FACULTY OF PSYCHOLOGY
AND EDUCATIONAL SCIENCES

SWIMMING AGAINST THE TIDE: HOW CAN THERAPEUTIC COMMUNITIES FOR ADDICTIONS SURVIVE IN THE 21ST CENTURY?

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OVERVIEW

- The state of TCs in Europe
- TCs and the evidence-base
- TCs in an era of community-based care: supporting addiction recovery
- Recovery and quality of life
- The role of quality standards: FENIQS-EU project
- Conclusion

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THE STATE OF TC'S IN EUROPE

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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 EUROPEAN 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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TC’S AND THE EVIDENCE-BASE

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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) (++)

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

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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]

- TCs have been widely evaluated
  - Numerous studies have underscored the strong relationship between TIP and success
  - Traditional & modified TCs; prison and community TCs;

- Majority of controlled TC studies has shown better substance use and legal outcomes compared with TAU
- Drop-out higher than in most comparison conditions
- Retention + participation in aftercare most robust predictors of TC outcomes

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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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WHAT TO CONCLUDE FROM ‘THE EVIDENCE’?

- Despite inconsistent findings, clear improvements regarding substance use, recidivism 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)

- Several strategies/methods have been developed to improve outcomes and maintain change:
  - Role of older peers (Broekaert, 2006)
  - Family and social network involvement (Kooyman, 1992; Soyez et al., 2006) + incorporating children and families
  - Welcome houses (Tompkins et al., 2017)
  - Personality traits (e.g. impulsivity (Stevens et al., 2015)) and psychopathology (Sachs et al., 2012) as predictors of drop-out
  - Attention for individual well-being and quality of life (Broekaert et al., 2017)
  - Focus on recovery rather than abstinence (Vanderplasschen & Best, 2021)

- Need to document the effectiveness of what we are doing and to monitor progress in and beyond TC treatment

TC’S IN AN ERA OF COMMUNITY-BASED CARE: SUPPORTING ADDICTION RECOVERY AND QUALITY OF LIFE

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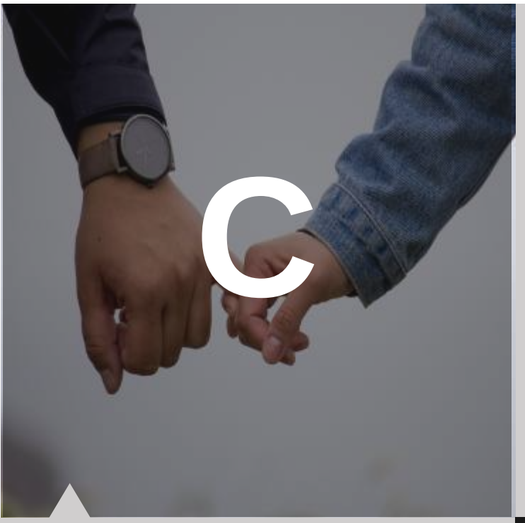
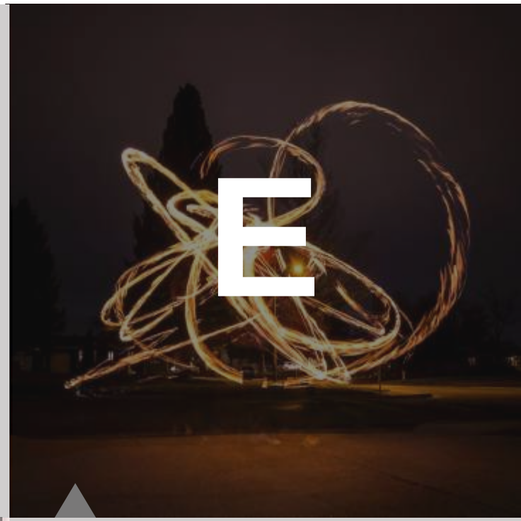
CHIME FRAMEWORK FOR PERSONAL RECOVERY (LEAMY, BIRD, LE BOUTILLIER, WILLIAMS & SLADE, 2011)



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:

“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 mostly on ‘hard’/socially desirable outcomes
- Often regarded as an ‘umbrella term’
- Scoping review of longitudinal studies of TC treatment and QoL (2016) :
  - 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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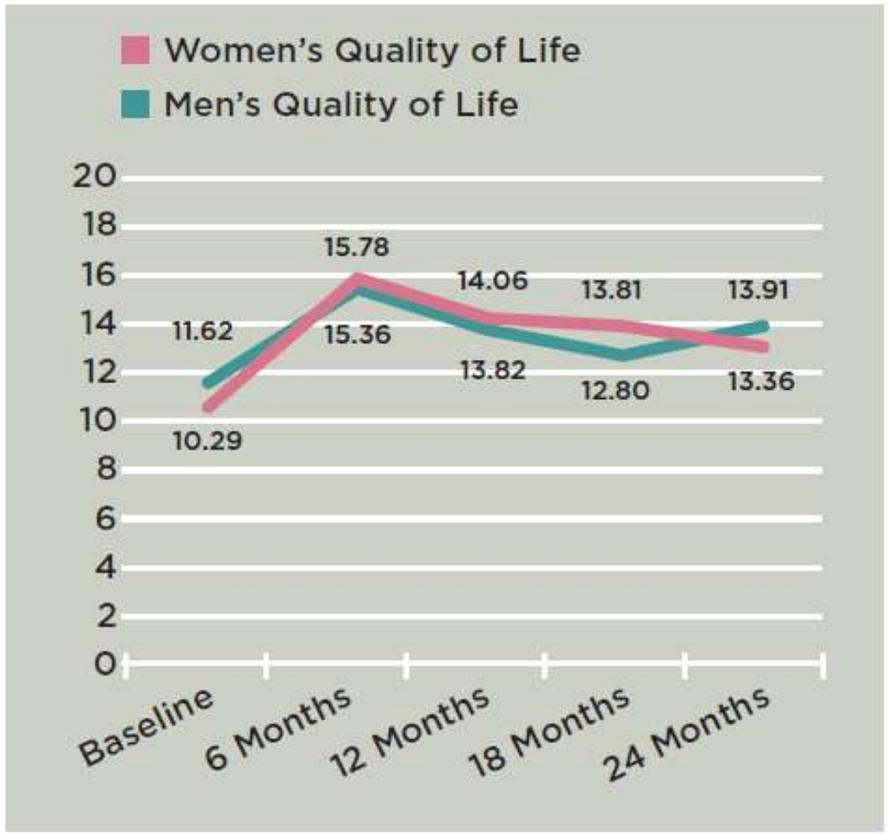
PATHWAYS THROUGH TREATMENT: A MIXED-METHODS LONGITUDINAL OUTCOMES STUDY OF COOLMINE THERAPEUTIC COMMUNITY

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 TC RESIDENTS' PROGRESS AND OUTCOMES

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- Increasing focus on routine monitoring in (mental) health care + introduction e-health systems
- From objective indicators to subjective experiences
  - Focus on PROMs and PREMs, also in mental health care
  - Development of specific tools to measure PROMs and PREMs, e.g. ICHOM Addiction Supplement

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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, and 24 months
- New entries between January 2018 and March 2021 (n=145)
- Computerised assessments using the MANSA (Priebe et al., 1999)
  - Objective as well as subjective indicators of QoL
  - Measured on a 7-point Likert scale
  - 5-10 minutes to complete

- Qualitative assessment of QoL among a small subsample (n=8)

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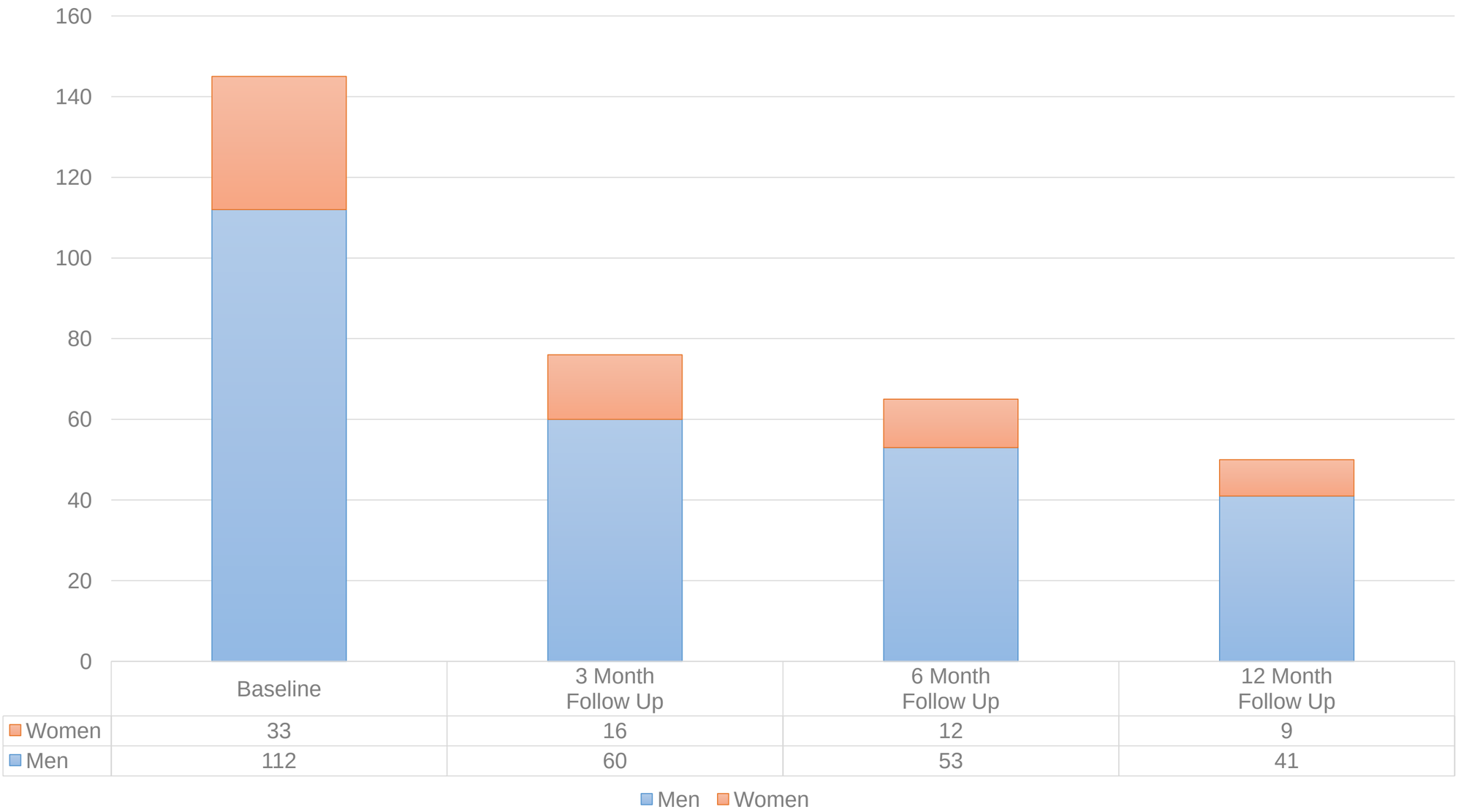
de kiem

Thanks to:
Luca Littera & Dirk Vandevelde (De Kiem)
Sam Baert & El-Amine Zerrouk (Ghent University)
Residents and staff of De Kiem



	Baseline	3 Month Follow Up	6 Month Follow Up	12 Month Follow Up
Women	33	16	12	9
Men	112	60	53	41

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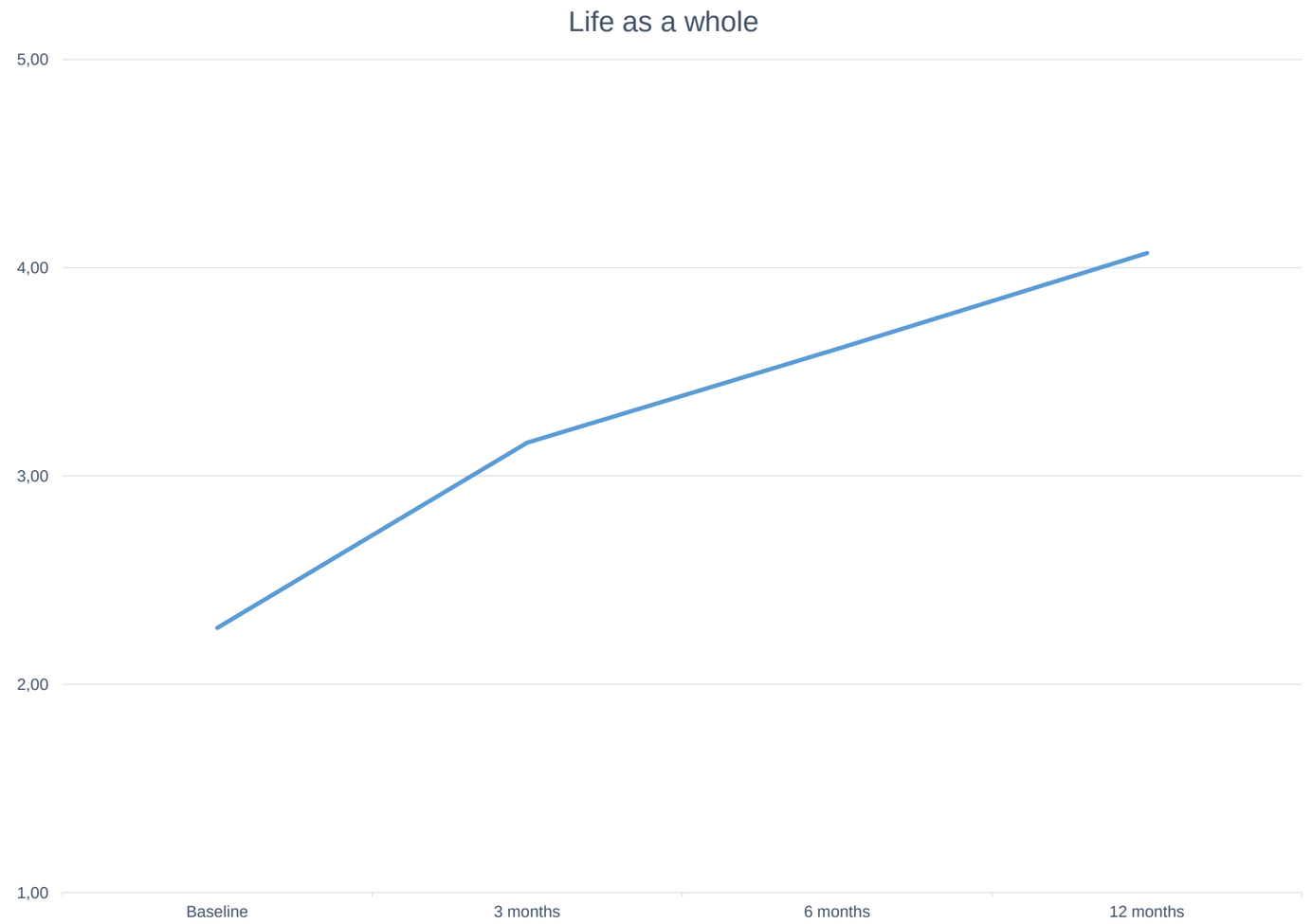
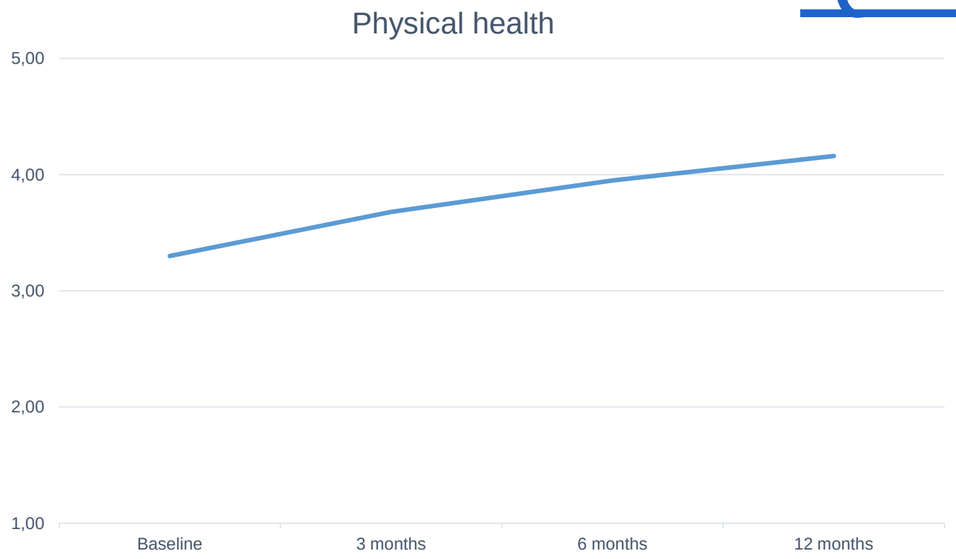
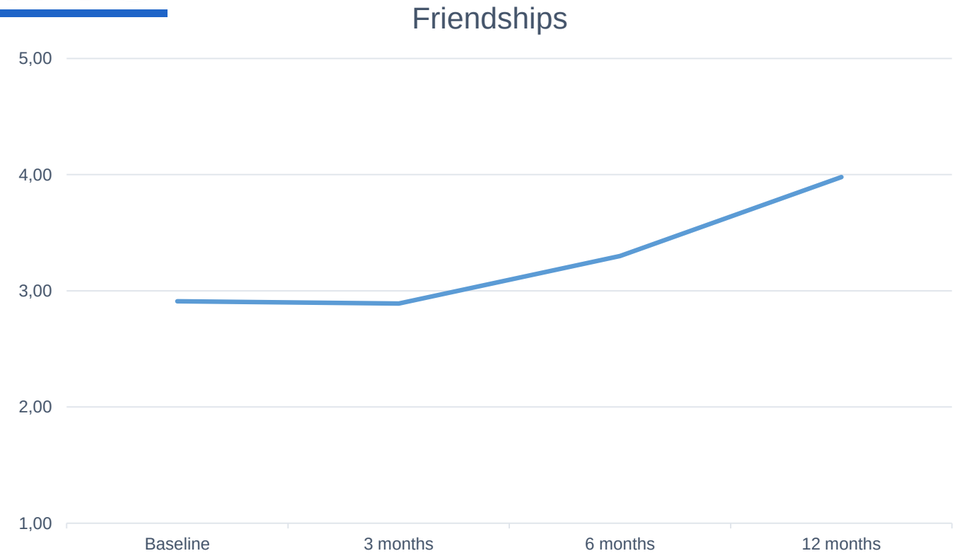
Satisfaction domains at baseline	Retainees	Dropouts	*P* value
Life as a whole	2,10	2,21	.533
Alcohol use	3,58	3,33	.547
Satisfaction with treatment	**4,80**	**4,45**	**.030**
Financial situation	1,46	1,73	.270
Drug and medication use	3,08	2,55	.159
People you live with	3,2	3,18	.969
Friendships	3,00	2,80	.454
Physical health	3,22	3,09	.655
Personal safety	3,96	3,81	.636
Family life	2,92	2,92	.902
Sex life	2,44	2,90	.130
Leisure activities	2,34	2,09	.291
Job/unemployment/retirement	1,58	1,82	.259
Accomodation	1,98	2,32	.285

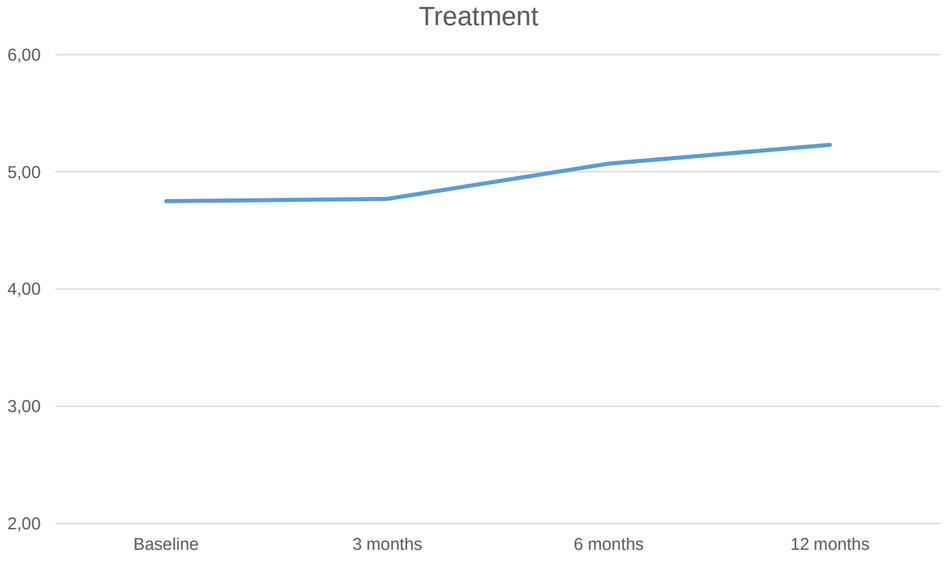
HOW DO YOU EVALUATE YOUR OVERALL QOL?



QOL DOMAINS







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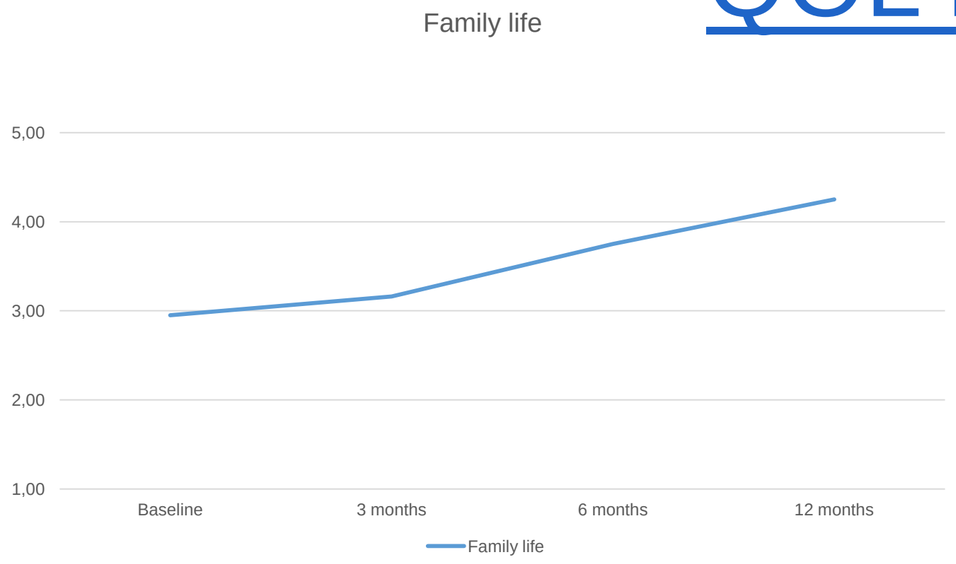
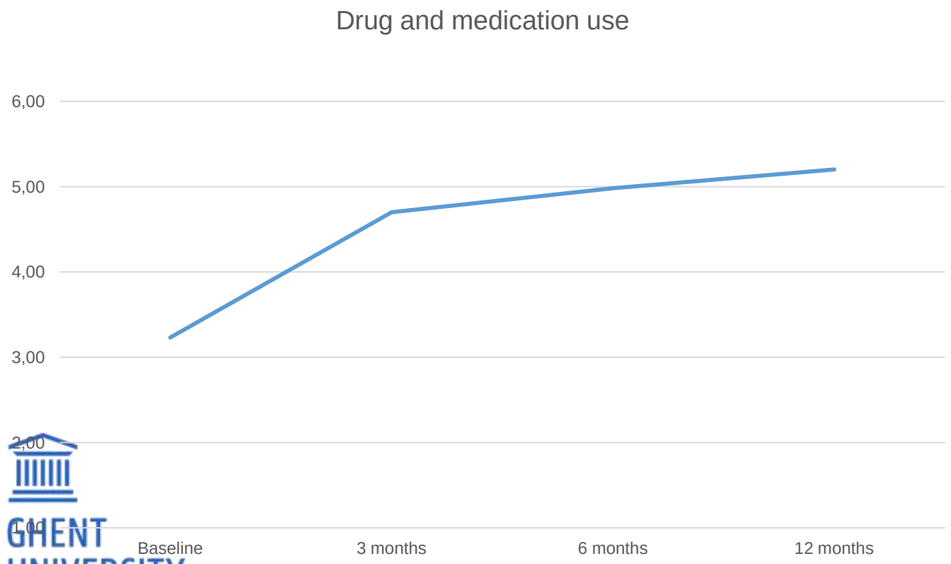
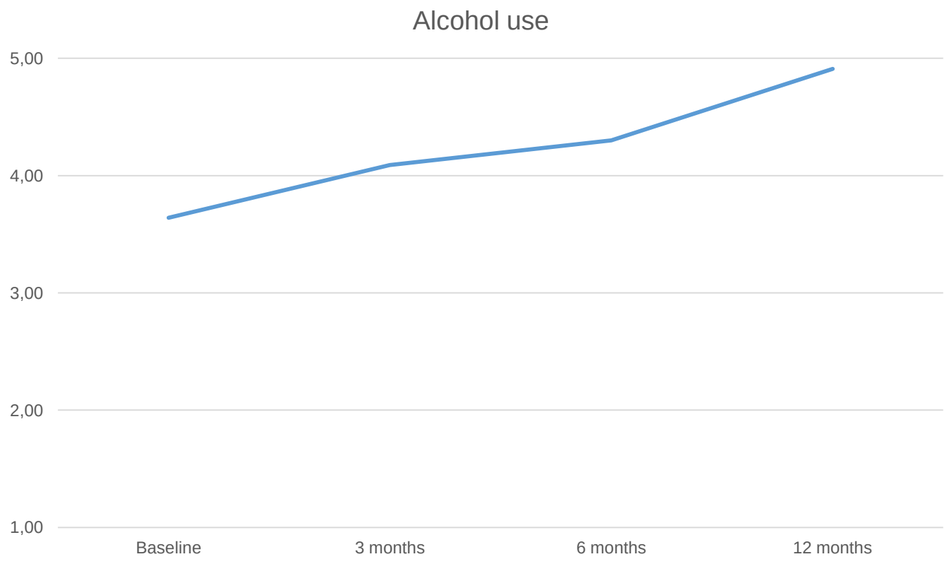
QOL DOMAINS







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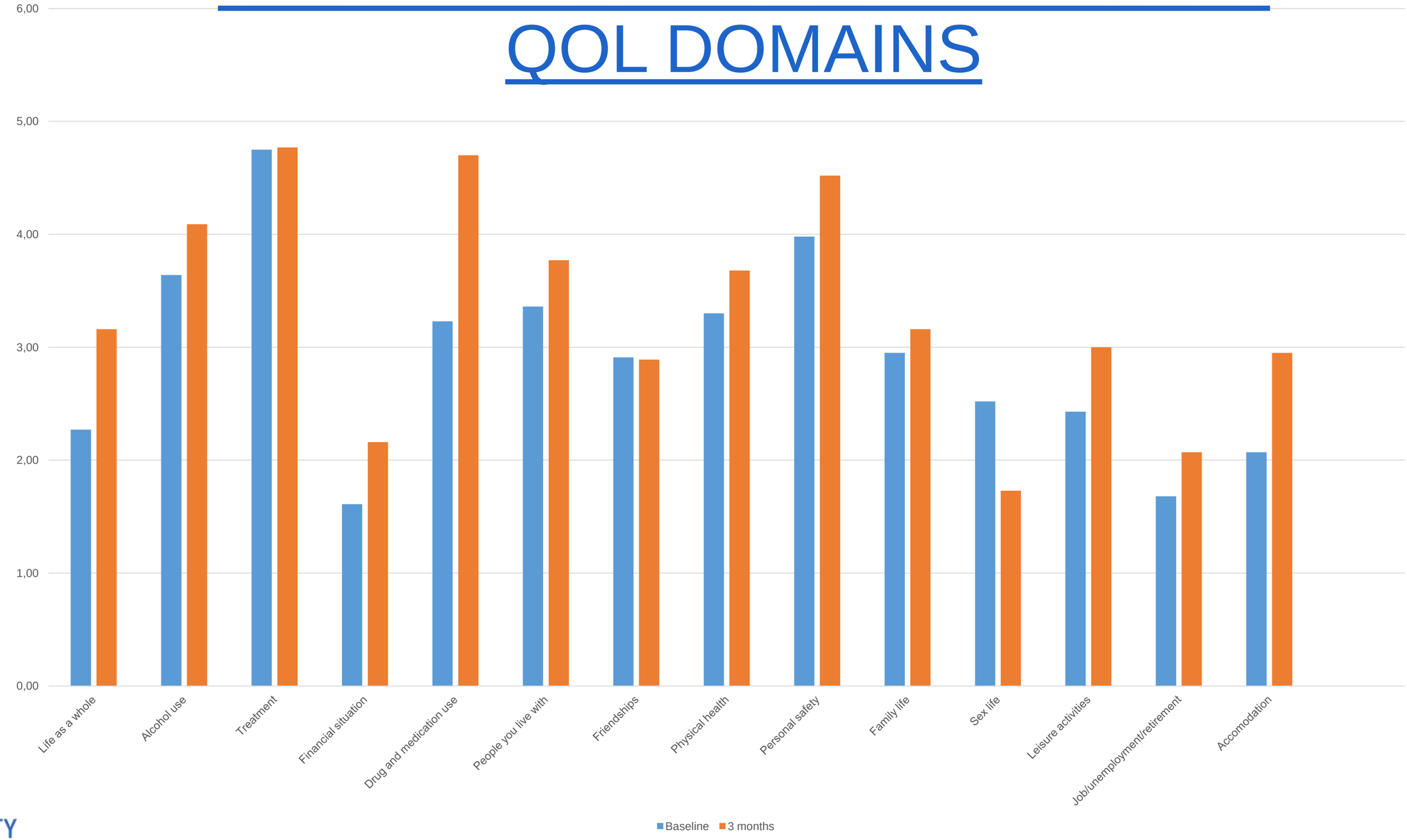
0 – 3M PROGRESS ON VARIOUS QOL DOMAINS



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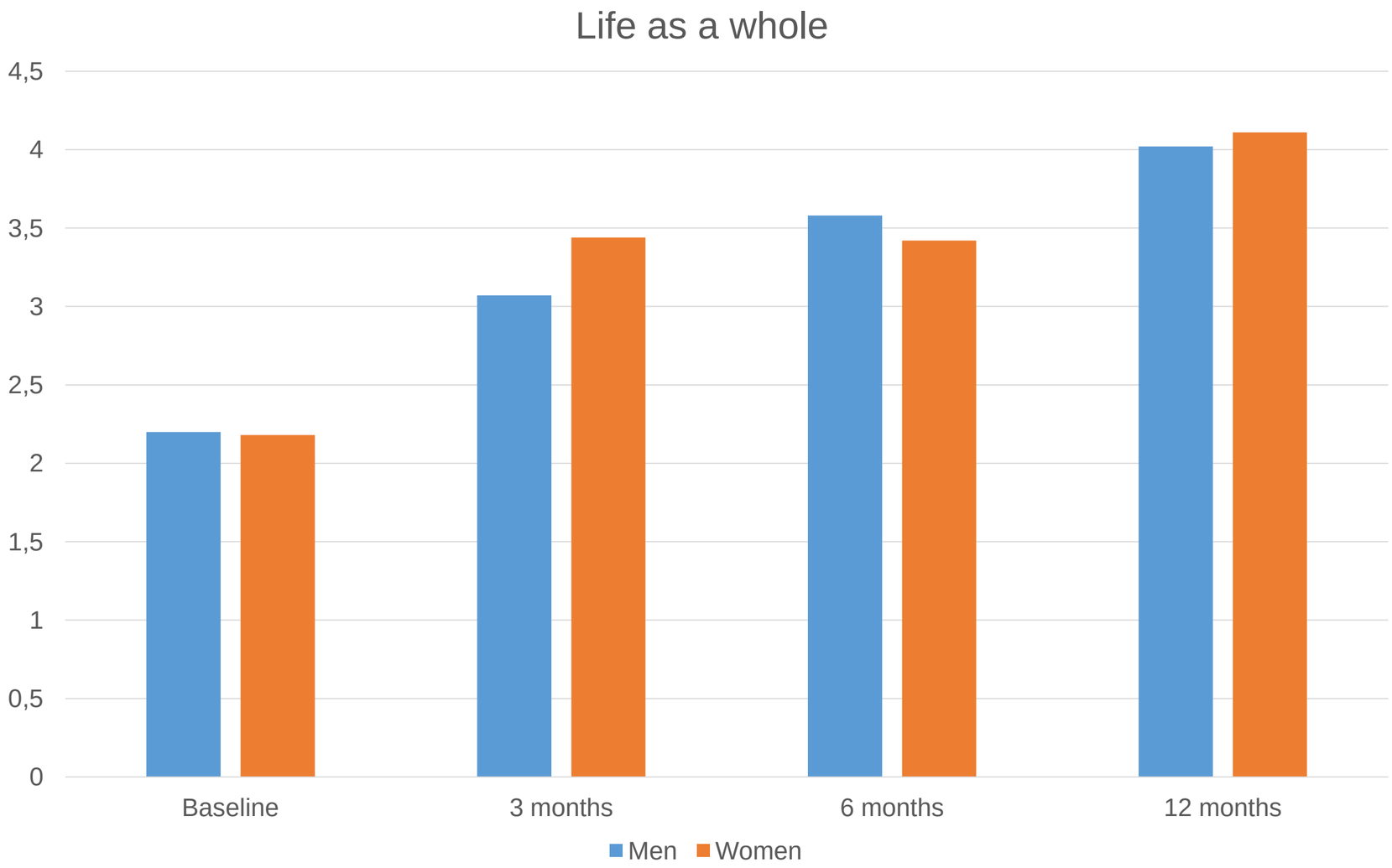
0 – 12M PROGRESS BY GENDER



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WHAT HELPED TO IMPROVE QOL DURING AND AFTER TC TREATMENT (BAERT, 2022)

Positive self-image

(belief in yourself, proudness, approval)

Meaningful relations

(connectedness, support, confrontation)

Independence

(control, agency)

Meaningful activities

(job, daily activities, hobbies)

Satisfying life

(dreams & expectations, new lifestyle, belonging)

Encountering the past

(losses, source of motivation, new life)

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LESSONS TO BE LEARNED

- Important to monitor QoL and subjective ‘patient experiences’ during TC treatment
- At least 1/3 TC participants has a significantly better QoL on all outcome domains one year after starting treatment
- Being not satisfied with treatment is from the start an important predictor of drop-out
- Significant improvements in QoL were observed on all domains, except one
- Substantial drop-out, despite intensive efforts from the staff, but hard to reach those who left De Kiem
- Need to look at global functioning and severity of dependence, beyond QoL

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THE USE OF QUALITY STANDARDS TO GUARANTEE THE TC AS METHOD

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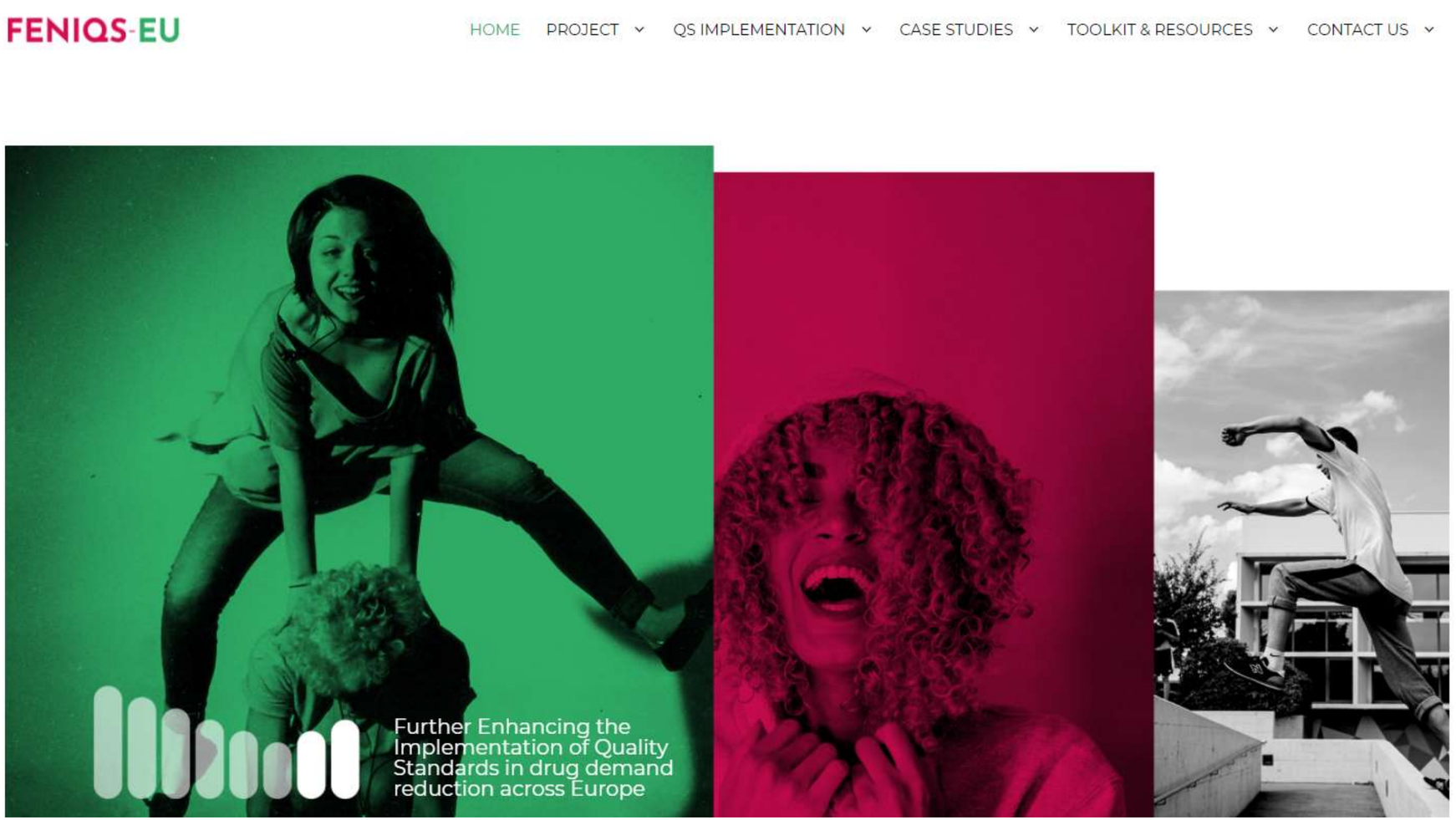
FENIQS-EU project on the implementation of QS

- https://feniqs-eu.net/



FENIQS-EU
Further Enhancing the Implementation of Quality Standards in drug demand reduction across Europe

Quality

- Quality - a very broad concept with no clear definition

Service availability	Safety & hygiene	Educated and competent staff	Service user engagement	Individualised approach

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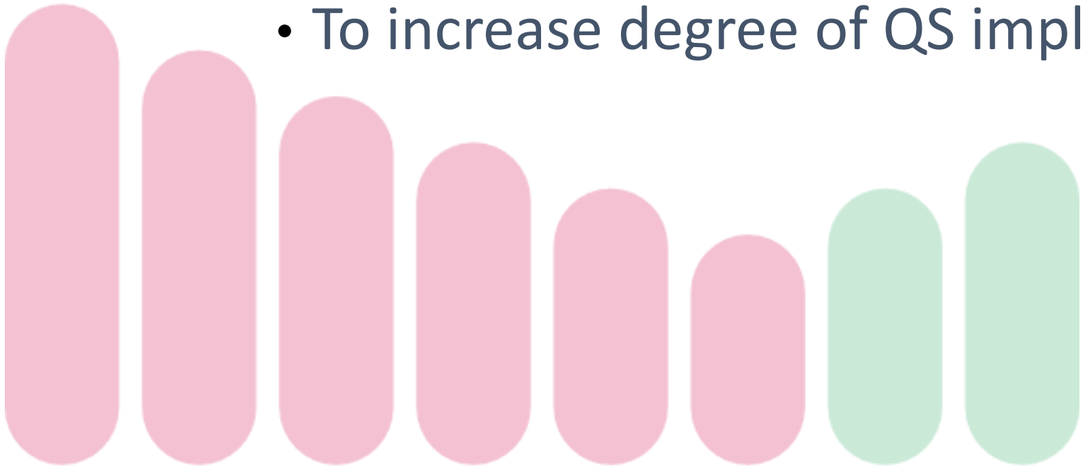
FENIQS-EU

Further Enhancing the Implementation of Quality Standards in drug demand reduction across Europe

On the need of QS implementation

Why are they needed?

- To enhance accountability and provide minimal quality guarantees across and within countries
- To improve quality of service delivery (individualised + continuing care, effectiveness and efficiency)
- To increase transparancy and facilitate evaluation and feedback procedures
- To increase degree of QS implementation in daily practice



What are QS?

- Generally accepted principles' or 'sets of rules for the best/most appropriate way to implement an intervention' (EMCDDA, 2013).

Processes	Structure	Content

- Expected requirements for a (minimum) level of quality

- E.g. Minimum Quality Standards (2015):

Treatment
- III. a. Appropriate evidence-based treatment is tailored to the characteristics and needs of service users and is respectful of the individual's dignity, responsibility and preparedness to change;

Treatment
- III. e. Treatment is provided by qualified specialists and trained staff who engage in continuing professional development;

EU and international context

- 2011 EQUS project (consensus-based minimal set of QS for DDR)
- 2015 EU Council conclusions on the implementation of minimum quality standards (MQS)
- 2020 UNODC standards (prevention / treatment)
- WFTC Standards and goals for TCs
- Community of Communities (C of C) quality improvement and accreditation programme for Therapeutic Communities (TCs)
- COPOLAD Project for the Validation and Piloting of Quality Standards in Drug Treatment in Latin America

A wide range of QS is available, but these standards are not widely applied and implementation varies substantially between countries!

FENIQS-EU

The main challenge remains:
How to better implement/apply QS in daily practice
+ what tranferable lessons can be learned from interesting practices?

CONCLUSION

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THE VALUE OF TC'S IN THE 21ST CENTURY?

- TCs promote change/recovery and contribute to QoL 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)
  - …

- TCs as unique method and model for (residential) drug treatment
  - Documenting and monitoring service user outcomes and experiences
  - Providing and setting quality standards
  - Not a stand-alone treatment, but as part of a network of services including
    - Adequate screening/referral
    - An integrated approach, including a clear vision, smooth transitions, case management, …
    - Continuing care : aftercare services, recovery housing, NA/AA meetings, recovery monitoring, …

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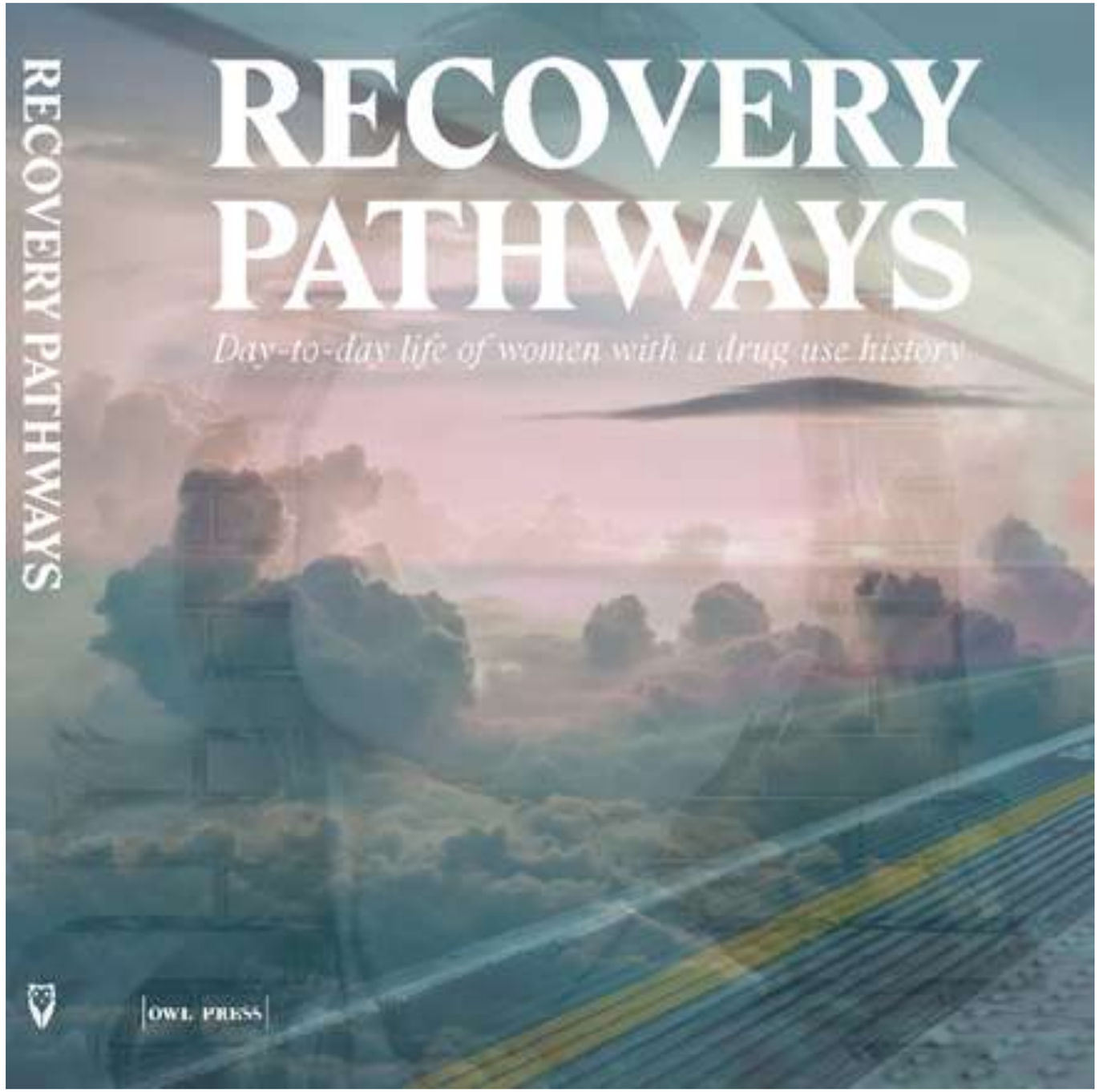
PHOTOBOOK ‘RECOVERY PATHWAYS: DAY-TO-DAY LIFE OF WOMEN WITH A DRUG USE HISTORY’ (OWL PRESS)

HTTPS://VIMEO.COM/525544742/12BF08E24B



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