy and self-esteem. Overall, participants aspired towards what they described as ordinary or everyday things, such as family contact, a home, children, a pet or the means to travel. The sense of hope extended beyond the material world to a more abstract, overarching sense of optimism that emerged from the narratives of drug-free participants*.”

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ROUTINE MONITORING OF QUALITY OF LIFE AFTER TC TREATMENT IN DE KIEM (BE)

- Exploratory study of QoL during and after TC treatment
- Baseline assessment + after 3, 6, 12, 24 and 60 months
- Computerised assessment using the MANSA (Priebe et al., 1999)
  - Including objective as well as subjective indicators
  - Measured on a 7-point Likert scale
  - 5-10 minutes

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CONCLUSION

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THE ROLE OF TCS IN A NETWORK OF DRUG SERVICES?

- TCs promote change/recovery through
  - Identity change (Goethals et al., 2015; Powis et al., 2017)
  - Increased self-efficacy
  - Establishing new social networks and group memberships (Savic et al., 2017)
  - Breaking ties with old networks and build new ones (! Neale et al., 2018)

- TC treatment should not be a stand-alone treatment, but needs to be accompanied by:
  - Adequate screening/referral of persons in need of TC treatment
  - An integrated network of services, including a clear vision, smooth transitions + case management
  - Some type of continuing care: aftercare, Oxford/recovery houses, recovery monitoring, NA/AA…

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